To the Graduate Council:

I am submitting herewith a thesis written by Christopher F. Meyers entitled "Freedom, Autonomy, and Responsibility." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Philosophy.

George G. Brenkert, Major Professor

We have read this thesis
and recommend its acceptance.

Accepted for the Council:

Vice Provost
and Dean of The Graduate School

FREEDOM, AUTONOMY, AND RESPONSIBILITY

A Thesis

Presented for the

Master of Arts

Degree

The University of Tennessee, Knoxville

By

Christopher F. Meyers

June 1985

DEDICATION

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

ACKNOWLEDGEMENTS

I wish to acknowledge the following persons for their help with this thesis: Rem B. Edwards, whose graduate seminar provided the original impetus for this work; Glenn C. Graber, whose constructive comments always provided me with helpful guidance; and George G. Brenkert, both for his perceptive comments and for his ability to persevere through periods of adversity. Special thanks to Dolores A. Scates, whose dedication helped preserve my mental health through times when it otherwise surely would have been lost. Finally, to my mother and stepfather, Diana Meyers Bahr and Ted Bahr, and my wife, Cynthia Grigsby-Meyers, I have an incomparable gratitude for their continuous, unqualified support.

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.

Through analysis of four contemporary accounts I attempt to show the following. First, autonomy is distinguishable from negative freedom in that considerations which constrain one's ability to be autonomous (e.g., illness, institutional factors, social roles, etc.) do not constrain one's negative freedom. Second, the status of being autonomous admits of degrees; i.e., one can be more or less autonomous with respect to any given situation. Third, the characterization of being autonomous that best captures these points and that provides the most guidance for the applied ethicist is that of being dispositionally responsible for one's life. In making this third point I emphasize the agent's identification with significant aspects of his/her life.

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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 springboard or a justification for any number of positions, ranging from informed consent to non-governmental interference of 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 all referring to the same concept . . . " (Dworkin, 1981, p. 203). In fact, it is clear that the term is used in distinctly different ways in the medical ethics literature. As a result, there frequently is a large discrepancy in ethical recommendations (both in case-by-case analyses and policy determinations) that use the principle of autonomy as a foundation.

I, too, for reasons that I hope will become clear in this work, place enormous importance on respect for autonomy. Further, I think a principle of autonomy which is based on a solid account of what it means to be an autonomous individual can be of great practical benefit for the applied ethicist.

As such, the goal of this work is to gain a fuller understanding of what we mean by "autonomous individual." I will not be attempting to give a strict definition of the concept of autonomy. Instead, I will be pointing to what is involved in being autonomous, what it is for a person to be autonomous. I will do this, first, by looking at the ways the

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

notion is used in contemporary literature; second, by looking at the kinds of constraints that can impede autonomous behavior; and, third, by looking at why being autonomous is a unique and special status.

The organization of the work will be as follows. In Chapters I and II, I examine two contemporary and respected versions of what is involved in being autonomous. Chapter I focuses on Robert Veatch's libertarian views in which he essentially identifies being autonomous with being free. I hope to show that his position is both simplistic and results in a serious inconsistency. However, it does provide us with a good starting point for further discussion.

Chapter II is devoted to the views of Tom Beauchamp and James Childress. In formulating their concept of autonomy they rely on Kant's notion of self-governance as well as on the kinds of Millian libertarian views to which Veatch appeals. In explicating Beauchamp and Childress' views, I will be pointing to some flaws in their interpretations of Kant and, especially, of Mill. Further, I hope to show that since their position is in many ways naive with respect to clinical realities, it is difficult to use as a guide for conduct. That is, it is not clear how their notion is applicable to problematic clinical situations.

Using the formulations explicated in Chapters I and II as a base, I shift emphasis in Chapter III, using Terrence Ackerman's work as a guide. The goals here are twofold: first, to examine what it is we are trying to accomplish in our respect for autonomy; and, second, to broaden the scope of what sorts of things act as constraints on autonomy. With respect to the first goal, Ackerman argues we are attempting to establish or affirm an individual's control in a given situation. He goes on, in

response to the second goal, to show how illness can create constraints on an individual's ability to have such control.

Chapter IV takes Ackerman's second point a step further to show how such things as economic, academic, institutional and social realities can represent constraints on an individual's ability to be autonomous. For these claims I rely on the work of Howard Waitzken, a medical sociologist working from a socialist perspective.

Finally, in Chapter V I attempt to provide a view of autonomy that links it with an individual being responsible for his/her life. In doing this, I attempt to explain what it is about being autonomous that we value so highly. Further, I point to ways in which this conception will be of more practical benefit than the standard conceptions. Part of that practical benefit results from a recognition that autonomy admits of degrees, a theme that crops up throughout the work. My arguments in this section borrow considerably from the work of Gerald Dworkin and S. I. Benn.

My intention in this work is that it not be destructive in nature. That is, while I am in many places quite critical of the views of the philosophers with whom I am working, my aim is to build on, rather than tear down, their claims. This is especially true of my arguments that some of the standard accounts do not go far enough. An example is my claim that Ackerman stops short in his analysis of constraints. My additions, though, are consistent with his arguments and I think that in many cases he would be sympathetic to my claims.

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. Though I suspect some subtle and possibly important differences may exist, I think they are not crucial to this particular enterprise.

Along those same lines, "liberty" (and/or "freedom") will be used in the sense of "negative liberty" suggested by Isaiah Berlin.[2] That is, one is at liberty when there are no external constraints (using "constraints" here in the sense explained in pp. 5-8 below) upon one's actions. I choose this over the sense of "positive liberty" (i.e. "not freedom from, but freedom to" . . . The freedom to be "one's own master," including master over, "my own 'unbridled passions'" and irrational impulses. [Berlin, 1969, pp. 131, 132ff]) for two reasons. First, the use of liberty in the sense of "negative liberty" is most consistent with ordinary usage of the term. That ordinary usage is more often affiliated with <u>political</u> liberty and is primarily concerned with whether there are legitimate interferences on one's liberty and if so what kinds. For example, when Ronald 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.

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[2]Isaiah Berlin, <u>Four Essays on Liberty</u> (New York: Oxford University Press, 1969).

What philosophers have meant by "positive liberty" seems more alligned wth our ordinary conceptions of, e.g., "having character," "being spiritually upright," and, often, "being autonomous." This is not to suggest that positive liberty has no political connotations. It is a prevalent concept in Marxist and other socialist literature. My point, rather, is that the use of "freedom" in contemporary popular contexts is intended in the sense of negative freedom. (My own account of autonomy will bear strong resemblances to "positive liberty," though I will not define autonomy in terms of a "true self," nor will I insist that autonomous actions necessarily be rational.)

However, there obviously is considerable debate as to whether a term's ordinary usage is its correct usage. Not wishing to step into that bloody fray here, I also appeal to my second reason for using liberty in the negative sense: most of the authors on whom I will be commenting use liberty (and freedom) in this same negative way.[3] Despite this common philosophical use, I think it is legitimate to ask whether such a concept of liberty is ultimately plausible; that is, is it possible to have actions that are in no way externally constrained? The answer to that ultimately will depend on how loosely or tightly one defines the term "constraint," which leads to my second point of clarification.

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[3]Waitzken, especially, is the exception to this claim. As such, there will be quotations in which his use of freedom is much closer to what I mean by autonomy.

As I will be arguing more fully later, the notion of autonomy I will be defending 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."[4] Miller, consistent with most other writers on this topic,[5] distinguishes between obstacles which are the result of human agency and natural physical obstacles (e.g. my inability to overcome the natural physical obstacle of gravity in order to jump ten feet high). To this effect, Miller distinguishes between that which causes someone to be "unfree" (an awkward locution that, unfortunately, seems to be gaining wide acceptance), 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 (as opposed to being merely an obstacle or restraint) 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, 1983, p. 72). Without going into the details of his argument, I merely note that he wants to make the notion of constraint narrow

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[4]In Ethics, Vol. 94, no. 1 (October, 1983), pp. 66-68. For other accounts, most of which overlap with Miller's account, see: Cheyney C. Ryan, "The Normative Concept of Coercion," Mind, Vol. 89, pp. 481-498; and Roland Pennock and John Chapman, eds., Coercion (Chicago: Aldine Atherton Inc., 1972), especially the articles by Bayles, Gert, Held and Weinstein.

[5]A possible exception to this might be John Rawl's discussion of natural assets and physical attributes in A Theory of Justice, especially section 77.

enough so as not to include all obstacles to a chosen end (e.g. I am not unfree to ski Stowe Mountain in the middle of August) and broad enough to include acts of omission as well as acts of commission (e.g. having arranged a one-chance financial transaction over a piece of property I own, I extract a promise from Fred that he will bring the property's title to the meeting. He forgets, thereby constraining my freedom to manage the deal). In these latter kinds of cases (primarily, but not strictly, associated with negligence) the responsible actor need not have intended the result. His/her responsibility is due, rather, to some sort of obligation s/he has to bring about or maintain a given end.

His insistence on moral responsibility, though, does not entail any necessary claim as to the justificatory status of the constraint. There are, he argues, justified constraints on freedom (e.g. Fred forgot to bring the title because he was occupied with saving someone from an automobile accident). Also, he explicitly argues that "some other person or persons" can include institutions or corporations, so long as it is "possible in principle to point to one or more individuals who contributed to the outcome intentionally or in dereliction of duty" (Miller, 1983, p. 81).[6]

While there are some difficulties with his argument (e.g. his notion of "morally responsible" is not spelled out and its reliance on an "obligation to see that the basic needs of everyone else are met"

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[6]For 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, Fall, 1983, pp. 33-44.

[Miller, 1983, p. 80] is at best tenuous), I think he is on the right track as far as constraints on freedom are concerned. As such, if autonomy entails freedom, all such constraints on freedom also represent (potentially justifiable) constraints on autonomy. While his account is useful for understanding constraints on freedom, it excludes elements that are constraints on a person's ability to be responsible for his/her life, and, I hope to show, are thereby constraints on autonomy. I have in mind such things as economic and academic realities[7] and the constraints Ackerman contends result from illness.[8] In the first two there need not be a "person or persons who are morally responsible for (their) existence." Economic realities and academic attitudes often have little or no direct connection to the activities of a person or persons. The third case, constraints resulting from illness, is even more problematic for Miller's account. 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 wants to

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[7]See Chapter IV. Throughout this work, and particularly in Chapter IV, I will be assuming a "structuralist" account of certain social and/or economic entities. That is, I hold that some of these entities have an identity that supervenes the individual persons who make them up. Hence, these entities can affect (and I hope to show in Chapter IV, constrain) persons' autonomy without there being a direct connection between those affects (constraints) and an individual or individuals (a necessary component of our understanding of a constraint on freedom). As I noted above (p. 5), I think autonomy is distinguishable from freedom at least in part because of these constraints in which there is no person or persons who may directly be held responsible for their existence. This point will be elaborated more fully in Chapters IV and V.

[8]See Chapter III.

claim that there is a general moral responsibility to cure all illness, a position I find untenable). Nonetheless, I hope to show in succeeding chapters how these elements do represent constraints on autonomy, even if we would not want to call them constraits on freedom.

What, then, is an adequate definition of "constraints on autonomy"? I find myself at a loss to provide a precise answer. It seems that such a definition would show that such constraints sometimes involve some sense of human involvement (e.g. economic and institutional realities) though they need not (e.g. illness-generated constraints). It will also show that the constraints would have some moral component, at least in the sense that in the best of all possible moral worlds these constraints would not exist. It is also important to stress that constraints, either on freedom or on autonomy, need not render one totally unfree or totally nonautonomous. As I will argue in the fifth chapter, both of these concepts allow for gradation. Further, as shown above, such constraints sometimes may be morally justified.

A third and final point of clarification involves the difference between respecting and promoting autonomy. Are or should we only be doing the former? It might be argued that promotion of autonomy represents a contradiction in that in promoting one's autonomy, we necessarily are interfering, in at least a loose way, with that person's decision-making. But, as I will be arguing against the view that respect of autonomy means noninterference, that objection falls aside. Nonetheless, we still are left with a problem. While there clearly are some morally significant differences between the claims that persons have an obligation to promote, as opposed to respect, another's autonomy, it is not always

clear how those differences are or should be revealed in the clinical setting. In some situations we seem to have an obligation to respect, in others to promote. While I think these are important issues, I will not attempt to give direct answers to them here; instead, I hope much of what I will be discussing in the thesis will give some indirect answers and will point to areas of possible future elaboration. In the meantime, my focus will be on the obligation to <u>respect</u> autonomy.

CHAPTER I

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. As such, he devotes attention to the conditions that need 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. In agreement with Nozick he states, "Freedom of the contractor must be acknowledged prior to the contract. It is a necessary condition for contracting . . . " (Veatch, 1981, p. 193).

However, Veatch equates freedom with liberty, and autonomy. A few of the numerous possible quotations that suggest this equation are:

> Morality implies responsibility for one's actions in some way and responsibility requires some action of freedom or autonomy of thought and action (Veatch, 1981, pp. 192-193);
>
> Would rational people taking the rational point of view find it necessary to include the principle of autonomy as one of the basic principles for the society in addition to the principles of beneficience and promise keeping? Time and time again, 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).

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

I shall argue that Veatch's discussion of autonomy is comparable to those often given in discussions of freedom in the negative sense described in the Introduction. While he does discuss, especially in his references to Kant, concepts more frequently affiliated with a broader notion of autonomy than negative freedom (e.g. "self-legislation" and "self-determination"), he does not draw a distinction between those concepts and negative freedom. At the very least he needs to show that these distinct concepts might each be elements of a complete explication of autonomy. Instead, he uses each of the terms as a substitution instance for each of the others and for autonomy.

Veatch never gives an explicit definition of autonomy. However, he approaches the concept from two directions, and from these I think we can extrapolate the meaning he has in mind.

Autonomy as Negative Liberty

The first approach evolves out of his treatment of "positive" and "negative" 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. In fact, despite his claim that entitlement rights are "related" to autonomy, he leaves consideration of them to his chapter on justice and devotes all but one page of his chapter on autonomy to negative rights.

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. While coming down on the side of egalitarianism, he does so saying that it will often result in the restraint 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).

Hence, autonomy for Veatch is almost exclusively involved with negative rights. 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). These negative rights are those affiliated with negative freedom, with not having one's free choices constrained. (He never gives an explicit explanation of what he means by "constraint", but the overall discussion suggests something akin to the Millerian sense described in my Introduction). His explanation of the nature of negative rights concludes with an express linking of autonomy with negative freedom: "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).

While 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 classical question of 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 most telling example here is of the "substantially voluntary [autonomous] individual" who commits him/herself to a mental institution [Veatch, 1981, p. 196]), it is still necessary that the actor freely (autonomously) choose to surrender part of his/her freedom (autonomy).

Throughout this first approach to the concept of autonomy, Veatch repeatedly identifies autonomy with negative freedom. His emphasis is placed on the individual and his/her ability to freely act. The end of this chapter and much of the thesis will be devoted to showing that such a position is simplistic and does not adequately account for the wide range of constraints on autonomy. Before turning to that, though, we need to look at Veatch's second approach, as it seems to suggest a broader notion of autonomy. As we will see, though, this second approach results

in a position that, depending on how one interprets a couple of ambiguous passages, probably involves an inconsistency.

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 this case study 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. His answer is to question the women in the obstetrics unit.

> 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).

This recommendation is doubly revealing of his philosophy. First, it again reveals the emphasis he places on non-interference of persons' freedom. If (at least five percent of) 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. The "inconvenience" would be compounded by having to ask each patient whether she would want to be informed. Veatch is trying to avoid

that further inconvenience by, in essence, getting a large enough confirmation (five percent) from a sample group. (Also, the process of asking the patients, given the subject matter, would have the same effect as telling them). The results from the sample group (Veatch seems unconcerned with whether it represents a true sample) would be extrapolated into future groups. His point is that in order to protect the future "five percent" all would have to be informed.

His underlying point here is that because the five percent have chosen to be informed, not informing them would be a violation of their negative rights of noninterference (i.e. of their autonomy). Because the other 95 percent have not so chosen, none of their rights are being interfered with. It is significant that, unlike many writers on this topic, Veatch does not include the right to be (more than minimally) informed[2] in the category of positive rights and thus, for him there is no obligation for someone else to provide that information. Obtaining more than the minimal amount of information necessary for taking a free action, since it is not a positive right, becomes the duty of the patient, if it is a duty at all. This point will come up again in Veatch's discussion of autonomy as an "inalienable" right.

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[2]He later argues (p. 200-207) that in order to make voluntary (autonomous) decisions one must be at least minimally informed. Though he is not explicit, his arguments imply that patients do have a positive right to be told that information the "reasonable person" would need to make a competently voluntary decision. I take it that in the above example the information in question is not of this required sort. As we will soon see, such information, though not subject to positive rights, is necessary, according to Veatch, for responsible decision-making.

The primary issue here is that even if utilitarian considerations suggest no need for the patients to be informed—no significant harm will be incurred by the patients if they are not told, if they are left ignorant of the whole procedure, and some minimal harm ("inconvenience") may result from their being informed—the autonomy of the five percent must be respected. Through this we get further confirmation of the emphasis Veatch places on not having one's free (autonomous) choices constrained. In addition, we see that, for Veatch, autonomy is a "right-making characteristic" that needs to be respected, even if utilitarian considerations suggest otherwise.

Veatch's conclusion in the placenta case also reveals, though, 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 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,[3] 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,[4] generates at least a prima facie duty 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 if having 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. It is crucial to clarify here a distinction between levels of information and unfortunately Veatch's own 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, amount of information is necessary for any free action. Without that minimal level, persons' actions are not competent and paternalism is justified (Veatch, 1981, pp. 195-196). However, more extensive information, even "critical"

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[3]In 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. Though Veatch never explicitly says autonomy is an inalienable right, I think what follows clearly shows that he thinks it is.

[4]Note the additional use of "if" preceding a proposition that we already know he does accept.

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."

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 an inalienable right 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 an individual" not to do what is necessary in order to act responsibly. This view (from his first approach to the question) tells us that being autonomous means freely choosing. If one freely (i.e. without constraint) chooses not to act responsibly, then the principle of autonomy demands that we respect that freely chosen decision. Hence the contradiction: how can the same principle of autonomy require that a person act in a certain way and require that his/her decision to not act in that way be respected as autonomous?

It might be argued that Veatch is simply expanding his view, that he has given up the simplistic "non-interference" view his first approach suggests, in favor of the second more sophisticated position. If this were true then the inconsistency would not be present. He would

not be holding two incompatible views; rather, he simply would be using the first as a foundation for the view he eventually wishes to adopt.

Veatch's own arguments show, however, that he is not taking this route. Directly after presenting the "autonomy as being responsible" argument, Veatch returns to his original 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).[5]

The principle of autonomy ultimately is, for Veatch, the principle of freely choosing. When the, never fully explicated, minimum conditions necessary for free choice are present, the agent is autonomous and must be respected as such, even when s/he is not informed enough to make a responsible decision. Hence, for Veatch, 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's reliance on the patient's right to freely choose is further revealed 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

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[5]Another inconsistency arises here. In his conclusion to the placenta case he argued that the 95 percent who did not wish to be informed nonetheless should be if the other five percent request it. Here he is saying it would violate their autonomy if they were.

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 the patient's voluntary consent; consent any free adult is capable of giving. If the patient consents to treatment, it is morally appropriate. If s/he does not, it is not. As before, this blanket conclusion reveals Veatch's lack of acknowledgement of how "free" decisions can nonetheless not be fully autonomous.

To quickly summarize, despite the section on "acting responsibly," Veatch ultimately defends the view that being autonomous is equivalent to negative liberty, to not being constrained ("interfered") 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. He does not take into account such considerations as power asymmetry, illness generated constraints, institutional coercion, etc. 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. Though he vacillates between accepting and rejecting this link, Veatch seems to recognize that there is a crucial connection between the concepts. A defense

of this position will be my major affirmative theoretical argument; i.e. given its intended use in applied ethics contexts, autonomy is best understood as "being as responsible as possible for one's life." Chapter V will be devoted to unpacking and defending this claim.

The second claim, 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 at least be conceded that society has the right to intervene to protect the welfare of individuals who are substantially nonautonomous, whose actions are essentially nonvoluntary . . .the 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 his/her status as an autonomous individual respected (Veatch, 1981, p. 196). By including these qualifiers Veatch (possibly without an 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 (i.e. voluntary, in his terms, or responsible, in my terms) behavior should be respected. And should these minimal levels differ in different therapeutic settings; i.e. should the same level of autonomous behavior be respected in a terminal cancer unit as in a family practice clinic? I will hope to show

in my fifth chapter that these questions are the ones with which the applied ethicist must be concerned. As it now stands, most theoretical analyses do not adequately account for morally significant situational variables.

CHAPTER II

BEAUCHAMP AND CHILDRESS

Despite the few suggestions to the contrary, I think it is clear from the preceding analysis that Veatch's use of autonomy is primarily associated with negative freedom. He pays only the slightest attention to the individual's psychological state and his/her moral development. That is, in his analysis of autonomy he seemingly is not concerned with the (source of the) moral rules that underlie actions. When he discusses self-determination he is primarily interested in negative constraints; i.e. what kinds of external influences are preventing an agent from acting in the manner s/he wishes to act. Veatch is right in recognizing that the concept of autonomy does involve negative liberty and any adequate treatment of it must be concerned with the constraints that impede liberty. However, of at least as much importance in any discussion of autonomy is the more Kantian notion of moral development and the self-governance which can follow such development.

Tom Beauchamp and James Childress recognize this in the second edition of Principles of Biomedical Ethics[1] where they argue that self-governance is a necessary condition of autonomy:

> 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

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

> present is a person autonomous (Beauchamp & Childress, 1983, p. 61).

Hence, for Beauchamp and Childress self-governance is a necessary condition that when combined with voluntary action-taking defines the autonomous person.

In using this definition Beauchamp and Childress have moved up a level in sophistication over Veatch. They recognize that though negative liberty is crucial to any account of autonomy, the two concepts are not identifiable. Some discussion of self-governance is also needed. For them, the autonomous person needs to be free (in the sense of negative freedom which Veatch focuses on) as well as to be an agent who chooses his/her own principles.

To substantiate these claims, Beauchamp and Childress 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. This chapter will be devoted to the following: first, I will outline their interpretation of Kant and discuss two areas in which their account is either misguided or inadequate. Second, I will show that standard accounts of Mill, of which theirs is one, place too much emphasis on his defence of libertarianism. Third, I will give a brief discussion of their views regarding the compatibility of being autonomous and complying with authority. I include this because I think it reveals some of their naiveté regarding clinical realities and because it leads into areas that will be expanded on in my final chapter.

For the most part Beauchamp and Childress' interpretation of Kant's conception is standard:

> "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).

This is the first of two areas in which Beauchamp and Childress' interpretation of Kant is inadequate. They do not give enough emphasis to Kant's argument that to be autonomous is to act in accordance with universalizable moral principles that are based in pure reason. The non-autonomous individual, for Kant, is one whose will is under control of any non-rational influence, be it external coercion (such as physical enslavement) or internal coercion (such as emotions, desires, etc.).[2] Hence, for Kant the term "rationally-autonomous" would be redundant. The autonomous individual is, by definition, rational; decisions based on non-rational considerations — his principal example is seeking happiness — are not autonomous decisions.

Hence, for Kant being autonomous necessarily means being moral and, hence, rational. As such, for Kant strict adherence to universal moral principles does not represent a non-autonomous life. He argues that any valid moral principle must be based on pure reason. Thus, the autonomous person, as rational, will by necessity choose valid, universal moral principles, i.e., the categorical imperative. In other words, the fully autonomous -- and thereby rational — person will necessarily choose the categorical imperative as his/her moral principle. Further, s/he will

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[2]There is considerable difficulty with respect to Kant here. Since the will, for Kant, is of the noumenal realm and cannot be affected by anything in the phenomenal realm, it is very unclear how it—the will—could be subject to any form of coercion, either external or internal.

have a duty to obey that principle — so long as it truly is based on pure reason (as the categorical imperative must be).

By linking autonomy with rational choice in this way, Kant anticipates an objection than an existentialist thinker might raise. S/he might claim that in giving absolute allegiance to universal moral principles, the individual is not choosing his/her actions but, instead, is relying on rules external to him/herself. But, as the above discussion shows, such rules, for Kant, are not external to oneself; they are expressions of one's true (rational) self. The debate here will ultimately rest on one's conception of the "true self," but it at least can be shown that Kant's argument can consistently appeal to the agent freely choosing to obey a universal moral principle (categorical imperative).

Beauchamp and Childress further substantiate this claim (that adhering to a universal moral principle is consistent with being autonomous) by noting that the moral principle is legislated by the individual; i.e. the individual is a self-governing person even while strictly adhering to the moral principle. This is not to say that each individual must "author" the moral principle. What Kant seems to have in mind, instead, is that through the rational process described above, the principle will, in a sense, be revealed. As Beauchamp and Childress put it:

> "Acceptance by the agent" needs emphasis. Kant is often interpreted as holding that each individual 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 I think 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 on pure reason and then as an autonomous (rational) individual s/he will accept that principle for him/herself.

The second aspect of Kant's view on autonomy that Beauchamp and Childress underemphasize is his metaphysical theory of persons and the ways in which parts of it demand respect for autonomous persons. Beauchamp and Childress point out that, "For Kant, respect for autonomy flows from the recognition that all persons have unconditional worth, solely as ends in themselves determining their destinies" (Beauchamp and Childress, 1983, p. 62). What they do not discuss is why it is that persons have unconditional worth. And what is it that separates persons from other entities? While these questions are not crucial to Beauchamp and Childress' account, answers should give us more insight into Kant's and (consequently) their views.

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

to be full members of the moral realm, and, hence, to have unconditional worth.

However, none of this is in conflict with Beauchamp and Childress' account; it merely represents an extension (and clarification) of their argument. Most of what they say about Kant is accurate and important to any concept of autonomy. Further, when this is added to their use of Mill, a considerably fuller and more engaging notion of autonomy emerges.

Mill and Liberty

A prefatory comment on terminology is needed. In my reading of Mill I have not come across an instance in which he uses the term "autonomy." However, in his chapter, "Of Individuality" in On Liberty,[3] he presents arguments concerning the development of "individuality" and of "character." I read his use of these terms to be similar to our use of "autonomy." As such, throughout this section I will be using the three terms interchangeably.

While Kant was mainly concerned with the kinds of moral principles chosen and the ways in which they were chosen, Mill was concerned that persons have the liberty to choose and to act upon that which was chosen, so long as those actions did not represent a significant harm to another.

Beauchamp and Childress rely heavily on this negative libertarian aspect of Mill's philosophy. (Veatch, too, only gives emphasis to the negative liberty claims of Mill). They present Mill's conception of liberty as being that the only justified interferences on a person are

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

those designed to protect the liberty of others. While such protection of liberty clearly was his primary goal, we must also keep in mind that Mill saw such protection as being valuable in part because it brought about other goods, i.e. the development of individuality, which in turn helped produce the greatest overall good for society. Further, he gave considerable attention to the conditins that need be present for a person to be able to make free decisions and thereby build character. When we include these additional elements of Mill's thought, his view is revealed to be considerably richer than the minimal negative liberty claims to which Veatch and Beauchamp and Childress appeal.

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, the autonomous person, thus is for Mill, the person who chooses "his plan of life," who does not blindly accept the dictates of others.

Mill presents the status of having character as being valuable for two reasons. The first seemingly 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. 77).

This and other quotations present this status as the epitome of what it means to be human. The development of such individuality "brings human beings themselves nearly to the best they can be" (Mill, 1956, p. 77).

However, Mill also presents a utilitarian argument for why individuality (autonomy) is valuable. In the above quotation regarding the "cultivation" of individuality, Mill goes on to say:

> [B]y the same process human life also becomes rich, diversified, and animating, furnishing more abundant ailment 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).

Hence, having character, being an autonomous chooser, is valuable for Mill in that it promotes the intrinsic good of "developing" oneself, while at the same time it promotes the overall good of the society. The converse of this is that the lack of such character represents a harm, both to oneself, and to others. It is not a harm in that someone's rights have been violated, but in that the most good has not been achieved. I will be returning to this point in a moment.

As I noted earlier, Mill recognized the need for some explication of what conditions must be present for a person to be able to be a freely choosing, autonomous individual. The first and most obvious condition is that they be at liberty; that, in the negative sense emphasized by Veatch and Beauchamp and Childress, they not have their actions constrained except when they represent a signficant threat to others.

But Mill also argued that not all person are competent to make free autonomous 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 affecting 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)[4] in which he extolls the virtues of laisser faire economic systems and disparages governmental interference in citizen's 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

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[4]J. S. Mill. Principles of Political Economy, Vol. II. This argument is also presented, in a less complete form, in the final chapter of On Liberty.

> 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, Vol. II, 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 accessable to all the children of the poor, either freely, or for a payment too inconsiderable to be sensibly felt (Mill, Vol. II, p. 576).

The implicit argument that justifies this governmental interference is: 1) Persons have more intrinsic value when they are allowed to develop their individual character; 2) Society as a whole will be improved, the greatest good for the greatest number will be enhanced, when persons are allowed to develop their individual character; 3) Developing individual character requires that persons be at liberty and have mature, developed faculties; 4) Some minimal amount of education is necessary for such development; 5) The restriction of the ability to develop individual character represents a harm to both individuals and the society as a whole; 6) Government has the right and the duty to prevent such harms; . . government has the right and the duty to secure those conditions necessary for the development of individual character, including the education of its citizens.

There are some problems with this argument. The move from it being valuable that individuality (autonomy) be developed, to it being a harm if it is not, needs at least some additional argumentation. Likewise

with the move from government having a right/duty to prevent harms (negative right/duty) to the conclusion that government has a right/duty to secure the necessary conditions (positive right/duty). But such a critical analysis is not my point here.

My primary motivation in presenting this argument is to show that while Mill's foremost concern was with recognizing and respecting individual liberties (as Beauchamp and Childress emphasize), he also stressed that such respect for liberties served other ends. The first is the (somewhat Kantian) notion of individuals choosing their own ends. The second is the claim that the restricting of such choosing represents a great enough harm that governments have the positive right/duty to secure the possibility of the development of individuality/character/autonomy. These additional elements move Mill beyond the negative libertarianism that he is frequently associated with and give his philosophy a considerably more complex and richer quality than Beauchamp and Childress explicitly acknowledge.

Autonomy and Authority

A final note of interest in Beauchamp and Childress' account of autonomy is their discussion of autonomy and authority. They question whether, as R. P. Wolff argues, being autonomous is compatible with unquestioning acceptance of authority. They claim that it is, but only after qualifying 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 reasons." That is, these authoritative figures, they argue,

have reached their status 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" place and continue to respect the authority figures because they have "justifying reasons" for doing so, e.g. the authority figure is the relevant expert in a given area. As such, acceptance of such authority is comparable to accepting the recommendation of a more technically competent advisor.

Two comments are in order. First, their view that positions of authority are confirmed or rejected by the "autonomous citizens" under them is quite naive with respect to political and medical 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. Hence, even though there are (in general) "justifying reasons" for medical practitioners having authority (i.e. they often are the relevant experts), those reasons are not always transferred into one-on-one interactions. That is, while the great majority of medical decisions are based on "justifying reasons," health care practitioners are not unknown to seek to maintain authority, with or without direct, immediate, medical justification.[5]

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[5]In fact, it has been convincingly argued that 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, Inc., 1982).

Given these medical/political realities, the kind of justified acceptance of authority Beauchamp and Childress defend can only emerge from a kind of fiduciary relationship in which the "weaker" party (in this case the patient) can be supremely confident that the "stronger" party (his/her medical practitioner) will be acting in the best interests of the weaker. Unfortunately much of the health care provided today does not allow for the establishment of such relationships. Most of the immediate care in major hospitals is provided by residents and interns who may or may not be familiar with a particular patient and who may or may not even remain on the same rotation for the 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 as to 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 autonomy that an autonomous person turn over the making of decisions to a more technically competent authority figure? It is if we understand autonomy to be a gradated concept with corresponding levels of obligation.[6] That is, in some circumstances (e.g. emergency situations) it may be the

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[6]Beauchamp and Childress, like Veatch, seem to recognize (without discussion) this 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 interesting that they include a section of determinations of competence and acknowledge a wide range of competency, but then do not directly apply that to their concept of autonomy.

wisest, most responsible/autonomous decision to give up some personal control and to place faith in the authority figure. However, in other, less immediately crisis-oriented circumstances, accepting fullest responsibility for one's own life would seem to require that autonomous persons question the directives of authority figures in all significant aspects of life.

One might question whether it would not be sufficient simply to accept the responsibility for giving one's life decisions over to another. But accepting the responsibility for one's decision/actions is not equivalent to living a responsible autonomous life, though it <u>is</u> a necessary part of what is involved. I will be expanding on this considerably in Chapter V, but suffice it for now to note that living a responsible life includes attempting to ascertain those elements existent in situations which will have a significant impact on one's life, which means not blindly accepting the dictates of someone in a position of authority.

Hence, while Beauchamp and Childress are correct in arguing that autonomy and authority are not incompatable, it is, as I will later show, because of the gradated quality of autonomy and not for the reasons they provide. Further, for a person in a position in which s/he has the reasonable capability to do so, questioning of even trusted technical advisors is legitimate and necessary for acquisition of fullest autonomy.

By combining the Kantian and Millian accounts, Beauchamp and Childress have moved up a level of sophistication over Veatch. Although their accounts of Kant and Mill are on the whole accurate and useful, they suffer from, in their account of Kant, an <u>under</u> emphasis of reason and of the metaphysical status of the entity in question and, in their

account of Mill, an over emphasis on his valuation of liberty. In general their account is lacking in two areas. The first is the great difficulty in applying their principle to practical situations. The second is their 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 next step in our analysis—identifying the nature and impact of these constraints—is I think, a predominant flaw in most contemporary accounts of autonomy.

Terrence Ackerman's views represent the exception. He places considerable emphasis on the psychological, physical, cognitive, and social effects of illness and shows how they can represent a constraint upon persons' ability to be autonomous. With this next chapter, we will be taking a turn away from strict conceptual analysis and toward a fuller understanding of some of the difficulties involved in stricing to be a fully autonomous individual. Chapter IV will continue this theme with a look at how social, economic, and institutional factors can further impede the attempt to be autonomous.

CHAPTER III

ACKERMAN AND "THE CONSTRAINTS OF ILLNESS"

Beauchamp and Childress, through their inclusion of self-governance, offer a considerably more sophisticated analysis of autonomy than does Veatch. However, their philosophy appears to rest on an implicit assumption that any person, so long as s/he is not substantially incapacitated through mental illness, is of mature years, and is provided with adequate information, will be capable of making autonomous decisions. Terrence Ackerman, in his article, "Why Doctors Should Intervene,"[1] takes this position to task.[2]

Ackerman has two major concerns in this article. First, he switches from a strictly definitional project to a discussion of what it is we are trying to accomplish in our respect of 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:

> 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 non-interference 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).

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

[2]Since publication of this article Ackerman has substantially altered his position. While he still wants to emphasize the debilitating effects of illness, he no longer sees them as being constraints on a person's autonomy; instead, he sees them as being constraints on a person's ability to achieve cherished goals or "personal growth." Following Dewey,

An explanation of the notion of "transforming effects" is his second major concern. These transforming effects represent, he argues, constraints upon an individual's ability to engage in autonomous behavior. And it is a description of the nature and extent of these constraints that make up the bulk of his article.

However, Ackerman is not using "constraints" here (and I am in agreement with him), in the same way that we heretofore have been using "constraints on freedom." I suggested in the Introduction to this work that the principal distinction between freedom and autonomy is that one can be free (i.e. unconstrained in the Millerian sense) and nonetheless have one's autonomy constrained.

This suggests two points. First, it suggests that autonomy is a broader concept than freedom. That is, if one can be free and have one's autonomy constrained, then the conditions necessary for (full) autonomy clearly are more inclusive than those necessary for (complete) freedom. I will give an explicit defense of this claim in Chapter V.

Second, if one can be free and have constrained autonomy, the definition of "constraint" provided in the Introduction needs to be

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he sees such an achievement as being that which all persons naturally seek. He further argues that the tradition of liberalism has attempted to promote this achievement through respect of the principles of autonomy, beneficence, and justice. And he now argues that since illness prevents the achievement of personal growth, the duty of beneficence require us to attempt to remove those constraints, even, at times, at the cost of violating a person's autonomy (personal correspondence, including a yet to be published manuscript, July, 1984).

I include the earlier version of Ackerman's position here because I find it intriguing and valuable to fully understand autonomy. Further, it is a position that I have found in my clinical experience to be attractive to medical personnel.

distinguished from the now intended use. That is, in the Introduction we defined a constraint on freedom as being that restraining condition the existence of which "some person or group of persons has direct moral responsibility." What I hope to show in this and the subsequent chapter is that there are conditions which constrain individuals' autonomy even though there is no person or persons who have direct moral responsibility for their existence. Hence, just as "autonomy" is a broader notion than "freedom," "constraints on autonomy" is more inclusive than "constraints on freedom."

I also noted in the Introduction that I am at a loss to provide a precise definition of the notion "constraints on autonomy." Instead, I will point to conditions that would not be included under "constraints on freedom" and show the ways in which they represent constraints on autonomy.

While I have not yet provided what I take to be the best characterization of "being autonomous," the analyses that accompany each of the new listed constraints point to conditions that I take to be crucial to such a characterization. Those analyses, in this chapter and in Chapter IV, will culminate in Chapter V, where the overall characterization of "being autonomous" is provided.

Hence, this point in the work represents a major switch in analysis. The notion of "constraint" is being broadened so as to indicate the differences between freedom and autonomy and, in the process, a new characterization of what is involved in being autonomous will begin to emerge.

It is important to note that despite his switch in emphasis, Ackerman maintains a fairly standard definition of autonomy; one that is very similar to the one 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).

Despite the similarity in definitions, Ackerman's project is, as noted, considerably different from those of Veatch and Beauchamp and Childress. Our task here is to look at those differences and see how they can benefit our understanding of what is involved in being autonomous.

What Respect For Autonomy Accomplishes

Ackerman sees respect of autonomy as valuable in that it serves as a means to another goal; however, there is considerable confusion in the article as to the nature of that goal. He gives at least three answers, ranging from the substantially libertarian position of, interference is only justified 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 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,[3] Ackerman's third answer, the one which is given the most emphasis here—and it is an emphasis given by many writers on autonomy—is on control. He quotes Eric Cassell's argument that the loss of control is the most destructive element of illness and talks about how returning such control is "the doctor's job" (Ackerman, 1982, p. 16). By putting it in this way Ackerman (in agreement with Cassell) has removed some of the adversarial character of the doctor-patient relationship that is frequently portrayed in philosophical writings. His claim is that while there obviously will be specific doctor-patient interactions that are adversarial--as one will find in any interpersonal interactions—the doctor-patient relationship is not by nature adversarial. Instead, the mutual goal is to return patients' ability to retain control over their lives, control that has been reduced as a result of debilitating effects of illness.

By giving the issue this kind of slant Ackerman has given a substantially different approach to the notion of control. Most authors are concerned with patients having control within the immediate interaction and pay less attention to the patients' control over more general 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 decision-making powers (e.g. in the overcoming of patient denial), in order to give the patient more overall control of his/her life. In other words, his goal is not necessarily concerned

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[3]CF. the above cited unpublished manuscript, especially chapter 3.

with creating an equal relationship between physician and patient: "When people are sick, the focus upon equality is temporarily misplaced" (Ackerman, 1982, p. 16).[4] In fact, he argues, such inequality may be a necessary condition for the patient retaining general control of his/her life. As such, the emphasis of most writers is misguided in that it limits its focus on control to the immediate interaction and either ignores or underrates the importance of more long-term, overall control of a person's life-plans.

Ackerman has hit on an important and difficult notion here; namely, what is it we are trying to protect: the individual's autonomous control over specific decisions, decisions which may be inconsistent with other long-range decisions s/he may have made, or those long-range goals themselves? Positions like Ackerman's, while in many ways attractive, imply the problematic conclusion: a) that the individual "under the influence" of a debilitating illness is in an important way a different person than the one who has made the long-range decisions; and b) that that latter person is the one to whom we owe our moral obligation to respect autonomous control. This conclusion results from the view that while we have an obligation to respect an individual's autonomous decisions that promote long-term control, we have at most a limited obligation to respect an individual's autonomous (though lessened by illness) decisions that promote immediate control, if those decisions

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[4]It 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 kinds of constraints listed in Chapter IV.

are inconsistent with the long-range goals. In fact, it seems, according to Ackerman, that we have an obligation not to respect those inconsistent 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 his/her long-range goals; we do not consider them to be another (morally second-class) person. We may disapprove of that decision and attempt to convince him/her to alter the decision;[5] however, so long as we regard them as competent, we respect their right to have autonomous control over all aspects of their lives, the immediate and the long-range, even when the two are in conflict.

What is it, then, about illness that should cause us to change this moral attitude? The most frequent response (especially in cases of mental illness), is that the ill person[6] is made incompetent and thus is incapable of autonomous decisions. Ackerman does not use this language, though he does discuss how illness represents a constraint upon autonomy. But simply to talk of how illness represents a "constraint," or of how "autonomy is specifically compromised by illness" (Ackerman, 1982, p. 15, my emphasis) does not go nearly far enough. That is, unless one is advocating the position that I have been specifically arguing against, vis., that being autonomous is a black and white proposition, either one

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

[6]Ackerman never really distinguishes between the catastrophically ill and less severe ailments, nor does he discuss how his argument would differ between the two. This is a significant problem to which I will return in a moment.

is or one is not autonomous. If that were true then any constraint on autonomy would render the patient non-autonomous. However, such a position is, I think, mistaken, as we are constantly faced with greater and lesser degrees of constraint while maintaining our status as autonomous persons. Further, Ackerman gives no evidence that he accepts such a black and white position and there is some evidence to suggest the contrary. When discussing the impact of constraints on autonomous behavior he avoids use of terms like "prevent" or "prohibit," using instead the weaker notions of "impeding" and "interference." Further, his examples do not portray individuals devoid of autonomy. Instead, he presents patients who are capable of some, though often not enough, autonomous control.[7]

Assuming, then, at least for the sake of argument, that Ackerman agrees that one can be both constrained and autonomous, the issue returns to whether it is legitimate to afford less respect for an individual's autonomous decision-making (including the immediate control needed for such decision-making) because of illness-generated constraints on that individual. The options are three: one, we can argue the strange position that long-term goals (and the corresponding autonomous individual who made them), are more deserving of respect than short-term goals (and the corresponding autonomous individual who made them). This position would, at the least, have to be supported by arguments that self-identity, personhood, dignity, etc. were necessarily connected to long-term goals,

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[7]He has also confirmed this view in personal discussions (November, 1983).

decisions, and activities. Such arguments are not the primary focus of this work, nor do I think in the long run such arguments will be defensible.[8] However, I will work with these issues, to a simplified degree, in Chapter V.

The 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 we still have the same problem of attempting to determine whether long-term goals will better promote/achieve those ultimate goals. One can appeal to knowledge of the individual in question or to experience with similar cases and their retroactive gratitude, but that appeal will involve nothing close to certitude. That is, the defender of the second option is justifying the overriding of short-term decisions by appeal to knowledge based on analogous cases. Knowledge in these kinds of situations often will include the lowered respect for the patient's immediate choices (assuming that a conflict exists). Hence, it would seem that the justification of overriding short-term decisions needs to be grounded on a more secure foundation.

In other words, in either choice there will be a risk of mistake. Respect for immediate choices may involve a disrespect of current and future long-term goals. Or, on the other hand, respect for long-term goals may deny the patient the ability to change more long-term goals.

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[8]For such a defense see John Rawls, A Theory of Justice (Cambridge: Belknap Press of Harvard University Press, 1971), especially section 78. See also, Charles Fried, An Anatomy of Values (Cambridge: Harvard University Press, 1970), especially section 10.

But if we do not respect immediate choices there will be a necessary violation of the individual's right to choose his/her own course. Here, we seem to have a moral obligation to choose the course that involves the minimal amount of disrespect; i.e. we still have an obligation to respect a patient's immediate choices, even if we hold that some further goal holds greater moral precedence.

The third option is one that seems to be an implicit (and it is interesting that it is left at that level) point of Ackerman's article.[9] The argument here is 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; that though not made <u>incompetent</u> by illness our judgment is enough affected to draw suspicion on illness-related decisions. While illness does not nullify the possibility of any level of autonomous behavior, it can place enough constraints to render that level minimal. And, hence, the decisions resulting from such constraints may not be <u>enough autonomous</u> to require our respect. That is, the amount of respect we afford will correspond with the severity of the illness and, hence, the severity of the constraint.

Acceptance of this third option involves two supporting arguments. The first is that autonomy is, in fact, a gradated concept. This, as I have earlier stated, will be the focus of a later chapter. The second is the argument that illness does represent this kind of constraint on

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[9]Ironically, as pointed out in the first footnote, Ackerman's most recent position is close to the second option outlined.

autonomous behavior. This second argument is the heart of Ackerman's article and we can now return to it.

The Constraints of Illness

In discussing how illness impedes autonomous behavior Ackerman makes reference to three traditionally named constraints--physical, cognitive, and psychological--and adds a fourth not usually 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 act autonomously.

With respect to physical constraints Ackerman quotes Edmund Pellegrino: "'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 "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 argument is that physical constraints involve considerably more than confinement or external restriction of action. What Ackerman and Pellegrino have acknowledged is that "we" are intimately associated with our bodies. Our goals and daily plans require the proper functioning of our bodily vessels. While this does suggest a form of dualism (the mere language of us and our bodies suggests this), it need not be a Cartesian dualism. Instead, a more accurate model is the kind suggested by Richard Zaner, among others,

in which he speaks of an "embodied self";[10] a self which is distinguishable, but not disassociatable, from its body. Since we are not disassociatable from our bodies, our decision-making abilities, goal-planning, etc. are inextricably connected to relatively healthful functioning of those bodies. When not healthy, the body can and often does represent a constraint upon our ability to act fully autonomously. Fatigue, fever, and pain all impair our ability for thoughtful consideration. Restricted body movement may impair our ability to engage in desired activities--such as athletics. And, as Ackerman points out, whole lifestyles may have to be drastically revised to accommodate the debilitating effects of illness.

It must be noted that not all of these will always represent a hindrance in autonomous decision-making. Instead, they sometimes will simply represent an alteration of the environment in which decision-making takes place. In such cases they would represent no more a constraint upon autonomy than other--e.g. climate, population changes, employment changes--alterations. Nonetheless, it seems clear that some forms of illness do represent a serious enough impairment on bodily functioning so as to represent a constraint on autonomy. As I stressed earlier, this does not suggest that the possibility of autonomous behavior will be nullified (except in the most extreme cases); rather, the level of autonomy will be limited, in degrees correspondent to the type of illness and the extent of impairment.

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

Cognitive constraints affect the ill in both direct and indirect ways. The direct effects involve the reduction in one's mental processes with a corresponding reduction in the ability to understand and respond to one's predicaments. Obvious examples of this are when the patient is suffering from such things as Organic Brain Syndrome, Alzheimer's Disease, Schizophrenia and other forms of mental illness, etc. In each of these cases the patient can suffer a dramatic reduction in comprehension of both the immediate situation and long-term effects. Given this, his/her ability to formulate personal goals is correspondingly reduced.

Less obvious, but equally severe, direct effects include the alteration of mental processes as a result of therapy—primarily the use of pain-killing and/or sedative drugs. Again, few would argue that one's ability to make any decisions has been removed. But one need only experience the immediate effects of such drugs as morphine or demerol, or the long-term effects of prolonged use of codeine, to recognize that one's ability for decision-making is seriously affected.

But even in cases where neither the illness nor the treatment represent a significant cognitive constraint (and the majority of illnesses fall into this second category) patients' autonomous behavior can be constrained by indirect considerations—primarily that of a lack of knowledge and understanding of medicine, both diagnosis and treatment. As Ackerman puts it: "without 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).

These indirect cognitive constraints have long been the concern of medical ethicists and have provided the foundation for the emphasis on the "informed" side of informed consent. More than enough has been written and said about the need to give patients an understanding of the medical/technical aspects of their condition to validate Ackerman's and my concern here. Only one point needs be made.

This point is a response to the frequent claim of physicians that for patients to be truly informed of these medical/technical components they would need to go through medical school and practice medicine for X number of years. In short, this claim is simply false. While the workings of both the body and medical technology are indeed complex, neither—when informatively simplified—are beyond the comprehension of any but the most simple of patients.[11] The all too common lack of such understanding on patients' part is due to three things. The first, and most common, is a lack of time and energy on the health care practitioner's part, especially when those health care practitioners are overworked residents, to do the extra work required to provide such understanding. The second is a desire to keep a certain aura of mystique surrounding the practice of medicine. When knowledge is shrouded in mystery, those who posess it maintain a distinct power-advantage over those who need it. The third reason why patients are frequently under-informed is directly

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[11]This claim is substantiated by the empirical studies of the President's Commission in Making Health Care Decisions, Vol. II. The authors of this volume state, "Numerous recent studies suggest that through the use of simplified language and written and audiovisual aids as adjuncts to discussion, lay people can understand health-related information." (President's Commission for the Study of Problems in Medicine and Biomedical and Behavioral Research, 1982), p. 12.

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 form of cognitive constraint, rather than just a willful decision to remain uninformed, we need to look at the psychological and social components of illness.

Appeals to psychological constraints are common in both ethics and law. The most obvious cases—e.g. insanity defenses, claims of mental incompetency—clearly border on cognitive constraints. That is, individuals' cognitive abilities (and, hence, their autonomy and responsibility) are felt to be compromised by serious psychological problems. And though specific cases are often controversial, there is a general acceptance in the legal, medical, and philosophical communities that such psychological impairments can represent genuine constraints on autonomy.

But Ackerman does not stop with the widely recognized forms of psychological constraint: "Pellegrino mentions the anxieties created by illness, but psychological constraints may also include denial, depression, guilt and fear" (Ackerman, 1982, p. 15). The effects of denial on terminally ill and cancer patients are widely documented. As Ackerman's example reveals (Ackerman, 1982, p. 15), denial prevents patients from being able to recognize and/or understand the significance of their condition and, hence, makes them unable to fully consider, or even consciously to see, the various options. As such, patients engaging in

such a denial are having a constraint placed upon their decision-making abilities.[12]

Depression, guilt, and fear can have similar results on an individual's decision-making abilities by clouding or altering one's perception of the situation and its possible outcomes. These constraints can result not only in impaired judgments, but in evaluations and emphases placed on areas inconsistent with an individual's character. A life-loving, energetic person's fear of the effects of chemotherapy--effects, which, because of that very fear, are seen to be much more debilitating than is true--will result in a decision inconsistent with all that person has believed and lived for. Similarly, one's guilt at not doing everything possible to preserve life, especially with a family unable to let go, can result in a decision to subject oneself (and/or others) to indignities and costs one would never endure without such constraints.

Although these psychological constraints are not as inhibiting as some of the others listed, they can seriously impair patients' ability to make responsible, autonomous decisions about their lives. Depending on the patient and his/her conceptual life-world, those constraints can range from temporary mood shifts to near-total incapacitation. In discussing how such constraints affect the successful achievement of informed consent, William C. Thompson concludes:

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[12]The problem of denial has been kicked around in philosophy, under other guises, for a number of years. The most famous and, I think, the most illuminating, is Sartre's notion of mauvais fois. An interesting task for the future would be to look at ways in which Sartre's account would be of benefit for the practicing medical ethicist.

> [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).[13]

While much of what Thompson is discussing at least borders on cognitive constraints, one can easily extrapolate to how such things as denial and guilt could have similar effects and require similar safeguards. And, again, depending on the patient and his/her constraints, those safeguards will range from emotional support, to improved communication, to--in the extreme cases—overriding the patient's immediately stated wishes.

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 autonomous decision-making. "Psychological research[14] 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 (probably without active intention) use to manage this manipulation (e.g. "framing or couching disclosures"), he fails to

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[13]William C. Thompson, "Psychological Issues in Informed Consent" Making Health Care Decisions, Vol. III, (President's Commission for the Study of Problems in Medicine and Biomedical and Behavioral Research, 1982).

[14]This terminology again suggests the very fuzzy boundaries that exist between these constraints.

discuss adequately both how it is that physicians have this power and why it is they wish to exert it.[15]

Ackerman, too, discusses social constraints, starting with the kinds of influences families exert over their members. He cites the typical case of a terminally ill child whose previous drug therapies had all failed. The child was asked to enter a phase 1 clinical trial. (Such trials are carried out with the sole goal of determining toxicities, with no anticipated subject benefit.) The patient, knowing his condition was hopeless, desired to live the remainder of his life in as much comfort as possible (the effects of chemotherapy, especially at the phase 1 level, are often quite unpleasant and can be physically debilitating). Unbeknownst to his parents he asked to be released from the hospital. "However, his parents denied the hopelessness of his condition [and] with deep regard for his parents' wishes, he refused to openly object to their desires and the therapy was administered" without success (Ackerman, 1982, p. 15). While in this case there is a conflict between two cherished goals (pleasing his parents and choosing his style of death), Ackerman is suggesting that without the expectations and constraints of the familial social structure, that conflict would never have arisen.

In addition to these more immediate social constraints are what Ackerman 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

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[15]This is not meant to suggest that such exertions of power always are <u>intentional</u> on the physician's part. They may be inadvertant.

in his reference to the sociologist Talcott Parsons, one of those forms of acceptable behavior has been dubbed the "sick role." Parsons, convincingly, if incompletely, 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. (His account is incomplete because it does not acknowledge both individual needs and the kinds of economic and political realities that define the "sick role" itself). But in addition to the above, the "sick role," as well as other influences, also "tell" us what are proper modes of behavior when seeking out the help of the health care professional. 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).

And, as Ackerman points out, the "sick role" is ingrained in us from childhood. The doctor is nearly always perceived as the authority who has the patient's best interest at heart. And, as such, the physician is often handed (sometimes at their objection) final decision-making authority. One of the best pieces of evidence as to the strength of this constraint is the way in which philosophers and sociologists of medicine, even ones who are otherwise assertive, deal with health care professionals. These frequently are people who understand and can discuss at length the ways in which social institutions constrain autonomous decision-making. Yet, frequently, these same people find themselves acceding to the authority of the professional, giving up their autonomy to the call of acceptable behavior.

It is easy to over-simplify this acquiescence as a mere adherence to the "sick role." Clearly such things as availability of health care services, being at the physical mercy of hospital staff, etc., lead to a willingness to give up decision-making authority. These economic 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. Because Ackerman fails to take these realities into account, his analysis is incomplete—at least insofar as we are trying to gain a full account of how autonomous behavior can be constrained. As I noted in the Introduction, the considerations raised in the following chapter are not in conflict with his views and I think he would be sympathetic to most of those claims. The following chapter will attempt to provide some of that missing analysis.

But before turning to that analysis, it is interesting to look at Ackerman's proposals for dealing with these constraints. The first issue, as I pointed out in the sixth footnote, is Ackerman's lack of distinction between the seriously ill and those with relatively routine complaints. His discussion of how illness "interposes" itself is primarily of import in serious illness. One would be hard pressed to show how a cold, influenza or even a minor orthopedic injury represents a significant constraint on the sufferer's autonomy. These conditions, in most cases, simply do not impair persons' ability to make decisions; they do not significantly impair persons' psychological or cognitive states in a way that would reduce their ability for responsible decision-making. His discussion of cognitive and psychological constraints is similarly limited. Hence, on the whole, his recommendations are restricted to

those situations in which illness has resulted in a major and disruptive impact on a patient's life.[16]

Despite the fact that he does not so apply it, there is use for an extension of his discussion—an extension similar to the one Thompson provides—of psychological and, especially, social constraints to issues in routine care. If Thompson's studies are accurate, enormous improvement can be made in the way information is relayed and received, making truly informed consent a more frequently attainable goal. The solutions to the social problems are not so simple. It is clear that some immediate changes (e.g. having persons other than physicians, in relatively neutral settings devoid of medical trappings, etc. provide information) would have some short-term positive effect on enhancing autonomous decision-making. However, as we will see in the next chapter, any long-term encompassing solutions will involve the kinds of changes few would be willing to make and which might not be justified by the return.

Keeping in mind, then, that Ackerman's discussion is limited in the ways noted, what does he offer as solutions? He sets up the problem as there being too much emphasis placed on noninterference--"we must reject the narrow focus of medical ethics upon noninterference" (Ackerman, 1982, p. 17)—so what kinds of interference does he recommend? Interestingly enough, they are quite circumscribed:

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[16]Though it is not spelled out in his article, Ackerman might appeal here to a gradation of autonomy, with more serious illnesses representing significant constraints and less serious ones, lesser constraints.

> [S]trategies must go beyond the mere provision of information. Crucial information may have to be repeatedly shared with patients. Features of the situation which the patient has brushed over (as in denial) or falsely emphasized (as in acute anxiety) must be discussed in more detail or set in their proper perspective. And the physician may have to alter the tone of discussions with the patient, emphasizing a positive attitude with the overly depressed or anxious patient, or a more realistic, cautious attitude with the denying patient, in order to neutralize psychological constraints (Ackerman, 1982, p. 16).

In other words, physicians and other health care professionals must employ good communication skills. They must be willing to consider each patient individually, taking into account his/her conceptual lifeworld and how that lifeworld alters his/her perception of a given situation. In some, very loose, sense this <u>is</u> interference. The health care professional is being told to treat two patients with similar medical problems in different ways, based on the patient's ability to deal with the various constraints upon his/her autonomy. But, though it is implied by his argument, Ackerman never explicitly states that a patient's decision should be overruled. He does argue that a physician may be forced to push past a patient's denial, but he does not offer a suggestion as to what to do in case that fails. One can, based upon consideration of the various constraints, do much to alter a patient's perspective and thereby hopefully alter his/her decision. But, in the end, Ackerman seems to imply that the emphasis should be placed on the (substantially autonomous) individual's decision.

If what we are striving for is to allow individuals to be as responsible for their lives as possible, then the kinds of constraints Ackerman brings up must be taken into account. But, if after repeated attempts to alter the perspective, the patient nonetheless maintains

his/ her conceptual lifeworld, we need to seriously question the moral appropriateness of overriding the patient's decision. While long-term autonomy may still be possible (assuming the new decision is in accord with the patient's long-term autonomy), the patient's short-term autonomy has been severely restricted. Though s/he may maintain some short-term autonomy in the ways s/he reacts to that decision, (e.g. non-compliance), it must be recognized that his/her autonomy has nonetheless been constrained.[17] The justifiability of such constraint will depend on whether long-term autonomy has been significantly enhanced and/or on whether other important moral goods have been promoted.

Ackerman's article is immensely valuable in that it both recognizes the value of autonomy and recognizes the wide range of constraints that can impede autonomy. Where it is lacking is in its failure to deal with the broader concerns that make such constraints, especially the social constraints, so much a part of medical care. For that we can turn to the next chapter.

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[17]I am indebted to Glenn Graber for his suggestion here.

CHAPTER IV

A SOCIALIST PERSPECTIVE

A brief summary of what has been done up to this point is in order. The first three chapters have traced increasingly sophisticated accounts of autonomy. Robert Veatch, in essence, equates being autonomous with having liberty of action. Give persons a free rein and their resulting decisions will be autonomous.

Tom Beauchamp and James Childress add to this by including that autonomous persons must be self-legislating; they must determine for themselves which principles must be followed. By including this, Beauchamp and Childress have recognized that being an autonomous person means more than just being capable of acting without constraint. They have recognized that being an autonomous person is a complex endeavor requiring considered thought and deliberation. However, as Terrence Ackerman points out, Beauchamp and Childress assume in their account that given adequate information, any competent adult will always be able to make such considered, deliberate, autonomous decisions.

Ackerman adds to these accounts by pushing the discussion in two new directions. First, he questions what it is we are trying to accomplish in our respect for autonomy. While his answer (retaining or establishing control) is frought with difficulties (primarily determining whether we are seeking long-term control at the expense of the loss of some immediate control), I think he is on the right track. Though I will not explicitly be arguing that particular line, the notion of control

does seem to have a close link to what I will be arguing for—being a responsible person.[1]

Second, and more significantly, Ackerman shows that traditional accounts of what is involved in being autonomous have been inadequate in that they have failed to recognize that various aspects of illness can act as constraints on autonomous behavior. Because of these physical, cognitive, psychological, and social constraints, decisions within a medical setting often are the result of a reduced autonomy and must sometimes be brought into question.

In addition to analyzing Ackerman's views, the arguments in Chapter III expand the notion of "constraints" so as to point to the distinction between freedom and autonomy as well as begin a final characterization of what is involved in being autonomous. This expansion of "constraints" will be carried further in this chapter on the socialist perspective.

A number of medical sociologists[2] working from the socialist perspective have argued, in effect, that Ackerman's position is accurate and helpful (especially with respect to his discussion of the "sick

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[1]In a subsequent, expanded work this connection likely will be one of my areas of concern.

[2]A couple of the better sources include: Vincente Navarro, ed. Health and Medical Care in the U.S.: A Critical Analysis (Farmingdale, New York: Baywood Publishing Company, Inc., 1975). Howard B. Waitzken and Barbara Waterman, The Exploitation of Illness in a Capitalist Society (Indianapolis: Bobbs-Merrill Educational Publishing, 1974). This precursor to Waitzken's, The Second Sickness (New York: The Free Press, 1983) (My primary source for this work) is a valuable if simplistic introduction to the issues.

role" and other social constraints), but that he stops short. He does not acknowledge either the institutional, economic, or political realities that shape and define such constraints on autonomy as the sick role. Their argument, in short, is that autonomy is as much constrained by these broader influences as it is by the more immediate ones listed by Ackerman. The following will be an abbreviated account of this socialist position and of the kinds of constraints to which they refer.

A few introductory notes. Individuals working within this perspective 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. Though 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 the socialists have to add to our discussion is valuable and its omission from standard accounts of autonomy has led to simplistic accounts.

I have chosen Howard Waitzken's, The Second Sickness, as my primary source of this chapter for three reasons. First, it is current (1983) and deals with current issues and concerns in health care delivery. Second, he is a well-respected and frequently cited source in medical sociology. Third, he attempts to deal with these issues on both the macro and micro levels. That is, he discusses both the broad economic factors that shape health care delivery and how those factors are reflected in doctor-patient interactions.

Waitzken has two main tasks that are of import for this work. The first is to show a direct connection between the economic structure and illness. He draws this connection in two ways. First, he shows how the basic social contradiction between profit and health results in increased illness. Related to this is the notion that illness gets defined, in part, by the structure of the workplace. The second connection involves the maldistribution of available health care--a maldistribution resulting from both economic and geographical reasons. His second main task is to show how the institution of medical care gets created and defined by the socio/economic structure of a given culture.

Profit vs. Health

Waitzken defines a social contradiction as:

> "antagonistic or opposing characteristics that arise among social groups, within organizations and institutions, across notions, 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).

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 capitalist society profit is given a high enough value that safety, by necessity, will suffer with the consequent reduction in worker health. Increased emphasis on worker health would require a substantial augmentation of product and equipment safeguarding. Such an augmentation can and often does result 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), as well as encouraging the wasteful abuse of resources precious to the health and well-being of society. Waitzken's claim, and I think it is a legitimate one, is that so long as profit, especially short-term profit, is a strong motivating factor in the way the workplace is run and the way the environment is used, there will be an increased rate of health problems.

These considerations act as constraints on persons' autonomy by, first and most importantly, affecting decisions about desired work and lifestyles. These decisions cannot effectively be made without knowledge of occupational and environmental hazards—knowledge that rarely, if ever, exists to a full enough degree.

The lack of knowledge here is comparable to such a deficiency in any situation involving voluntary informed consent. What Waitzken has

done, though, is to show how the kinds of information necessary for making autonomous decisions is often extended beyond immediate situational variables. Even if such extensions are acknowledged in contemporary medical ethics literature, they almost never include the kinds of socio/economic analyses Waitzken provides.

Second, even if such knowledge is made available, options for avoidance of hazards need be available. In a societal structure which promotes, through the profit motive, such hazards, those options frequently do not exist. We cannot expect someone to take responsible, autonomous control of their lives if the possibility for that control does not exist.

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 workplace.[3] If one has an illness that does not substantially inhibit one's ability to carry on with work, then one generally does not seek out professional help nor does one consider oneself really sick. This is especially true of definitions of mental illness. One can be as eccentric as one pleases, so long as it does not represent a significant disruption of one's productivity. Hence, what Parsons (and Ackerman) refers to as the "sick role," with all its already mentioned constraints upon autonomy, is very much a result of the working conditions and emphasis on productivity that are in turn a result of the

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[3]See 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 Navarro ed., Health and Medical Care in the U.S..

motivational force of profit. Hence, we see a self-perpetuating cycle. Illness gets defined, in part, by one's (lack of) ability to be productive and one's (lack of) ability to be productive diminishes when too much emphasis is placed on productivity with its resulting increase in occupational and environmental hazards.

The Maldistribution of Health Care

Waitzken's second connection between the economic structure and illness is the maldistribution of health care, of which there are two forms. The first is geographic maldistribution. Rural areas have greatly reduced numbers of health care personnel in comparison to large cities and desired living areas (such as the East and West Coasts). The second form of maldistribution is economic. Health care workers, sometimes driven 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, by and large, in areas of relative economic prosperity. When their training is completed they desire, on the whole, 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. Finally, one of Waitzken's strongest points is his discussion of how medical training is creating, more and more, a technocratic form of health care. This results from the hospitals' (most of which are profit motivated) need to buy and employ technologically advanced equipment so as to maintain a competitive edge with other hospitals in the area. With such technology comes a need for professionals

skilled in its use, at the cost of more general knowledge about medicine.[4] Seeing this need for technically competent health care workers, medical schools train their students accordingly. These students, in turn, will seek to practice in those areas for which they have been trained (Waitzken, 1983, p. 23-24). This results not only in the exacerbation of geographic maldistribution but in a shortage of persons trained in general medicine for those consumers who cannot afford the costs of high technology.

The connection between this maldistribution of health care and autonomy is straight-forward. If illness represents a constraint upon autonomy in the various ways outlined in Chapter III, then those unable to get relief from their illnesses clearly will have their autonomy more constrained than those who are not faced with that socio/economic impediment. Given both this and the preceding argument, it is evident that a direct connection exists between the economic structure of a society and the health and illness (and, consequently, the level of autonomous behavior possible) of the members of that society. However, it does not necessarily follow that an alteration of that socio/economic structure is the only or even the best solution. Nor am I suggesting that a solution is either desirable or possible. Rather, the main point of this chapter is to show that such socio/economic factors must be taken into consideration when giving a full account of what is involved in being autonomous.

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[4] The emergence of family practice programs is a direct response to this technolization and consequent specialization. Despite this positive step, family practice physicians have not and will not make a significant impact on the problem of maldistribution.

The Creation and Definition of Medical Care

Waitzken's second main task is to show how the socio/economic structure creates and defines the institution of medical care. We have already seen how medical training is linked to profit through the promulgation of advanced technologies. Other connections include, "uneven socio/economic development, public subsidization of the private sector, and features of the medical labor force that impede humanistic care" (Waitzken, 1983, p. 89). All of these, when examined in detail not possible here, reveal how the profit motive shapes institutional medicine. One of the most pervasive of all these influences is corporate involvement in medical care.

With corporate involvement in medical care comes an increased emphasis on profits, since, by their nature corporations are profit oriented. And, "from the standpoint of private profit, there is no reason that corporations should [or do] view medicine differently from other goods and services" (Waitzken, 1983, p. 7).

There is an underlying and never spoken assumption that serves as a foundation for Waitzken's arguments concerning corporate involvement in medical care: that persons have a right to health care (he also implies that a similar right applies to the other "human frailties" [Waitzken, 1983, p. 35] of food, housing and transportation). While I think there are a number of difficulties in speaking of a right to health care, I also think that some minimal standard of medical care should be one of the first things with which a society should concern itself. Accepting this, without argument, the issue then becomes whether corporate involvement will enhance the possibility for such medical care. Waitzken's claim is a flat no. He argues that the need for profit results in a

need for expansion which, in the medical field at least, results in increased technology and higher costs for the consumer, thereby excluding a vast portion of the population. Because of profit oriented corporate involvement, medical care, increasingly, means expensive lab tests and reliance on expensive high technology equipment. This represents a constraint on autonomy in the obvious way I have already mentioned--the less wealthy simply cannot afford medical care and the resulting enhancement of autonomy.

Corporate involvement, with the corresponding increase in high technology medical care, also represents a constraint for the wealthy. With this technology comes a medical mind-set that frequently produces an even 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 him/herself dependent on a system of people and machines s/he knows nothing about. Whether or not a power asymmetry actually does follow from this alienated dependency, the consumer generally <u>feels</u> 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 the decision-making. And, as Ackerman points out, this alienated dependency is ingrained in us from a very young age. It becomes a natural part of our conceptual lifeworld. The doctor has the knowledge and with that knowledge comes power--power such that questioning of his/her medical authority is inappropriate behavior.

It has been argued that this need for responsible involvement is unimportant. Even granting that such involvement may not be possible in the great majority of our medical interactions, the health care professional is, after all, working in our (the consumer's) best interest. However, while it is extremely rare to find a professional who actively seeks to do his/her patients harm, it is not at all obvious that they are always working in the patients' interest. Just as hospital administrators are constrained by the need to show a profit, so are individual health care workers. In hospital clinics, only so many health workers can be on duty and still have the clinic show a profit. Hence, those workers are constrained by a lack of time, resulting in the need to work with patients in an "assembly line" manner (which further increases the alienation between provider and consumer). In any large clinic setting the health workers are under constant pressure to keep costs down and productivity (in the form of number of patients seen and procedures performed) up. Given this kind of pressure, it is naive to assume that patients will always be given the attention they need or that unnecessary procedures will never be performed.

For individual physicians in private practice these economic pressures are more immediate if not necessarily as constraining. The private physician may not have the safety of a hospital salary to fall back on and thus must run his/her practice in a way that will result in whatever profit margin s/he is seeking. This is where the private physician has more leeway. S/he can choose to not be as concerned with a high margin of profit, thereby making it possible for him/her to provide services to persons otherwise uable to afford it, for him/her to spend more time with

patients, and reducing the risk of unnecessarily performed procedures. Whether or not it is in fact the case that medical care is better in the ways described could only be determined through more extensive empirical analysis. It may be the case that the corporate run organizations are more efficient and as a result provide more of an opportunity for individuated patient care.

Either way, what is of importance for our current task is a recognition that doctor-patient interactions are exceedingly more complex than one free agent seeking services from another free agent, as Veatch suggests in his contractual model. These agents may or may not be free (depending, as per Miller, on whether there is some person or persons who have a direct moral responsibility for the existence of the constraint [see above, p. 6]). The issue for our purposes is whether either or both parties are having their autonomous decision-making constrained. I think the above arguments show a clear answer. The physician is constrained by economic and social concerns[5] to provide services in particular ways. The patient is constrained in the kinds and amount of health care available, in his/her alienated dependency on the health care professional, and in his/her societal training of what is proper behavior when seeking assistance from a health professional. And as we have seen,

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[5]A number of writers have emphasized other influential factors in the doctor/patient relationship, e.g. Sexism, racism, and prejudice against low-income patients. See Elizabeth Fee, "Women and Health Care: A Comparison of Theories" in Navarro ed., Health and Medical Care in the U.S. See also, Sue Fisher and Alexandra Dundas Todd, eds., The Social Organization of Doctor Patient Communication. (Washington, D.C.: Center for Applied Linguistics, 1983).

those constraints cannot be understood without acknowledging the economic factors that shape and define medical care.

Taking all of the preceding in perspective seems to result in quite a gloomy picture. We have physicians constrained by economics, educational training, social position, etc.; we have patients constrained by economics, social position, the "sick role," their very illnesses, etc. Given all of these constraints, is it possible to have a mutually satisfying interaction between an autonomous patient and an autonomous physician? I think this can be accomplished by gaining a slightly altered understanding of what it is we are trying to achieve in our respect for autonomy. It can be done by not losing sight of the individual in the midst of these psychological, physical, social, and economic constraints. Waitzkin makes that very mistake, calling for reforms that take away autonomous decision-making from the individual:

> 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).

Given the value I place on autonomy, such a "subordination" of individual preferences" could only be justified if it: 1) resulted in the promotion of autonomy for a majority of those it was affecting

(which might result from the suggestions Waitzken makes, i.e. patient autonomy might be enhanced, but he neither argues it should be, nor shows how it could be); and 2) if it can be shown how the original disrespect of autonomy is legitimate (e.g. an argument along the following lines: since physicians are trained out of public monies, they have an obligation to provide the necessary services needed by that public, again an argument Waitzken does not provide). Waitzken's refusal to deal with either of those justifications reveals his devaluation of the individual. In the following chapter I hope to show that such a devaluation is not necessary to accomplish our goal of promoting/respecting autonomy; in fact I will argue that just the opposite is what is needed.

CHAPTER V

AUTONOMY, RESPONSIBILITY, AND IDENTIFICATION

To this point we have seen four accounts of what is involved in being an autonomous individual. Robert Veatch has on the whole indentified being autonomous with negative liberty, without discussing more than the most simplistic account of what could constrain such liberty. Tom Beauchamp and James Childress, borrowing from Mill, acknowledge the need for liberty in their account of autonomy and add, borrowing from Kant, self-governance. Through their inclusion of self-governance they recognize such constraints as mental illness, immaturity and lack of information. Terrence Ackerman, though, argues that such standard accounts do not acknowledge how such things as illness, denial and social expectations constrain an individual's ability to be autonomous. By these arguments Ackerman shows that what is involved in being an autonomous individual is a much more complex enterprise than simply determining rational goals and being free to pursue them. Finally, such contemporary socialists as Howard Waitzken, while being sympathetic to Ackerman's claims, feel they too are restricted. In addition to Ackerman's physical, psychological and cognitive constraints, Waitzken points to broader kinds of considerations such as economic, academic and institutional constraints. These too, he argues, constrain an individual's ability to be fully autonomous.

If the compilation of these increasingly sophisticated accounts is correct, if what it means to be an autonomous individual involves liberty

and self governance in the face of these seemingly all-pervasive constraints, is it possible to be autonomous? If what we mean by being autonomous is that these constraints cannot be present, then it is not possible. It may be possible to be free, in the sense discussed by Miller in the Introduction, i.e. the lack of constraints for which any person or persons can be held directly responsible. It does seem possible that one could, at times, be free of such constraints. However, the broader sense of constraint discussed in chapters III and IV cannot be totally evaded. Economic and institutional realities, social roles, etc. are a pervasive part of our realities, of our conceptual life-worlds. They can be, and most often are, present even without our explicit awareness of them.

Now, since I have maintained that respect for autonomy is a, if not the, crucial principle in any ethical system, it surely must follow that I have a different sense of autonomy in mind than the complete lack of constraints. Further, I think the position I will be defending is common to each of the previous four accounts offered. It is a thread that runs throughout the literature on autonomy.

In discussing the sense of autonomy I have in mind, this chapter will be devoted to three tasks.[1] First, I will argue that autonomy is best understood as including, rather than being identified with negative freedom. Second, I will argue that when we are defending or promoting someone's autonomy, we are in essence defending or promoting that person's

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[1]Given the abbreviated nature of this work, the following will be, in some ways, superficial. I hope to lay out the issues here and point to some answers, answers which will be expanded on in a subsequent work.

being responsible for his/her own life. Third, I will argue (what I suggested is implicit in the other accounts) that this conception of autonomy results, to its advantage, in a recognition that autonomy admits of degrees, that one can be more or less autonomous, that autonomy is not an either/or concept.

Autonomy and Freedom

In Chapter I, I revealed a number of serious problems with Robert Veatch's account of autonomy while emphasizing his identification of autonomy with liberty. I did not mean by that discussion, though, to suggest there was no relation between negative freedom and autonomy; rather, my point was to show that the relation is not one of identification. Is there, then, any relation and if so what is it?

There clearly is some relation. When we talk of respecting someone's autonomy in a medical decision-making situation, it is clear that we are in part respecting that person's free, uncoerced, ability to make decisions. And frequently when we decry the violation of someone's autonomy, we are noting moral outrage at the fact that his/her free decision-making powers were ignored or overruled. Along these same lines, the moral foundation for the principle of informed consent plainly lies in the value we place on freedom. We say this principle has been violated when one's body or person has been handled, used, etc. without freely given consent.

But the main thrust of Chapters III and IV was to show how one's autonomy could be constrained without his/her freedom being constrained; i.e. without there always being a direct relation to a person or persons

morally responsible for the existence of the constraint. If I am right in my claim that illness, institutional roles, economic realities, etc. are sometimes constraints on autonomy, then one's autonomy can be constrained without one's freedom being constrained. There frequently is no person or persons who have a direct moral responsibility for the existence of the constraint.

Gerald Dworkin states it as follows:

> 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).

Hence, one's autonomy can be constrained in situations in which freedom is not. But what of the reverse? Is it possible to have one's freedom constrained and not have one's autonomy constrained? While my claim is that it cannot, it is a qualified response.

My answer is primarily based on the recognition that in all the standard medical examples (all of which have some link to violations of informed consent) in which we claim one's liberty has been violated, we also claim one's autonomy has been violated. When ethicists denounce for example, the forced treatment of a terminal patient there is disapprobation of his/her restricted liberty and violated autonomy. In all of these traditionally debated cases there is an inextricable link between freedom and autonomy; i.e. when the first is violated, the second necessarily is as well.

Thus, freedom would seem to be a subclass of autonomy. Every constraint on one's freedom involves a constraint on one's autonomy, though, according to the preceding, the reverse is not true. S. I. Benn[2] makes a similar claim. Benn characterizes the notion of "autarchy" as being the condition of choosing. Of significance for our purposes is that, for Benn, autarchy is itself included in the considerably broader notion of autonomy in which one is capable of choosing and in fact does so (I will be working with this some more in the next section). His characterization of autarchy includes—but is slightly fuller than—the notion of negative liberty in that one's autocratic status can be constrained by internal as well as external forces. That is, for Benn, liberty is a necessary though not quite sufficient criterion of autarchy. Hence, for Benn, freedom is included in the broader notion of autarchy which is in turn included in the still broader notion of autonomy.

Is, then, freedom a necessary condition of autonomy? That is, can one be "unfree" (have one's freedom constrained) and still be autonomous? It is clear that for Benn one cannot. Anything which represents a constraint on negative freedom also represents a constraint on autonomy. My own response is, as I noted, qualified. Freedom is necessary to be autonomous in a very full sense. One cannot be fully (or even near fully) responsible for all (or nearly all) aspects of one's life unless there also are no constraints (in the Millerian sense) on one's freedom.

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

In short, we can not hold someone responsible for being in a condition s/he would not be in if s/he were not constrained.

Why, then, do I hedge? Because the notion of autonomy is very commonly used in a way that does allow for situations in which liberty is constrained yet we do not hesitate to recognize the (unfree) person(s) as autonomous. This usage of autonomy reveals an important characteristic of what is involved in being autonomous; namely, that it is a global concept.[3] This means that there will be situations in which specific elements of one's status as an autonomous person can be constrained (e.g. if the person's liberty is significantly constrained), yet, depending on the extent of those constraints, can still be autonomous. This helps support my claim that being autonomous admits of degrees: because I have been constrained in a specific element of my life, my status as an autonomous person (in general relation to that situation) has been reduced. But, I nonetheless maintain some level of autonomy, a level determined by the nature and extent of the constraints placed on me. My overall status as an autonomous person, as a person able to be responsible for (other) significant aspects of my life, remains.

Hence, we can have situations in which one is not at liberty and yet one maintains some level of autonomy. The issue then becomes whether that level is sufficient for us to recognize the person as autonomous. Ordinarily, for the reasons given in the preceding discussion, that level would not be sufficient. However there are situations in which we seem to hold that it is sufficient. The kind of case I have

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[3]I am indebted to George Brenkert for his suggestions here.

in mind is that of the Irish Republican Army members who having been imprisoned, nonetheless, autonomously choose to engage in hunger strikes. It is clear that their liberty, to a great extent, has been constrained; there are persons who have a direct moral responsibility for their imprisonment. Yet, we generally want to say, and it seems altogether appropriate to me, that these men autonomously chose to engage in the hunger strikes.

The obvious response to this is that while they did autonomously choose, it was not with full autonomy. Only if they had also chosen without constrained freedom (and without any other constraints unknown to us, constraints) could they have done so with full autonomy. This is, I think, a plausible account of the situation and one consistent with the position I have been defending all along--that autonomy is a gradated status. However, this response seems to be simplistic. For when we claim that they acted autonomously we seem to be saying it with full conviction. Our ordinary evaluation of the situation declares the status of autonomy without the least hesitancy. In fact, if one's sympathies lie with the strikers, it seems natural to say their choice is the epitome of an autonomous choice.

This argument suggests one of two things. Either our ordinary usage of autonomy in such situations is inadequate, or some less-than-fullest sense of autonomy is often what we generally strive for; i.e. the level of autonomy achieved by the strikers often satisfies what our principles of respect for autonomy are trying to achieve. My sympathies lie with the latter explanation. We respect the strikers' status; if we are friends or relatives we feel morally obliged not to override their

decision (e.g. force feed them) because, despite the severe constraint on their liberty, they are attempting to take as full a responsibility for their lives as possible—in this case by continuing their political struggle.

This does not suggest that a fuller sense of autonomy which included freedom, even in the ordinary usage of the term, could not be achieved or that it would not be morally desirable. In fact, as I hope to show in a succeeding work, different medical climates demand fuller and lesser degrees of autonomous behavior and respect thereof, with such climates as family practice demanding a nearly full degree. The case of the hunger strikers does serve to show, though, that respect for one's autonomous status need not require that one be fully autonomous.

The upshot of all of these arguments is that while a full degree of freedom is a necessary condition of full autonomy, it need not be present for an individual to make autonomous choices. As we saw in the standard medical examples autonomy is most often regarded as a global concept that includes the concept of freedom. However, there clearly are situations in which our ordinary usage of autonomy does not include being at liberty.

Autonomy as Being Responsible

A major portion of this work has been devoted to discussing the inadequacies of some of the contemporary notions of autonomy. I have claimed that these contemporary accounts are inadequate in that they often do not take into consideration how the broader kinds of concerns suggested by Ackerman and Waitzken can constrain autonomy. Further, these accounts frequently do not explain why we should respect persons'

status as autonomous beings. Finally, they do not, on the whole, provide an adequate guide for someone concerned with whether another's autonomy is being respected. It is my hope that by linking autonomy with being responsible we can more adequately deal with these issues.

The first consideration in making the link between autonomy and being responsible is a clarification of what is meant by "being responsible." There are at least three different senses of the notion. The first is "being responsible" in the sense of being causally accountable, having some causal link to an event in the sense of, "She did it and is thus responsible for it." This sense is, I think, our most common usage of "responsibility." For example, we would claim that because Fred kicked the chair, it fell over, upsetting the glass of water on the floor behind it. Due to the causal link, Fred is responsible for the chair falling and the water spilling.

The second sense of responsibility is the moral sense. We ascribe moral responsibility whenever an agent has a moral obligation to either prevent or bring about a given result. Important to this sense of responsibility is the idea that one can be morally responsible when one does not do something, the doing of which is necessary for fulfilling one's obligations. It is also important to note that moral responsibility can involve a negative (or responsive) evaluation as well as a positive evaluation. That is, negative evaluations result when an agent is responsible for a given moral state of affairs that would not otherwise exist without his/her involvement. Positive evaluations are of the sort, "he is responsible for his little brother, his brother is dependent on him." These positive evaluations reveal that the agent has an obligation

to promote or maintain a moral state of affairs. In both the positive and negative aspects of moral responsibility, though, the agent in question must satisfy certain minimal conditions. That is, in order to be morally responsible the agent must be capable of certain levels of reasoning, intelligence, etc. When those capabilities are not present, it is illegitimate to hold the agent morally responsible either for the existence of, or the promotion of, a moral state of affairs. This issue will come up again in my discussion of why it is we respect individuals who are responsible.

The third sense of responsibility is the dispositional sense in which we make aretaic judgments of the sort, "She is a responsible person," or, "She led a responsible life." Like the moral, the dispositional sense seems also to be divided into two aspects, in this case a moral and a non-moral aspect.

The moral aspect of the dispositional sense involves an evaluation of the individual's moral character, of whether s/he led a moral life. This evaluation is concerned with whether the individual is disposed to fulfilling his/her moral obligations. It can take the form of, for example, "She took responsibility for her morally related actions," or, "He fulfilled his moral obligations toward others."

But there also seems to be the second, non-moral aspect of dispositional responsibility. This aspect involves an ascription of responsibility to individuals who choose important elements of their lives, who determine for themselves who or what they want to be or accomplish and go about fulfilling that determination. Such choosing may involve (im)moral goals as, for example, choosing to be a mass murderer. In

such a case we would say the individual is responsible (and, as we will see, autonomous), though s/he made an irresponsible (as in immoral) choice. The choosing often, though, will not involve any direct moral elements. For example, we say the athlete who maintains a strict and rigorous training schedule is being responsible, even though there is no moral evaluation in that ascription. Further, this choosing need not be of a long-term plan of life. We recognize as responsible individuals who directly and actively respond to specific concerns in their lives, who choose their own courses in response to those concerns, regardless of whether that choosing is in line with a given plan of life.

What seems to be of prime importance in this third sense is the agent's identification with his/her life. The person whose life we respect because it is dispositionally responsible is the person who chooses his/her own goals, values, beliefs, etc., attempts to live a life in accordance with those goals, values, beliefs, etc., and thereby sees that life as being his/her own life. This notion of identification will be a crucial part of my argument and I will be returning to it in a moment. For now it is important to recognize the preceding distinctions in what we mean by "being responsible."

While all three of these senses of responsibility may be present in a given situation, the sense of being responsible which is linked with being autonomous is the dispositional sense. The fully autonomous person would be the person who is dispositionally responsible for his/her full life. S/he would choose all significant aspects of his/her life and s/he would do so in a way so as to meet all of his/her moral obligations. However, being dispositionally responsible quite clearly admits

of degrees and as such will provide part of the basis for suggesting that autonomy also admits of degrees. Given, then, this understanding of what I mean by "being responsible for one's life," why is it important to recognize its link with autonomy?

Why We Respect Persons as Autonomous

Benjamin Freedman[4] gets us started on an answer with the following:

> A small child can certainly make choices. Small children can also be intelligent enough to understand [in some situations] the necessary information. Yet surely we would not want to say that a small child can give valid consent to a serious medical procedure. The reason for this is that the child cannot choose responsibly (Freedman, 1975, p. 35, his emphasis).

In other words, though small children are often capable of voluntary decisions, and though they can sometimes gain a relatively sophisticated grasp of the necessary information, we still do not want to say they have the status of responsible decision-makers. We do not because the child knows neither enough about him/herself or about his/her world; s/he is unable to evaluate the consequences of the decision, both as they relate to him/her and to the world around him/her. As Freedman notes, children are capable of certain levels of intelligent, deliberative and, hence, responsible choice. But that level, in young children at least, is quite minimal and is not a status that we generally respect as representative of a "responsible agent."[5] For these and other reasons

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[4]Benjamin Freedman, "A Moral Theory of Informed Consent," Hastings Center Report, August, 1975, pp. 32-39.

[5]There obviously is considerable debate as to what kinds of cognitive, physical and other capabilities one must have in order to be responsible. I do not wish to step into that fray in this work, but I

we generally do not hold a young child accountable (morally or otherwise), nor do we chastize him/her for not being a "responsible person." What we do is attempt to elicit "appropriate" behavior through praise and admonishment as well as attempt to develop those abilities that allow someone to meet the requirements of being a "resposible person." While in some, very minimal, sense young children are responsible, my point here is that that minimal sense does not seem sufficient for them to be recognized as autonomous.

I suggest it is this ability to make responsible choices that we value when we extol the virtues of decision-making. When we voice moral indignation at the violation of one's autonomy we are, I suggest, noting outrage at the abrogation of an individual's ability to be responsible for him/herself. Such abrogation has the effect of ignoring the person's special status as a responsible, moral, autonomous agent. It has the effect of saying, "we do not recognize you as a being with the unique ability of moral decision-making. Our respect for you is comparable to that we would afford a being incapable of such activity, e.g. a dog."[6]

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think at least these two conditions need minimally be present: 1) An ability to reflect on oneself <u>as</u> self; and 2) An ability to reflect on <u>others</u> as moral agents, worthy of respect.

[6]As a long-time dog owner and near fanatic animal-lover, I by no means wish to suggest that animals are not worthy of our respect. In some ways, they are <u>more</u> deserving of respect (a dog has never discarded of chemical wastes in a manner that would threaten the other members of his species). Nonetheless, we <u>do</u>, and <u>should</u>, place enormous value and respect on persons' capability to engage in moral decision-making. When that respect is deserved and not afforded, it seems to me that a serious harm has been committed.

Hence, one of the forceful reasons for recognizing that autonomy is linked with being responsible is that much of our moral indignation at the violation of one's autonomy seems directed to the lack of respect that follows our failure to recognize a responsible agent as such. Being responsible, being capable of making responsible decisions, distinguishes us from nearly all other things in our known universe. And deserving or not (the ability to make moral, responsible decisions also presupposes the ability to make immoral, irresponsible decisions), we do in fact place great value and respect on that ability.

Identification

In linking autonomy with dispositional responsibility I placed emphasis on the agent's choosing the important elements of his/her life and on his/her fulfilling his/her obligations toward others. As I noted in the section on responsibility, such choosing presupposes certain necessary conditions; i.e. that the agent have certain minimal levels of reasoning abilities, intelligence, etc. But the mere capability is not sufficient for being autonomous. As Benn puts it, the autonomous person "is not merely capable of deciding for himself, he does so" (Benn, 1975-1976, p. 124, his emphasis). The autonomous person approaches the world from a perspective of questioning, constantly evaluating his/her world and attempting to alter it and his/her goals, values, etc., so as to achieve a coherence.

There seem to be two processes involved in such active choosing of the significant aspects of one's life. The first, as I noted earlier, involves the choosing of those significant aspects that one can call

one's own. It is in part through this process of identification that persons come to be dispositionally responsible for their lives.

The second, related, process involves the willingness to act on those components with which one has come to identify. The autonomous person uses them as a standard for questioning the dictates of the various authoritative elements in his/her life. S/he also uses them as a standard for questioning his/her own value structure.

With respect to the first process—of identification—Dworkin argues[7] that there is a crucial link between it and being autonomous. "The autonomous person," he says, "is one who does his own thing" (Dworkin, 1981a, p. 275, his emphasis). (Though he refers to "doing one's own thing" as being "authentic," his arguments show him to be speaking of the person who chooses the goals, values, believes, etc. with which s/he can most readily identify.) But, how does one go about "doing one's own thing," or identifying with the significant aspects of one's life? What does it mean to have such identification?

A common approach is to argue that such identification only results when one has a well-established, rational life-plan. This claim—that identification must be associated with rational life-plans—is most frequently associated with Rawls (Rawls, 1971, pp. 409-415), but it can also be found in Bruce Miller[8] (though, he, like Dworkin, uses "authenticity"

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[7]Gerald Dworkin, "Autonomy and Behavior Control" in Biomedical Ethics, Thomas Mappes and Jane Zembaty, eds. (New York: McGraw-Hill, 1981a), pp. 273-279.

[8]Bruce L. Miller, "Autonomy and the Refusal of Lifesaving Treatment," Hastings Center Report, August, 1981, pp. 22-28.

where I use "identification"): "Autonomy as authenticity means that an action is consistent with the person's attitudes, values, dispositions and life plans" (Miller, 1981, p. 24), and possibly[9] in Beauchamp and Childress: "The autonomous person determines his or her course of action in accordance with a plan chosen by himself or herself" (Beauchamp and Childress, 1983, p. 59, my emphasis).

Part of my hesitation with this position is that it may conflate identification with (self or personal) identity. Though what follows is simplified, the establishing of and adhering to life-plans seems to provide the agent with a sense of self existing with some degree of continuity through time. When that continuity is disrupted, as for example when the individual makes a significant decision that is in sharp disagreement with his/her life-plan, the sense of self-identity is also disrupted.

Sartre makes a similar claim.[10] He implies that when one's "fundamental project" (life-plan) changes, one, in a sense, becomes a different person. Hence, having and adhering to a life-plan seems to be an important element of having an identity of self existing through time. But a strong sense of continuous self-identity does not seem crucial to being dispositionally responsible. While there clearly must be some thread of self-identity that persists (or at least some overlap between various

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[9]My own reading of Beauchamp and Childress does not include the emphasis on life-plans. But see, for example, Alfred Beasley and Glenn Graber, "The Range of Autonomy: Informed Consent in Medicine," Theoretical Medicine, Vol. 5, 1984, pp. 31-41.

[10]Jean Paul Sartre, Being and Nothingness, Hazel Barnes, trans. (New York: Pocket Books, 1956), especially Part IV.

stages), there does not seem to be any conflict between being dispositionally responsible and undergoing a number of changes in one's "fundamental project" or life-plan. The individual may not see him/herself in the same way after such changes, and others may have a similar shift in perspective, but that individual may nonetheless choose significant aspects of his/her life while also fulfilling his/her moral obligations; i.e., s/he may nonetheless be dispositionally responsible.

Instead of focusing on long range life-plans, then, it seems we need to examine the processes by which individuals come to identify with specific actions or specific groups of actions. What is involved with this sense of identification?

Dworkin notes that to have such identification one must be capable of reflecting on one's current goals, values, beliefs, etc. (i.e. one's nomos). Such reflection is what makes possible the sense of that nomos being one's own nomos. This "second-order" deliberation is what allows us to question whether, for example, a person "desire that he desire to smoke" (Dworkin, 1981a, p. 275). If that second-order desire were not present, it would make sense to question the agent's identification with the desire. If upon further reflective questioning the agent did not establish such an identification, then one could claim the desire was not an autonomously chosen desire. (That does not mean, though, that the agent's smoking was entirely nonautonomous. The act of smoking itself is something which the agent must recognize as being his/her act, and one for which s/he must accept responsibility [accountability]. Nonetheless, given the lack of identification with the desire, it seems to make sense to acknowledge some reduced level of responsibility.)

Through this critical reflection we are able, in a sense, to stand back from ourselves and our decisions. In doing this we can evaluate ourselves (including our nomos) and our decisions. When there is conflict with this evaluation, when our nomos or our decisions are alien to us, we feel a sense of disconnectedness, a removal of ourselves from what we have done or chosen. We become alienated from our nomos or our decisions so that they do not seem to be ours; we cannot identify with them. The result of this alienation is a diminishing of our being dispositionally responsible. How can one be dispositionally responsible when s/he is confused as to which significant aspects of his/her life and their related decisions, are his/her own?[11]

This process of critical, reflective, identification not only gives us a connection with our nomos and decisions, but also a sense of identification with ourselves, at least insofar as the nomos and decisions help define who we are. While my project here is not one of self-definition, it does seem that a major part of how we come (at least) immediately to know ourselves is through the nomos and decisions with which we identify. Critical reflection aimed at identification in part allows us to become our own authors. Through identifying with our nomos and our decisions, or through altering them so that we do identify with them, we help to make ourselves into the persons we think we should be. Benn states 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

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[11]For a similar view see: Frithjof Bergmann, On Being Free (Notre Dame: University of Notre Dame Press, 1977), pp. 79-104.

> 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 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 (Benn, 1974-76, p. 124).

The obvious problem with the type of identification I have spelled out is the possibility of an agent identifying with a nomos chosen within a (unknown to him/her) "false" environment. For example, imagine a situation in which Norman deliberately creates a deceptive environment so as to trick Eileen into making a certain decision she would not otherwise make without that deception.[12] Eileen, unaware of the "false" nature of her environment, establishes a set of goals, values, beliefs, etc., one of which includes the belief that she should in fact make the decision Norman is hoping for. She uses critical reflection and comes to fully identify with this decision. Despite this identification, I think all would agree that her decision was not autonomous enough to demand our respect. But, given my previous linking of identification, responsibility, and autonomy, how can I claim it was not an autonomous decision?

In order for an individual to have identification with a belief, decision, etc., there must not be any true, relevant, information that would serve to defeat the agent's identification with the belief, decision, etc. To the notion of identification we must add something like

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[12]I am indebted to George Brenkert for his suggestion of this example.

a simplified version of Peter Klein's "defeasibility clause."[13] In the above example, the defeating information is Norman's deliberate deception. If Eileen was aware of that information, her identification with the eventual decision would not be present. Since that relevant information was not available to Eileen, it does not make sense to say she made a responsible decision which she would call her own.

Given that knowledge of such relevant information is crucial to making responsible decisions with which an agent would identify, the requirement that a patient be so informed in order to give valid consent obviously follows. For example, if Jonas is unaware that certain chemotherapies have been shown to result in secondary problems five to ten years subsequent to treatment, he cannot make a responsible, autonomous decision as to whether to undergo that treatment. The obvious difficulty lies in determining what information is in fact relevant. Such a determination is not the focus of this paper, but it seems clear that it will vary within contexts and among patients.

A second response to the problem is a reminder that while identification is a crucial element of being responsible, it is neither necessary nor sufficient for responsibility ascriptions. One can easily imagine situations, as in the previous examples, where the agent's identification is "false" and as such is not sufficient. Further, we can just as easily imagine situations in which an agent has no identification with an action

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[13]Peter Klein, "Knowledge, Causality, and Defeasibility," The Journal of Philosophy, Vol. 73, 1976, pp. 792-812. While I do not think Klein's discussion suffices as a response to the Gettier counter-examples (his stated goal), it is useful for our purposes.

s/he is responsible for. S/he may not be aware that his/her action led to certain consequences, or s/he may simply be quite good at self-deception. S/he literally may have convinced him/ herself that s/he did not take a given action. In both of these kinds of cases we probably would appeal to diminished responsibility, but we would not absolve him/ her of all responsibility. It is not rare to have cases in which the agent is not the best judge as to whether s/he is responsible. There frequently are persons with more relevant knowledge of a situation. Nonetheless, while such situations are not rare, they are by no means the ordinary case. In the ordinary case the agent's honest identification with an action is our best guide.

This directs us to the second process involved in being dispositionally responsible: what should the autonomous person's response be to authority? That is, can we identify with actions that result from authoritative directives or must the responsible, autonomous person make independent choices?

Dworkin claims that being autonomous means being authentic and independent. He divides independence into two categories. "Procedural independence" is concerned with the kinds of deceptions and misinformations discussed in the Norman/Eileen example (Dworkin, 1981a, p. 276). In order to be procedurally independent, Eileen would have to have the relevant information. Such procedural independence, Dworkin agrees, is necessary for a person's being autonomous.

The second category of independence Dworkin calls "substantive independence." He does not clearly characterize what he means by

"substantive independence," but he seems to have in mind that the agent must be the source of all his/her decisions. He says,

> A person may want to do whatever his mother, or his government, tells him to do, and do so in a procedurally independent manner. [But,] by giving up what I call substantive independence he has authentically abandoned something we are inclined to think of as an important part of autonomy (Dworkin, 1981a, p. 276).

Dworkin bemoans what he fears to be the result of seeking substantive independence, "That we should be prepared to accept the idea that the compassionate [and, later, moral] man is less autonomous than the selfish one" (Dworkin, 1981a, p. 277). But I do not see that this must follow. His fear is that in desiring to accept the dictates of one's mother, government, etc. one gives up independence and thereby gives up (some) autonomy. But if we shift the focus away from independence and toward critically reflected and informed identification, the problem loses its punch. On this view an agent would not need to be the source of a particular goal, value, belief, etc. Instead, s/he needs first to engage in critical reflection (a reflection which must include a recognition that s/he has the desire to obey his/her mother, etc.), and following this critical evaluation, determine whether s/he identifies with the original consideration.

This kind of approach acknowledges that we are, in reality, not strictly independent individuals making independent choices in the world. Rather, we are beings who reflect the desires, goals, values, beliefs, etc. of the important people around us. It is the autonomous person who engages in critical reflection (at least in relatively serious decisions) aimed at an attempt to determine whether s/he identifies with what s/he

originally desired, etc. When such identification is present, and if it does not conflict with his/her moral obligations, the resulting decisions or actions are dispositionally responsible and thus are autonomous, regardless of their original source.

A Characterization of Being Autonomous

A characterization of being autonomous now emerges. The autonomous person is one who is dispositionally responsible. That is, s/he engages in a process of critical reflection whereby s/he comes to identify with the significant aspects of his/her life, with his/her nomos and decisions, and with (at least) an immediate sense of self. S/he uses those elements to critically evaluate the dictates of authority and, finally, having achieved this critical, reflective, identification s/he fulfills his/her moral obligations toward others. Obviously, accomplishing all of this, all of the time, is beyond our grasp. However, greater and lesser levels are possible and the greater the level achieved, the more autonomous we are.

How does this characterization take us beyond Beauchamp and Childress' formulation of a negatively free and self-governed person? First, it gives a fuller explanation of why these ingredients are important. It explains how from an evaluative perspective (the loss of respect for one as a responsible chooser) being autonomous is linked with being responsible. It also explains why identification, a crucial element of being responsible, is important to our notion of being autonomous.

Second, it gives an account of how the considerations described by Ackerman and Waitzken serve as constraints on autonomy. Illness, through

its physical, cognitive, and psychological impediments constrains our ability to make responsible decisions. It can cause an alienation from ourselves and our bodies; it can cause a reduction in the mental process necessary for recognizing, and being able to accept responsibility for, crucial elements of our life-world; and so on.

Economic realities, as I noted in Chapter IV, constrain our autonomy by creating work conditions that a responsible person would not desire to be a part of if full knowledge of those conditions were present, knowledge which is necessary for making responsible decisions. Economic realities also constrain autonomy by restricting the number of options that would need to be present to allow for a responsible choice of life-style. Without repeating the text of Chapter IV, there is a clear connection between an economic structure and the various ways (illness definition, available health care, doctor-patient interaction, etc.) one's responsible decision-making is constrained. These elements result in an alienation between the agent and his/her actions, world, and self, with the subsequent breakdown of responsibility already discussed.

Finally, how does this revised account of autonomy serve to guide one concerned with the respect for others' autonomy? By aligning autonomy with being responsible our task changes from the strict avoidance of interference with persons' actions or decisions to the seeking of ways to allow persons to be more responsible for their lives. This would involve, on the interactional level, promotion of patient decision-making based upon goals, values, beliefs, etc. s/he cherishes. Also on the interactional level, it would involve an attempt to break down the power discrepancies that often exist between medical practitioner and patient

and that often result in patients' relinquishing decision-making to the authority figure. On the policy level, it would result in an attempt to reduce those economic, academic and institutional factors that serve to constrain individuals from being responsible.

The list of possible and recommended changes could be considerably extended. The main point is that by recognizing more fully what it is we are trying to accomplish in our respect for autonomy—being as responsible as possible for one's own life—the task of bringing that about will be greatly simplified, at least to the extent of understanding what changes are necessary (the actual implementation may not, obviously, be simple).

Through the above arguments I hope to have shown first, that autonomy includes freedom (as opposed to being identified with it) and second, that autonomy is best understood as being dispositionally responsible for one's life. The third and final goal of this chapter is to show how this conception of autonomy results in a recognition of its being a gradated concept.

Autonomy as Admitting of Degrees

Despite all of the above, we are, it seems, stuck in the same position we started with: how, in the face of these overwhelming constraints can we hope to be autonomous? That task surely is not an easy one, but I think it is possible to resolve it.

By the above characterization, the fully autonomous person is one who has liberty of action, takes an active, critical, and deliberate role in his/her immediate definition of self, fully identifies with all

of his/her actions (recognizing that many of those actions are responses to a factual environment), and thereby lives a life of full dispositional responsibility.

The crucial clause in that formulation is the full identification with actions. I argued that Ackerman and Waitzken's considerations are constraints in that they cause an alienation between the agent and his/her actions and him/herself. But need they cause such an alienation? Only if they always represent a conflict between an individual's values, goals, etc. and what his/her environment makes possible. If, upon recognition of these elements s/he nonetheless identifies with his/her decisions or actions, if s/he gives critical evaluation of his/her decisions or actions (including evaluation of how these elements alter such decisions or actions), then it cannot be said that s/he is constrained by them. However, my (limited) empirical research suggests that most persons do view these kinds of elements as conflicting with their goals, values, beliefs, etc.

This again reveals that it is not necessary that we conceive of ourselves as being the source for all the components of our actions; rather, as I argued in a previous section, we need to be willing to adapt the external elements into our agreement with the decision or action. That is, one can recognize that without a particular environmental element we would not be carrying out a given action; yet, so long as we accept that element as being consistent with our goals, beliefs, etc., we can still have full identification with the action. Given this, it is not at all

implausible that one could be, if only temporarily,[14] a fully autonomous individual.

But, even if such full autonomy is possible, it certainly is not one's ordinary mode of existence. Does that mean the rest of the time we are not at all autonomous? Surely not, as our earlier discussion of the hunger strikers pointed out. We most often do not demand either full identification with actions, full responsibility, or full autonomy. I know of no one who I would claim has led a fully responsible life, yet there are many whose level of responsibility I greatly respect and admire. When we attempt to determine whether an individual accused of criminal behavior is responsible for that behavior we do not ask for complete, total responsibility. We acknowledge that external circumstances affected his/her behavior and the more extensive those circumstances, the less we hold him/her accountable.

Instead of attempting to determine when we are or are not autonomous, we should recognize that such a status falls on a continuum. At times in our lives we will be more autonomous, at other times we will be less. In fact, it seems perfectly natural to say that during the same day certain decisions will be more or less autonomous.[15]

Further, given the discussion about the pervasiveness of constraints on autonomy, there will be a multitude of situations in which it simply

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[14]I do not find it plausible that one could have full, critical, identification with all the components of one's life-world.

[15]See William Ernest Hocking, The Self: Its Body and Freedom (New Haven: Yale University Press, 1956).

is not possible to be fully autonomous. Does that suggest we should, then, accord no respect to, e.g., a seriously ill individual incapable of being fully autonomous? Surely not. What we should do instead is attempt to promote that level of responsible/autonomous behavior which is possible and respect it when it is present.

The obvious question that now emerges is how much autonomy is enough, particularly when respect for autonomy will conflict with other things we value; e.g., in decisions to forego or terminate life preserving procedures. My abbreviated response is that it will depend; it will depend on the context, on the kinds of issues at stake, on the individuals involved. While I hope to give a much fuller account of these issues in a subsequent work, I think it is helpful to at least look at a couple of borderline types of cases and show how an analysis based on the preceeding argument would look.

Case #1

> Mrs. X., forty-five years of age, was diagnosed as having cancer of the colon with metastases to the lymph nodes. Miss N., a young but experienced nurse in the oncology unit, developed good rapport with Mrs. X. during the three days before the scheduled operation. Miss N. was off duty the day after surgery. When she returned, she could not locate the physician to ascertain what he had told the patient about her condition, and the associate nurse indicated that the patient had not requested or received any information from her. In talking to Mrs. X., Miss N. discovered that she did not know that the tumor was cancerous, that it had metastasized or that her condition was serious. Mrs. X., however, was concerned about the sharp pain in her abdomen, and specifically inquired about the results of the tests. She also wondered when she might be able to return to work. The nurse avoided direct answers to these questions, and Mrs. X.'s two daughters tried to divert the conversation. When Mrs. X. asked, "Is everything all right?", no one answered.
>
> Later Mrs. X.'s daughters, who knew the truth, asked the nurse to reassure Mrs. X. about her condition. They were worried

> about the possible impact of the truth, especially since Mrs. X. had recently undergone very difficult divorce proceedings. They thought that she would not be able to bear this additional burden. Although the nurse made no promises, she did try to keep the conversation with Mrs. X. as light as possible until she could talk to the attending physician—a procedure recommended by the head nurse. When the attending physician arrived in the patient's room, Mrs. X. indicated that she felt "pretty good," but asked no questions. He left after a brief examination.
>
> Later when the nurse was finally able to talk to the physician, he indicated that no one had told Mrs. X. about her cancer because such information would only cause her unnecessary anxiety and suffering. Furthermore, he ordered Miss N. not to disclose this information, warning her that he would consider such an act a violation of the patient's best interests and a breach of professional responsibility.
>
> After talking again to the head nurse, who recognized the dilemma but advised her to follow the doctor's orders, she decided not to disclose the information to the patient, despite her uneasy conscience.[16]

I think it is clear in this case that Mrs. X. was attempting to take significant responsibility for her life and thereby be correspondingly autonomous. She sought information as to her <u>immediate</u> state (what was causing the pain) as well as to her <u>future</u> status (when could she return to work). One might question as to whether she <u>really</u> wanted to know what was her condition, since she did not directly question the physician. But that kind of argument does not acknowledge the <u>alienation</u> patients often feel toward their physician and how that leads to a reluctance to directly question these authority figures. Mrs. X. seemed to be attempting to work around that reluctance by questioning the medical person with whom she did <u>not</u> feel that alienation—Miss N. While there

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[16]Taken from Beauchamp and Childress, 1983, pp. 290-291.

undoubtedly would be an increase in anxiety associated with the attainment of the missing information, there clearly also is anxiety for Mrs. X. in not having that information.

If we do in fact have an obligation to respect individuals' being autonomous, then it seems clear we have at least a prima facie obligation to respect Mrs. X.'s attempts to accept responsibility for her life. While she has been significantly constrained (most immediately by the effects of her illness and her surgery, by the social constraints being imposed by her family, and by the power asymmetry between her and her physician), there is no evidence to suggest that, like a child, she is unable to assume some level of responsibility for her life. She still is capable of sophisticated levels of reasoning and intelligence and she displays a crucial element of being responsible: she seeks information (from those she has a fidiuciary relationship with—primarily Miss N.) about how significant aspects of her life have been and will be altered. Given all this, Mrs. X is displaying a high enough level of responsible, autonomous behavior to require our prima facie respect of her decisions. (Whether Miss N. should violate the physician's instructions is a separate and very difficult problem. I will not attempt to address it here as it brings up issues not directly related to this work.)

Case #2

> Mrs. R., a forty-five-year-old housewife, has multiple sclerosis and suffers frequent asthma attacks that require treatment in the emergency room of the local community hospital. The physician has written a "no code" order for Mrs. R. This means that no efforts will be made to resuscitate her if she were to suffer a cardiac arrest during an acute asthma attack in the hospital. As far as the nurses know, the physician's decision was made without discussion

> with the patient or the patient's family. Mrs. R.'s husband, a middle-management executive in a local firm, divorced her several years earlier, and Mrs. R. has been responsible for two teen age daughters (ages 14 and 16), who live at home.
>
> According to some of the nurses, Mrs. R.'s medical condition and situation at home are "intolerable." They even feel that they certainly wouldn't want to live under those conditions." There is, however, no evidence that Mrs. R. feels this way. She usually seems depressed when she comes into the emergency room, but she has not expressed her views to the nurses. The nurses wonder what they should do if Mrs. R. suffers a cardiac arrest when they are on duty.[20]

This case presents the classic example of not knowing whether a patient is or has been accepting responsibility for her life. It is clear that the physician has shown no respect for Mrs. R.'s autonomy (assuming the nurses' information is accurate). By not consulting the patient the physician has in essence declared that s/he is him/herself accepting responsibility for Mrs. R.'s life. While that is a common and sometimes justifiable reaction on physicians' parts, it is not justifiable in this case. Mrs. R. has given evidence that she is at lest minimally responsible in that she reports to the hospital whenever she has the asthma attacks. How responsible she is otherwise cannot be ascertained from the given information. What would need to be determined in order to find out how much she is, or is capable of, accepting responsibility for herself are such things as: her understanding of her condition; her future goals; whether she is capable of taking care of herself at home and whether she in fact does so; how she conceives of herself given her current and future condition; etc. Until these kinds of things are determined, there can be no justification for imposing the "no code,"

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[20]Taken from Beauchamp and Childress, 1983, p. 304.

at least not if we are placing considerable value on respecting a person's being autonomous.

These cases provide a rough sketch of how such analyses would follow from linking autonomy with being responsible. In both cases there was a recognition that the patients were displaying some level of responsible behavior. In the first, I determined that that level was enough to demand our respect, despite the fact that Mrs. X. was significantly constrained. In the second, there was evidence of a minimal level of autonomous behavior, though there was not enough evidence to determine whether she was responsible enough to be respected as an autonomous agent. What the given evidence does suggest is the crucial need for obtaining more information about the patient. Such additional information might suffice to demand our respect. (Even if it did not, the decision for the "no code" should clearly not rest solely with the physician.)

Summary and Future Concerns

I have attempted to show in this work that two prominent and common explications (those of Robert Veatch and Tom Beauchamp and James Childress) of what it means to be autonomous do not adequately capture the normative concerns inherent in the clinical environment. They are inadequate in that they do not address the broader kinds of constraints suggested by Terrence Ackerman and Howard Waitzken, they do not discuss why it is that the status of being autonomous is respected, and their accounts do not provide useful guides for the applied ethicist.

By linking being autonomous with being responsible I hope to have at least made a step toward the resolution of these issues. However, I

realize there are still a number of questions that need to be addressed. In a subsequent work I hope to push the current project in the following directions.

By showing that being autonomous admits of degrees, we are pushed into the problem of deciding what level of autonomous behavior is sufficient to demand respect. I have suggested in a number of places that the level will vary within contexts (e.g. as between emergency vs. routine care). I will provide a fuller defense of why it should vary, as well as a discussion of what levels correspond to what (general) settings.

Part of the way in which that analysis will be worked out will be by developing the connection between being responsible and having control in a situation. In discussing the notion of control, I will be extending the examination of power asymmetries, showing the ways such asymmetries affect the amount of control individuals have in specific situations. This extension will, in part, involve analysis of actual doctor/patient interactions.

A further issue I hope to consider is the means by which persons can determine whether another is sufficiently autonomous. What methods will be involved in that process and is the physician always the most qualified to undertake them?

Finally, I hope to address the issue of whether persons have an obligation to be autonomous. How is one's status as an autonomous individual altered when s/he refuses to identify with certain aspects of his/her life that others take to be crucial to being a responsible, autonomous person?

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