

Medical Ethics Needs a New View of Autonomy

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The notion of autonomy commonly employed in medical ethics literature and practices is inadequate on three fronts: it fails to properly identify nonautonomous actions and choices, it gives a false account of which features of actions and choices makes them autonomous or nonautonomous, and it provides no grounds for the moral requirement to respect autonomy. In this paper I offer a more adequate framework for how to think about autonomy, but this framework does not lend itself to the kinds of practical application assumed in medical ethics. A general problem then arises: the notion of autonomy used in medical ethics is conceptually inadequate, but conceptually adequate notions of autonomy do not have the practical applications that are the central concern of medical ethics. Thus, a revision both of the view of autonomy and the practice of “respect for autonomy” are in order.

Keywords: *concept of autonomy, medical ethics, principles, respect, self-rule*

I. INTRODUCTION

Within medical ethics, the principle of respect for patient autonomy has been criticized from many different perspectives. Some are concerned that focusing on autonomy undermines other values like those of beneficence or community.¹ Others are worried about the cultural specificity of the notion of autonomy in contrast to its supposed universal application.² Finally, some simply think that empirical evidence shows a discrepancy between what patients actually want and the call to respect their autonomy.³ Despite all these critiques of the principle of respect for autonomy, however, the notion of autonomy at work in medical ethics has itself received much less critical discussion.⁴

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No account of autonomy is adequate if it fails to properly identify which actions and choices are autonomous or gives a false account of which features of actions or choices makes them autonomous. Furthermore, if autonomy is a feature of persons that is to be respected, an account of autonomy that provides no grounds for such respect is thereby suspect. It is my contention in this paper that the notion of autonomy commonly employed in medical ethics literature and practices is inadequate on all these fronts: it fails to properly identify nonautonomous actions and choices, it gives a false account of which features of actions and choices make them nonautonomous, and it provides no grounds for the moral requirement to respect autonomy. The solution for such problems is clearly to offer a better account of autonomy. However, in this paper I offer only a general schema that such an account should follow and endorse no particular theory of autonomy. This is because once we see what an adequate notion of autonomy looks like, we also realize that such notions are not useful within medical ethics in the manner usually supposed. That is, not useful in determining which particular choices must be respected (or, practically speaking, abided by). A problem then arises: the notion of autonomy used in medical ethics is conceptually inadequate but conceptually adequate notions of autonomy do not have the practical applications sought within medical ethics. Thus, a revision both of the view of autonomy and the practice of “respect for autonomy” are in order.

II. THE COMMON VIEW OF AUTONOMY

The requirement to respect patient autonomy is often discussed in medical ethics in absence of any specific explanation of what is meant by “autonomy” either of the person or of their actions and choices. In looser usage, it seems implied that *whatever* competent persons freely choose can be counted as autonomous. When care is taken to add additional qualifiers, autonomous choices seem to be equated with the *informed* choices of competent persons not unduly influenced by *external pressures* (coercion, manipulation and the like). These ways of understanding autonomy offer versions of what I call “black box” views. Given any patient meeting a particular description (here competent), proper input (presumably relevant medical information and the lack of coercive or other manipulative pressures), whatever choice or action is the output, counts as autonomous and is to be respected.

To avoid the charge of going after a straw man, however, I will not articulate my concerns about the view of autonomy common in medical ethics by looking at the largely undeveloped uses of the term in the literature. Instead, I will set my concerns against the backdrop of what is one of the most demanding and at the same time most influential views, namely that of Beauchamp and Childress in *Principles of Biomedical Ethics* (hereafter *Principles*).⁵

The view of autonomy explicated in *Principles* is self-consciously focused on autonomous choices and actions rather than explicating criteria for the autonomy of persons generally (100). In keeping with this focus, my critique in this section will rest explicitly on disagreement about when autonomous persons act and choose nonautonomously. As shall be seen, however, I think focusing on the autonomy of individual actions and choices is misguided. Rather, medical ethics should focus on respect for the autonomous person, not her actions.

According to the authors of *Principles*, autonomous choices and actions are of “normal choosers” made intentionally, with understanding, and without internal or external controlling influences that determine action (101).⁶ To return to the black box metaphor, on this view we look inside the box into some corners, into intentionality, understanding, and a lack of internal controlling influences. My claim will be that in order to get a good view of autonomous actions and choices, we need a view right into the center of the box—at how the self or the will rules itself. But before we get to that, we ought to have a slightly better grasp on what I am terming the “common” view of autonomy in medical ethics.

In at least the most recent edition of *Principles* (which one must take as representing the authors’ most settled view), there is little discussion of what is meant by “intentional,” but it appears to be a relatively thin notion, requiring in essence that the action is done “on purpose” as opposed, for example, to accidental or inadvertent action. On their view, this requirement does not admit of degrees, and with respect to intentionality, actions either are or are not autonomous. Understanding and controlling influences, however, admit of degrees and, since the authors aim at criteria of autonomous action and choice that are easily met by “normal choosers,” autonomous actions are said to require only “substantial” understanding and freedom from constraint (101).

The requirement of understanding is presented as follows: “persons understand if they have acquired pertinent information and have relevant beliefs about the nature and consequences of their actions” (127). Some barriers to understanding explicitly include problems with information processing (as may occur with information overload or because of the way information is presented) and failure to believe true information despite an adequate comprehension of the information (130–1). Despite these high standards for meeting the requirement of “understanding,” there are no requirements of rationality discussed with respect to understanding or any of the other elements of autonomy. Thus, there is no requirement that a person’s beliefs relevant to their choices are rational, that choices are arrived at through a rational process, or that actions are generally practically rational.

Finally, the requirement that autonomous actions be substantially free from controlling influences is identified with “voluntariness” and discussed in detail only in terms of control by others. Such autonomy-undermining

control includes coercion as the intentional use of “credible and severe threat of harm or force to control another” (133) as well as some types of manipulation (134). The authors also claim that control by some types of personal conditions undermines autonomy. They write, “debilitating disease, psychiatric disorders, and drug addiction can also diminish or void voluntariness” (132). However, no detailed discussion regarding these types of controls is offered. Thus, although the requirement of a lack of controlling influences applies explicitly to what might be termed “internal” and “external” controls, there is in fact no sustained discussion of the internal controls that would undermine autonomy.

III. PROBLEM CASES

So far, then, it seems that all nonautonomous actions and choices of autonomous patients must fall into one of three categories: they must be unintentional, lacking in understanding, or externally or internally controlled. However, there are all sorts of other ways in which actions and choices can be nonautonomous. Examples include failures of the will to motivate one to action, problems with theoretical or practical rationality generally, and actions and choices that are deeply at odds with the settled and reflective (“authentic” if you like) self. What all these varieties of nonautonomy have in common is that they are problems of autonomy that occur at the very heart of the matter; problems, that is, with self-rule, and not with events external to the self (like coercion or a failure to provide proper information). Thus, getting a grip on whether or not actions and choices are autonomous or nonautonomous in these ways requires shining a light right into the center of our “black box” at the self and/or the will and/or the proper functioning of reason in relation to these elements. In this paper, I am purposely vague both about what these various terms (e.g., “self,” “will,” and “reason”) mean exactly and about which among them should be looked at to best understand autonomy. My project here requires no endorsement of any particular view of autonomy (any of which would be controversial) but only aims to show that some key exploration in this area is missing from the medical ethics notion.

To give a better sense of the various ways in which patient actions and choices may be nonautonomous in a manner not accounted for by the common view in medical ethics, I offer a few hypothetical cases. These cases are meant to serve a purely illustrative purpose and not much else should ride on them. In each case we hold as a constant that the featured *person* is generally autonomous on whatever model you like:

Weak-willed William

William has had surgery on his knee and has been undergoing physical therapy in the hospital to regain his full capacities. He has been discharged from the

hospital, but is under strict instructions to follow a personally monitored regime of physical therapy at home. If he does not follow this regime, it is likely that his ability to walk will be permanently compromised. William goes home with the full intention of following the regime. Nevertheless, when left to his own devices, William just never gets around to doing the exercises. William fervently wants the benefits that the exercises will confer, he fully agrees that the exercises will confer these benefits, and moreover he fully agrees that the benefits are worth the temporary discomfort and inconvenience of actually doing the exercises. In general it may be said that William thinks that doing the exercises is clearly the best course of action all things considered, yet he fails to do them.

Desiree's unendorsed desires

Desiree reflectively endorses and strongly identifies with feminist values according to which, as she sees it, having cosmetic plastic surgery is an unacceptable acquiescence to male dominated social norms of attractiveness. She feels that breast implants, for example, are among the worst expressions of this problematic practice. If asked to identify her core values and ideals, she responds, and truly believes, that women should be accepted for precisely who they are, warts, fat, big noses, small breasts or whatever. Furthermore, she thinks it is patently immoral for individual women to undermine the community of women by getting plastic surgery themselves for the sake of individual benefits, which she thinks of as ill-gotten gains. Yet, despite all this, Desiree has a strong and overwhelming impulsive desire to get breast implants. She doesn't know why she wants this and indeed she is horrified by her desire. Nevertheless, it is strong enough for her to approach a plastic surgeon about doing the operation.

Tim's time slice reasoning

30-year-old Tim is told that he has colon cancer but that with immediate surgery and follow-up therapy his chances of recovery are extremely high. Tim thanks his doctor for the information, but says that he isn't interested in treatment. His doctor is surprised and emphasizes that any delay in treatment will cut Tim's chances of survival significantly and that failure to act in the fairly near future will mean a death sentence. Tim remains steadfast in his refusal. When the doctor presses further, Tim admits that he has simply lost his taste for living at the moment and thinks that the cancer is rather fortuitous. Tim's doctor asks him to undergo a psychiatric evaluation. The psychiatrist reports that Tim's only abnormality is his wish to not continue living. Tim's other cognitive and emotional faculties appear to be fully normal. In fact, the psychiatrist is tempted to call Tim's wish a "phase," perhaps brought on by reading too much existential philosophy, and assures the doctor that Tim is not suffering from depression. All indications are that Tim will most assuredly "grow out" of this phase and reacquire his love of life in a year or so if he continues to live. As it turns out, Tim acknowledges that he would no doubt choose differently had the diagnosis occurred next year or even one month ago, but since his current wish is not to go on living he doesn't see how such future interests should affect his decision.

Each of these cases illustrates a particular type of nonautonomy understood as a faltering of self-rule. William is experiencing weakness of the will. He fully agrees that the reasons for doing the therapy are decisive and yet he fails to act. Desiree's approaching a plastic surgeon for breast implants is also a case of weakness of will when this is understood as intentional behavior conflicting with the agent's own reflectively endorsed values. However, the cases are different in so far as William's involves a lack of motivational efficacy in his will to act while Desiree's is most easily analyzed as a case of conflict between "first order" and "higher order" desires or preferences that results in a choice that is not reflective of the authentic self. Tim's case, on the contrary, is not one of weakness of will, but rather of an irrationality of a different sort (assuming one categorizes weakness of the will as a kind of irrationality). His decision evidences a kind of practical irrationality because he privileges his current wish to stop living over his future interest in surviving even though his current wish is transitory *and* acting on it will cause his future self not to exist at all.

These three cases also illustrate nonautonomous actions and choices that differ in their relationship to medical consequences (from choosing an elective and nontherapeutic medical procedure to refusal of a life-saving medical intervention) and differ as to whether the treatment or procedure is requested, refused, or agreed to but without follow-through ("noncompliance"). These differences between the cases are significant only in showing that nonautonomous choices and actions involving a faltering of self-rule can show up in a wide variety of medical and decisional contexts.

Crucial to my argument in this paper, however, are two features that all three cases share: first none are accounted for on the common view of autonomy in medical ethics, and secondly, all stem from problems with the agent's autonomy in an area that must be explicated on any plausible theory of autonomy, that is the agent's achievement of self-rule. With respect to the first feature, it should already be clear that these kinds of cases are not accounted for on the view offered in *Principles*. Each of these actions or choices is intentional in the minimal sense required. None of these actions or choices is entered into with a lack of understanding. For example, each person believes and accepts the medical facts relevant to his or her decision and processes those and other relevant facts without distortion or other error. Finally, there is no external or internal control that would count as autonomy undermining in the sense endorsed in the view. That is, there is no psychiatric disorder, debilitating disease, or drug addiction.

Of course the problems are precisely problems with internal control of a quite different sort, that is, problems with the self or the will *properly* controlling behavior and problems with the rational determination of the will. Yet, as already discussed, these kinds of "controls" are not usually considered. Hence the second claim; each of these actions or choices is nonautonomous

by virtue of its connection to a problem with the agent's self-rule, an area of autonomy that must be addressed by any adequate view of autonomy, yet that is not adequately accounted for by the theory under consideration.

This last point may actually be appealed to by authors like Beauchamp and Childress as a way of defending the common view. After all, discussions of the self and the will usually take place in the context of general theories of the autonomy of persons, which is precisely what they want to avoid. However, as we have seen through our examples, these general features of autonomous persons easily translate into specific instances of failures of autonomy at the level of action and choice. That is, even those persons who are generally autonomous may act and choose nonautonomously precisely because those actions or choices instantiate weakness of the will and/or irrationality and/or conflict with the authentic self.

IV. VARIETIES OF CONTROL

At this point, someone otherwise satisfied with the common view of autonomy in medical ethics might simply reject my claim that the cases at issue illustrate instances of nonautonomous choice or action. They might instead claim that the choices and actions in these cases are *autonomous*, though respecting them might lead to conflicts with other moral principles such as beneficence (thus giving a ready explanation for why cases like these seem morally problematic). This response would be quite strong if the problem proposed was simply the presence of differing intuitions about whether several particular actions or choices are autonomous. But this is not the case.

First, as already discussed, the actions and choices at issue are not peripheral cases of nonautonomy about which different intuitions might reasonably lead to a judgment of autonomy *or* nonautonomy. Rather, they are examples of failures in the core feature of autonomy: self-rule. If the claim that these actions and choices are autonomous is simply based on a particular interpretation of the cases presented, then the details of the cases can simply be modified to meet the objection. All that is necessary to make the point is that there are core cases of nonautonomous action or choice of this *general sort* (e.g., problems of weakness of the will, irrationality, or lack of authenticity) not accounted for by the common view of autonomy within medical ethics. The particular cases offered here are, as already stated, mere illustrations of this shortcoming.

Yet, even if there is disagreement about this point, perhaps due to a difference in the understanding of the definitive or core features of autonomy, there are additional reasons to think that the view of autonomy common in medical ethics is deeply problematic. In the present section, I will argue that the characterization of "controlled" actions and choices as conflicting with autonomy is in fact a flawed claim. This argument serves to drive home the

point that the common view of autonomy in medical ethics does not properly characterize the distinction between autonomous and nonautonomous actions and choices. Furthermore, this failure connects up with the importance of a theory of autonomy addressing core features of self-rule (e.g., the rational determination of the will by the authentic self). In the next section, I will ask whether the view of autonomy in medical ethics can support a *moral* principle of respect for autonomy.

Autonomous actions and choices often are contrasted with those that are controlled by some kinds of external forces. Actions might be forced by the threat or actuality of physical or emotional abuse or controlled by the deviant manipulation of our understanding. These kinds of control are usually straightforwardly autonomy undermining. Control by internal forces can also undermine autonomy. Actions that are done in the midst of a psychotic break or are the result of addiction can also be generally counted as nonautonomous. Yet on some views of autonomy, particular sorts of internal necessitation are required for an action or choice to count as autonomous at all. Leaving this point aside, it is clear that what is important is not *whether or not* an action is internally controlled, but rather the *kind* of control. In terms of necessitation (understood as the availability of only one option), the point is better put that what is important is not what the options are, but how the choice is made and acted upon. What matters is whether choices and actions are controlled (or necessitated) by features of the self or the will that are identified with, necessary features of any will, essential to the authentic self or what have you (e.g., depending on the theory at issue) or whether they are controlled or necessitated by forces that are in some sense external to the self. That is, external in so far as they are experienced as, or do in fact, act on the self from the outside.

Some kinds of addiction and psychotic episodes are classic examples of the sorts of forces that are autonomy undermining in this way. Significantly, however, states of being like these are not always autonomy undermining. Even an addict (and presumably a psychotic) might identify with their behavior or condition in a way that makes it part of the authentic self.⁷ Dr. Gregory House, on the TV series *House, MD*, is a great example of this kind of addict. He is clearly addicted to pain pills, but embraces that addiction with uncommon consistency. His pain and the addiction that results are both central to his narrative identity. In such a case it seems a stretch to call instances of his taking the pain pills “nonautonomous.”

Admittedly there is room for disagreement about whether actions that are really attributable to addiction or psychosis can be autonomous, so to drive home the point that some actions are fully controlled yet also fully autonomous, I offer two very different types of cases: actions from love and actions from moral principle.⁸ Certain sorts of action done out of love are not open to alternatives; they are in this sense fully necessitated (there are no other options) and, if necessity and control are different, they are fully controlled (love is itself driving the will). If I love my child I will feed him when

he is hungry, I will snatch him from a ladder when he is about to fall, I will even risk or sacrifice my own life to save his—in a heartbeat and without second thought. If I truly do these things out of *love*, then there are no other options that I have. It is not an option for me to sit by and watch him go hungry nor is it an option for me to hesitate before shielding him from a pointed gun. I simply must do it. But none of this is autonomy undermining. My love for him is in fact so centrally a part of my will or self that these actions are, if anything, pure expressions of my autonomous nature.

Moreover, in so far as what one loves is an important part of one's identity as an individual, different from others, love is also part of one's autonomous nature in a way that contributes to one's narrative identity. Thus, it is autonomy enriching in a distinctive way, as a self dedicated to specific relationships of value with specific other selves. Sometimes it is these particularities about a person that are precisely what we "respect" when we respect their autonomy.

Actions done from moral principle are quite different from actions done from love in so far as they are universally required. Nevertheless, they share the features of necessity and control with actions done from love. It might well be argued that all actions that are necessary from the moral point of view (e.g., when there are not several equally morally good options) are both controlled and necessitated in so far as we act out of respect for moral principle. However, we need only one example. Consider the case of a war-time interrogator who has been asked to use torture to get information from a prisoner of war. He goes into the room equipped with the tools of torture, yet he simply cannot act on the command. It is not in him to violate this person's humanity in the manner required. He cannot so act simply because it would be morally wrong, thus his actions are controlled by his moral principles. It is not an option for him to torture and so his choice is also necessitated. Yet, if anyone is, *he* is autonomous, more so, one thinks, than the person who can be persuaded to do such things. So it appears that the requirement that actions and choices not be controlled, at least internally, is a requirement of the wrong sort.⁹ What matters is not control, but the sources of that control and the reasons why those sources necessitate the action.

Now the authors of *Principles* might well say at this point that they do not actually claim that all necessitated or controlled actions are nonautonomous, just those specific types that we have agreed *may* be nonautonomous. That is, actions like those controlled by psychiatric disorder or addiction. Yet, in point of fact, the conditions on autonomous action are stated as requiring generally freedom from "controlling influences that determine ... action" (101) and the specific instances of "debilitating disease, psychiatric disorders, and drug addiction" (132) are mentioned only once as *examples* of controlling influences. Moreover, even in these cases, it is reasonable to say that it is not the controlling influence that matters but the acceptance or rejection of that influence by the person. I surmise that the highly significant distinction between controlled and autonomous and controlled and nonautonomous

actions is elided in *Principles* precisely because the authors do not consider the autonomy of actions and choices in light of the essential features of the autonomy of persons. The distinctions we have been making operate at the level of the relationship between the controlling force at issue and the self or the will.

V. RESPECT FOR AUTONOMY AS A MORAL PRINCIPLE

It is widely assumed that whatever we may mean by a requirement to respect a patient's autonomy, that requirement is itself primarily a moral requirement (and only secondarily, if at all, a legal or pragmatic requirement). Even if we think that respect for autonomy is not the only moral requirement, and even if we think it is not a "trumping" requirement, we must still make sense of its pull as at least a *pro tanto* moral obligation.¹⁰ Oddly, however, although the moral force of a requirement to respect autonomy is assumed in medical ethics, the justification of such a requirement is very rarely addressed. When it is addressed, an appeal may be made to both Kantian and Millian supports for such a principle. Candace Cummings Gauthier writes, "Contemporary characterizations of respect for autonomy clearly reflect the influence of Kant's principle of humanity and Mill's principle of liberty" (2000, 339).

Now it may be the case that contemporary accounts of autonomy are influenced by both Kantian and Millian considerations, yet it is also quite clear that they offer neither Kant's nor Mill's own account.¹¹ Thus, it is equally clear that they cannot legitimately claim justification for their particular principle of respect for autonomy from either of these sources. Furthermore, it is difficult to see how a principle of respect for autonomy could be supported as both a utilitarian and nonconsequentialist principle without some additional interesting argument.

Onora O'Neill claims that although contemporary accounts of autonomy like those offered in medical ethics often pay homage to Kant's name, they in fact bear a much closer resemblance to Mill's account of liberty (2002, 30). But as O'Neill also points out, Mill has trouble offering a satisfying moral justification for a requirement to "respect" liberty. His justification must be consistent with his utilitarian stance and thus he must find a way of claiming that respect for liberty is the best means of achieving the greatest overall welfare. Such a claim may or may not be true in fact. Importantly, the moral requirement to respect autonomy usually assumed in medical ethics does not appear as a contingent moral requirement justified only *if* actually consistent with an overall utilitarian agenda.¹² Thus, it may seem that the views should be best characterized as "Kantian" in order to receive a nonconsequentialist moral justification, but it is impossible to see how a view of autonomy that does not even require that choices and actions be rational could be "Kantian" much less Kant's. After all, whatever disagreements may still

reign about Kant's theory of autonomy, it is quite clear that on his view no irrational actions or choices could be autonomous.

Beauchamp and Childress would likely reject this way of framing the problem of justification with regard to the principle of respect for autonomy. They offer "common morality" in conjunction with a process of reflective equilibrium as the justificatory framework for their general approach to medical ethics (381–96) and see each of the principles of medical ethics as "very general starting points fixed by morality" (395). Thus, although both Kant and Mill could be appealed to as supporting the "action guiding norms" shared by these theories and by common morality (394), they do not appeal to these or any moral theories in an attempt to justify the moral norms they employ (395).¹³

Whether or not a general moral principle of respect for autonomy can be justified by appeal to common morality is a matter for serious debate. What is at issue in this paper, however, is the claim that respect for autonomy is justified as a moral principle *given* a particular notion of autonomy. Beauchamp and Childress do not attempt any specific justification for the claim that autonomy *as they understand it* is due respect as a matter of moral principle and I do not know how such a justification would go.

The need to give an account of autonomy adequate to supporting a moral principle of respect for autonomy connects to the specific claim I have made: accounts of autonomy must attend to the core features of self-rule. This is because the most satisfactory explanations of the *moral* obligation to respect autonomy appeal precisely to autonomy as some specified relationship between the self or will and the person's actions and choices that can support her capacity for morality. That is, the most promising views supporting respect for autonomy as an independent moral principle rely on accounts of autonomy as self-rule allowing us to create (or sustain) moral value or valuation and to act and choose in accordance with that value or valuation.

We have seen that the requirement to respect patient autonomy needs some good explanation of why it is a *moral* requirement. This explanation is so far missing in the standard accounts of autonomy in medical ethics. Furthermore, it seems these accounts cannot easily offer such an explanation. A satisfactory story of the requirement to respect patient autonomy would most likely appeal to some aspect of the patient's autonomy that makes possible her capacities as a moral agent.

VI. RESPECT FOR AUTONOMY IN MEDICAL ETHICS

There is a good reason why medical ethics accounts of autonomy focus where they do. It is one thing for health care professionals to interfere with patient decisions because the decision was coerced or made in the absence of proper information. There the solution is practical and simple: provide a better supportive environment for autonomous decision making and then

see what the patient decides. It is quite another thing to interfere with a decision because of suspicion that the patient suffers from weakness of will or is being irrational. Even if we did have a good way of establishing weakness of will or irrationality (which we do not), it still seems that these sources of nonautonomy are themselves rarely grounds for interference with otherwise autonomous persons' choices or actions. Rather, if the *person* is autonomous, then she should have purview over her life decisions including those specific decisions that may be nonautonomous in the sense of not being properly ruled by the self or will.¹⁴

In response, it might be argued that this is true for cases where the risk of harm to the patient or others from abiding by the nonautonomous decision is low, but that in some other cases whether or not the decision is autonomous is of critical practical importance. So, for example, one might argue that Tim's decision not to undergo treatment should not be abided by precisely because it is nonautonomous. But is it really the autonomy or nonautonomy of the particular decision that is at issue? Isn't it instead the *harm* to Tim that would provide the most plausible justification for interference? The *practical* ethical conflict in this case is most reasonably construed as a conflict between respecting the autonomous *patient* by not coercing or forcing treatment and protecting him from life-threatening harm. This is so regardless of whether the particular choice is autonomous in the sense of evidencing proper rule by the self or will.¹⁵

Thus, a dilemma is apparent for practitioners of medical ethics. The practically useful account of autonomy that is currently appealed to in medical ethics is conceptually inadequate. On the other hand, conceptually adequate accounts of autonomy are less practically useful and seem to provide suspect grounds for interference with patient decisions. So what is the best solution? Perhaps respect for "autonomy" is neither here nor there in practical applications of medical ethics. Instead, we should rely solely on competence to make particular decisions regarding one's medical treatment, freedom from interference with those decisions, protection from bodily assault once those decisions have been made, and rights to medical treatment under appropriate circumstances. However, while these notions might protect autonomous persons from wrongful interference with their medical decisions, they do not give enough weight to the requirement to positively support autonomous decision making by patients including giving proper information, reasoning through medical decisions with patients if necessary, supporting their independence and other such efforts.

The better solution is to re-cast "respect for autonomy" in medical ethics as support for the conditions that are conducive to autonomous decision making on the one hand and abidance by the decisions of autonomous persons made under those conditions on the other hand. Perhaps surprisingly, there is some practical agreement, then, between myself and those who hold "black box" views of autonomy. While I think it is a significant conceptual error to equate the informed choices of competent persons (not unduly

influenced by external pressures) with autonomous choices, I agree that these decisions should by and large be “respected” or at least abided by.

So then of what real significance is my rejection of the view of autonomy in medical ethics? First, the conceptual clarification about the nature of autonomy is itself worthwhile. Secondly, the conceptual clarification should help practically to disentangle debates about whether patient decisions are to be abided by. The proper focus is not usually on whether the decision *itself* is autonomous but on: (1) whether adequate positive support for autonomous decision making has occurred along with a lack of conditions undermining such autonomous decision making and (2) potential conflicts between abiding by the decisions of the autonomous person and other values (e.g., patient well-being or protecting the patient and/or others from harm). Third, this account puts emphasis on the positive role of “respect for autonomy” of the person in terms of efforts to create an environment conducive to autonomous decision making in general. Finally, when we understand autonomy as fundamentally a matter of adequate self-rule, we have the conceptual tools to combat the practical conflation of “respect” for a person with “abidance” by her actions and choices. Although one of the ways we show respect for a person is to abide by her choices, we need not thereby respect her nonautonomous choices (even if we must *abide* by them).

VII. CONCLUSION

We have seen that the characterization of autonomy common in medical ethics fails to properly identify core cases of nonautonomous action and choice. Such nonautonomy may stem from failures of authenticity, weakness of will, and other rational failure. I have given reason to think that autonomous persons act and choose nonautonomously when the self or will fails to properly guide or “rule” choices and actions, not when those choices are controlled. I also argued that the notion of autonomy appropriate to medical ethics must be able to support the claim that respect for autonomy is a moral requirement.

Although I have endorsed no specific view of autonomy as self-rule, I have argued that this is the proper framework to use in understanding autonomy. Any complete theory of autonomy would offer some specific understanding of the nature of that self-rule as a particular type of relationship between the self or the will and the individual’s choices and/or actions. However, I have also contended that such theories of autonomy should not generally be used as a means of determining when an autonomous patient’s actions and choices should be abided by or overruled. Thus, once we have a better notion of autonomy, the autonomy of any specific action or choice (of an autonomous person) seems mostly irrelevant to whether it should be abided by. The question of whether or not particular actions and decisions are autonomous, once the starting point for discussions of autonomy in medical ethics, should go by the wayside. What is important is respecting the

autonomy of the person (not her actions) and that involves both abiding by her decisions (whether or not autonomous) and creating an environment supportive of autonomous decision making.

NOTES

1. Jennifer Beste offers an overview of some physicians' concerns that emphasis on autonomy undermines beneficence (2005). Candace Cummins Gauthier reviews the communitarian critiques of the principle of respect for autonomy (2000).

2. See, for example, Fagen (2004), Glick (1997), and Carrese and Rhodes (1995).

3. There is overlap here with the cross-cultural critiques. See also, more generally, Schneider (1998).

4. The most notable exception is Onora O'Neill's (2002) support of "principled autonomy".

5. Beauchamp and Childress (2008). The Principles view of autonomy has been identified with the standard view in bioethics by other authors. Kukla (2005, 35) reviews these citations. The view in Principles is also similar to the influential view offered by Faden and Beauchamp (with N. M. P. King) (1986). That book offers more explicit detail about many aspects of the view. The most significant difference, for our purposes, from the view in *Principles* is that Faden and Beauchamp do not include "internal" control as an autonomy-undermining feature, although they do discuss this possibility (268).

6. Two points must be made about this way of stating the authors' definition of autonomous choices and actions. First, only action is mentioned in the definition itself, however, the start of the section in which this definition occurs heralds an account of "autonomous choice" (100); thus, one can assume that the authors are discussing generally autonomous actions and choices. Second, the authors mention only "controlling influences" determining action and do not differentiate internal influences from control by others. However, elsewhere they do explicitly include influences other than control by others (100 and 132).

7. Harry Frankfurt (1971, 19) introduces the idea of the "willing addict."

8. The example of love as both autonomy enriching and action necessitating comes from Harry Frankfurt (1999). The example of moral necessitation comes originally from Kant, by way of Frankfurt's reminder in this same paper.

9. It is important to note that actions that are externally controlled or necessitated may also be autonomous. Leaving aside issues of general determinism, an action can be coerced, for example, and still autonomously chosen. I could really want to shoot Jim and set things up so that you put a gun to my head thereby forcing me to shoot Jim.

10. "Pro tanto" moral obligations are ones that have a specific moral valence but may be overridden in particular circumstances. Beauchamp and Childress identify the principle of respect for autonomy as providing a "prima facie" moral obligation. However, if one means by a "prima facie" obligation one that only appears to be a moral obligation but may not be, then I take it that "respect for autonomy" is actually a pro tanto moral obligation.

11. Barbra Secker (1999) gives a nice review of the distance between contemporary "Kantian" accounts of autonomy and Kant's own account.

12. As Warren Whipple has noted to me, one might argue that the requirement is dependent on the utility of the general rule of respect for autonomy, thus drawing on the "rule" vs. "act" utility distinction to support the Millian interpretation of a requirement to respect autonomy. However, my impression is that the moral requirement to respect autonomy is also not commonly understood within medical ethics as depending on the utility of the rule. Admittedly, this claim is somewhat controversial. The issue may ultimately turn on the viability of rule utilitarianism itself, which debate is beyond the scope of this paper.

13. I find the text a bit conflicted on this point. Beauchamp and Childress (2008) generally claim support for the principle of respect for autonomy from both Kant and Mill (104) and even refer to Kant's second formulation of the categorical imperative as the "substantive basis" for the principle of respect for autonomy (349). On the other hand, they recognize that Kant's view of autonomy is very unlike their view (346), and they do not attempt to actually justify their view of autonomy by appeal to moral theory at all.

14. I discuss this point in more detail in R. L. Walker (unpublished).

15. I do not claim that nonautonomy of the sort at issue never offers a sufficient reason for not abiding by a patient's choice. When respect for the autonomous person does not require abiding by a nonautonomous choice, then the nonautonomous nature of the particular choice is likely to be more relevant to a

decision whether or not to abide by the choice. This might be true, for example, in Desiree's case or generally with respect to nonautonomous requests for medical procedures that are not medically indicated.

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