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Historical and Philosophical Reflections on Patient Autonomy

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Abstract. Contemporary American medical ethics was born during a period of social ferment, a key theme of which was the espousal of individual rights. Driven by complex cultural forces united in the effort to protect individuality and self-determined choices, an extrapolation from case law to rights of patients was accomplished under the philosophical auspices of 'autonomy.' Autonomy has a complex history; arising in the modern period as the idea of self-governance, it received its most ambitious philosophical elaboration in Kant's moral philosophy. In examining the Kantian construction, it is evident that neither his universal moral imperative nor his rigorous application of self-legislated ethical action can sustain our own notions of moral agency in a pragmatic, pluralistic society. But the Kantian position is useful in highlighting that self-governance is not equivalent to 'autonomy,' and this distinction defines the limits of autonomy in the clinical setting. A critique of Engelhardt's idea of 'principle of permission' is used to illustrate autonomy's eclipse as a governing principle for medical ethics.

Key words: autonomy, Kant, medical ethics, pragmatism, self-governance

Introduction

I have been invited to discuss the principle of autonomy as applied to medicine, largely to represent a skeptical view. While I hope to offer a different slant to the discussion, much of what I will say is a reiteration of other critical appraisals, for the controversy about autonomy has been at the heart of medical ethics since the late 1960s. Indeed, according to virtually all students of the discipline, this principle has dominated the debate on the moral foundations of clinical practice and research. Whether presented as the basic ethical principle or one of several, the recurrent questions seem always to be, Where and how does patient autonomy fit into the framework of bioethics? I take these questions as my own starting point.

I wish to explore this issue from general historical and philosophical perspectives. I acknowledge readily that my argument is sketchy and incomplete. But I must observe, given the obvious limits of this discussion, that in order to understand the central role of autonomy in medical ethics we

must decipher the various other roles it might be playing on the stage of biomedicine and within the even vaster drama of Western moral philosophy and culture. After all, medicine is not some isolated enclave, but resides squarely in our social midst, and the rules of governance apply there as in every other domain of the community. I think it no accident that the moral philosophy which informs and directs American liberal, democratic society, where respect for the individual dominates judicial and political precepts, was so readily transferred to the medical arena. But I maintain that this extrapolation is exactly that – an extension from one domain to another – one which may not be a fitting site for erecting the same ethical edifice.

I have previously argued that bioethics functions too often as applied jurisprudence, reflecting a parallel legal ethos rather than effectively asserting its own agenda (Tauber, 1999). This is hardly a novel observation. For instance, my colleague at Boston University, George Annas, an acknowledged expert on the relation of the law to bioethics, has made the following remarks in this regard:

> American bioethics has been driven by the law. ... The stress on autonomy and self determination comes from our Bill of Rights, our Declaration of Independence and the whole common law tradition. And law's primary contribution to bioethics is procedural. Lawyers are expert at procedure. The common law itself is based on deciding individual cases and using these cases as the basis of creating law. Bioethics has adopted this technique. In the United States, with its pluralism of beliefs and people, the law is what holds us together. There is no other ethos. Thus, the law – procedural, autonomy based and case focused – came into bioethics. (Annas, 1992; quoted by Jonsen, p. 343)

My comments are focused on the autonomy issue, and by exploring its philosophical heritage, I endeavor to show the limits of the concept for guiding medical practice.

My position, simply stated, is that while the *restoration* of a patient's sense of autonomy is the ultimate aspiration of the clinical encounter, autonomy itself can hardly serve as the foundation of medicine's moral philosophy. By holding autonomy to be *the* governing principle, I believe we only obscure the doctor-patient relationship and confuse the moral standing of the patient. I am not attempting to banish self-governance as a moral principle from medicine, but here I will argue why 'autonomy' is such a problematic concept not only for medicine, but for culture-at-large. In *Confessions of a Medicine Man* (1999) I presented a history of the idea of the Self in philosophy, the Self's particular reign as an autonomous entity, the severe limitations of that construct as a guiding principle for medical ethics, and finally I concluded by proposing an alternative basis for thinking about the doctor-patient relation-

ship. Others, like Carl Schneider (1998), have arrived at the same point from the perspective of actual practice and patient preferences. While I will allude to the realities of clinical praxis, here I wish to further explore the philosophical basis for my skepticism about autonomy by discussing another aspect of its historical evolution, namely its genesis in Kant's thought and its philosophical fate in our own era. The focus of my discussion is how Kantian autonomy was originally defined within a particular cultural moment and rested on a distinctive metaphysical foundation, neither of which has endured intact into our own era. While we steadfastly hold on to the sanctity of 'autonomy,' it behooves us to understand that our current understanding and use of the concept is quite different from that originally proposed two centuries ago. With that insight, perhaps 'autonomy' might be better understood and its application to the clinical setting more appropriately exercised.

The Birth of Medical Ethics

Customarily, we consider the birth of medical ethics as a quite recent development. Although we can discern antecedents as ancient as medicine itself, the contemporary movement began with a series of conferences during the 1960s and formally emerged with the establishment of permanent academic forums for the discipline, The Hastings Center (1969) and the Kennedy Institute (1970), a theologically-oriented Society for Health and Human Values (1969), and the concomitant appearance of the first systematic presentation of a moral philosophy for medicine. If we seek an ur-text for the birth of modern medical ethics, let me nominate Paul Ramsey's *The Patient as Person* (1970), a book Albert Jonsen rightly calls "the first truly modern study of the new ethics of science and medicine" (1998, p. 50). The text, based on lectures Ramsey delivered at Yale in 1969, was a call to an action-based ethics, a medical ethics fully engaged in bedside decisions. He firmly placed medical ethics within the moral ethos of its human community as a special genre of a more general moral philosophy. That philosophy enveloped both the physician and researcher in the same covenants "of moral discourse concerning the claims of persons" (Ramsey, 1970, p. xii), namely the preservation of their autonomy. Such covenants were moral instruments to protect the freedom and rights of the patient. Ramsey claimed that medical ethics must be committed "to show respect for, protect, preserve and honor the life of fellow man" (ibid., p. xiii). Indeed, medicine is a unique setting for the exercise of such moral action.[1]

Before pursuing that matter, let me make a sociological observation. This may appear as a digression, but I believe that these comments will be useful in orienting my discussion about philosophy. I would ask you to consider

for a moment some of the social factors that enabled the ready acceptance of autonomy as a governing principle in medical ethics. Foremost among these is the birth of contemporary medical ethics during the Nixon era. Within a very short period, between the 1968 collapse of the Mondale hearings to create a Presidential commission on ethical concerns in biomedicine to the successful Kennedy hearings of 1973 that resulted in new ethical oversight provisions for federal sponsored research, bioethics was legitimated by Congressional mandate. This was the period of social ferment which immediately followed the crested wave of the Great Society and the expansion of civil rights. It witnessed the political birth of feminism and homosexuality as assertions of free choice about sexuality. Newly affirmed abortion rights extended the legal domain of personal moral choice; insurgency against the Vietnam War attested individual responsibility; radical life styles, including new standards in dress, music, and sex, claimed new vistas for private choice. In short, the hegemony of the self was forcefully asserted in all domains of our society.

We often speak of the 1980s as the decade of the (selfish) Self, based on the consumerism and materialism that characterized the Reagan years, but I think that this later period was simply an evolved form of a preoccupation with self that became clearly visible in the 1960s. Irrespective of John Kennedy's call for us to ask what we might do for our country instead of for ourselves, before the decade was out that message was drowned by an extraordinary preoccupation with self aggrandizement – first in the name of individual life style choices, and then later in terms of material gain. I see each form of behavior as sides of the same coin.

Patient rights grew in this social ferment. Two protective processes worked hand in glove, one proactive, the other reactive. The first, of course, was the enunciation of bioethical principles and the formal affirmation of patient rights; the other was the dramatic rise of malpractice suits and resultant awards. The medical establishment quickly assumed a certain defensive posture, one that has taken a while to equilibrate, but we can look back at the last thirty years with some satisfaction: Bioethics is firmly in place as a crucial part of medical practice and biomedical research, and the hysteria about defensive medicine has calmed, while a significant sensitivity to patient rights has taken hold (Rothman, 1991).

Lest I sound cavalier, let me emphasize as a participant in that period that activists were driven by moral fervor – first for civil rights, then against the war, and then for sexual freedom. In regards to medical ethics, moral repugnance was a major driving force. I refer specifically to the ways that our awareness of the Nazi and Japanese experimental atrocities performed on slave laborers and prisoners of war heightened our sense of the sanctity and the integrity of the patient (Annas and Grodin, 1992). We have been careful

not to fall into the laxity of another Tuskegee, for we had declared before the world court that certain American moral precepts were universal, and one of these was respect for the individual.

A complementary but independent moral imperative motivating the medical ethics movement of the 1960s and 70s was the general attempt to reclaim humane values from an ever-encroaching technology and debasing material view of the world. This Romantic reaction took on renewed vigor in the late 60s and throughout the rest of the twentieth century. The human body was only one of the contested areas, the other principal one being the environment. In this latter instance, environmentalists saw nature turn inhospitable to its various inhabitants. In the case of medicine, the body, analogous to nature, was found to be objectified and divorced from our sentient egos to become the alienated object of study and of use. For Michel Foucault, Ivan Illich, Thomas Szasz and other radical critics, medicine was just another industry or arm of the state, imbued with arrogance and self-aggrandizing power, ignorant or oblivious to the impact of its own encroachment. These critics tapped into a widely felt anxiety stimulated by rapid technical advances in clinical medicine (e.g., the challenges of fetal research, artificial life support, and human experimentation), as well as the specter of new vistas opened by basic research.

To these neo-romantics, as our bodies were relentlessly reduced to biochemistry and genetics, the disjunction of our material being from our integrated sense of selfhood was epitomized by the objectification of disease. Their complaint, of course, identifies both the success and weakness of scientific medicine. Here, I cannot delve into this aspect of this crisis in our self-image, but suffice it to observe that medical ethics has derived its moral authority as the champion of the rights of patients within the particular context of jeopardized humane values. For better and for worse, medical ethicists, more often than not, have been seen as some kind of Resistance fighters battling against an ever encroaching scientific ethos, which rightly or wrongly is regarded by many as the opponent of compassionate care. The lines too often have been rigidly drawn as both ethicists and their opponents have pressed their own agendas, but there is no doubt that the forum of medical ethics has served as an important stage upon which the moral character of the human body and our human nature have been debated.

To be sure, I have omitted other critical contributing factors to the upheaval in medicine of which bioethics was one important response. But even with this brief sketch, the sociological point should now be clear: The various components that went into building the bioethics movement had to fall into proper alignment: the Nuremberg trials incubated for twenty years; basic social organs – the military, the government, the universities, – suffered crit-

ical reassessment; a period of activism centered on championing individuality became widespread, especially among racial minorities, women, and homosexuals; and medicine itself underwent a significant technological revolution. This is not the place to further explore these complex social forces, other than to remind us that autonomy in the medical setting became the articulation of both a deep social preoccupation with free choice and our collective reaction to a world seemingly increasingly hostile to individuality and subjectivity. While I readily admit that I have severely limited the stage props for my discussion, I have done so deliberately in my effort to suggest how notions of autonomy so readily fit a complicated agenda well beyond the confines of medical ethics per se. In short, our applied philosophy must be seen within its local historical context, the larger political and social fabric of American democracy during the cultural upheaval of the late 60s.

Kantian Autonomy

I have so far highlighted a single point: The philosophical concept of autonomy in American bioethics developed within a unique cultural moment and thereby assumed a particular character, a role it was to play as part of a larger social and political drama. Not to trivialize the philosophical discussion, I think it crucial that we keep clearly in focus the cultural maelstrom in which medical ethics was born, for it helps us to better understand the place autonomy holds in medical ethics and the broader reaches of its standing. But I have made no attempt to actually define 'autonomy,' and to do so I must go back to the Enlightenment to explain its most ambitious philosophical elaboration in Kant's moral philosophy. This brief description will then serve to highlight the differences between the original Kantian meaning of autonomy and its current understanding, and in that comparison the philosophical limits of autonomy as a guiding precept for medical ethics in the 21st century should be clear.

It is not possible, nor even necessary for us to review the political and religious revolution of the early modern period to make an important point: Moral philosophy both led and followed the momentous political changes of the 17th and 18th centuries that saw monarchical power eroded, religious authority weakened, and egalitarian rights expanded. In the wake of this drastically altered social and political landscape, moral philosophers struggled to provide a framework by which a new ethics and political philosophy might support and guide the new order. Liberal democracy required a philosophy that effectively extended religious independence (a question of personal belief) to moral independence (a question of private moral authority). In that effort, two looming questions appeared: First, if religion

was no longer the source of moral authority, what was to take its place? And second, if morality was an individual responsibility, what would sustain a society of men holding differing interests? Each of these questions required almost two centuries of deliberation to sort out.

In many ways, an answer to the second question was more readily arrived at than the first. The new egalitarian moral pluralism supported both a philosophical and political solution: Moral and political deliberation must be based upon mutual respect. Morality was re-conceived from a dogmatic religious code to one that provided some basic rules by which people could live together despite their differences about ultimate matters. And why would men be mutually respectful? The initial responses: Laws were followed either because of fear of punishment or they were adhered to because humans were intrinsically virtuous, seeking either a communal utilitarian end or personal perfection.[2]

Kant rejected each of these approaches and in the process radicalized moral philosophy. The basic turn he effected was to deny all those philosophies which held, in one form or another, that the ends justified the means. For Kant, morality is neither the pursuit of good results or obedience to a divine will. He argued instead for moral necessity, that is, he thought that we must act in accord with moral principle whether such action were in our supposed best interest or not.[3] In other words, he maintained, there is a non-contingent moral imperative which each of us senses, and our moral character dictates that we follow this inner ethical perception. Thus the Kantian answer to why humans are moral rests in his understanding of this fundamental human capability, the capacity to perceive a moral imperative and, to greater or lesser degrees, follow it. No room for our current versions of moral relativism here – the ethical universe, thought Kant, like the natural one, is singular, which is not to say that everyone would interpret the moral imperative in identical ways. And, to be sure, there is a moral hierarchy between imperfect and perfect duties, each commanding different ethical criteria, but the key point of interest here is that Kant established a moral philosophy which allowed the free exercise of individual "practical reason" to self-determine rational conduct. So just as our "pure reason" allowed us to construct and thereby know the natural world, so too would our "practical reason" guide us in constructing a human moral universe.

Thus Kantian self-governance rested on a new notion of autonomy, which contained two necessary presuppositions, ones we must keep in mind as we consider our own notions of moral agency. The first was that moral conduct is ultimately self-generated; we know, through our 'practical reason,' *what* is right. And 'the ought' is derived from an *a priori* moral law "the categorical imperative."[4] The second component was that humans control themselves

through their own moral reason, which is independent of subjective wants and needs. Humans might even oppose their own desires because they have a sufficient (rational) imperative to act as they ought in reference to a self-perceived moral understanding. Thus for Kant, the idea of 'the right' was also individually determined, not by personal caprice but by the inviolate ability of humans to interpret a universally accessible moral universe. In short, "the Kantian self is literally 'auto-nomous,' that is, defined by a *self-legislation* that is carried out on itself as well as by itself" (Ameriks, 2000, p. 4).

Kant substituted this transcendental moral imperative for received religious wisdom in answer to the first question I posed concerning the source of moral order. And to the second question as to why humans are moral, he offered a radical notion of self-governance, one based on his assessment of human rationality. This is a crucial turn, namely, that while the basis of moral law resides beyond human understanding, our rationality nevertheless mediates our ability to know it and follow it. This places moral responsibility firmly on us, enacted by a particular faculty of our human character – the rational mind. Autonomy, according to Kant, thus resides in the person's rational ability to independently perceive and act upon an *a priori* moral dictate in the particular setting of contingent and individual moral choice. Self-governance has thereby been notched up to another level. Indeed, "he held that we are self-governing because we are autonomous" (Schneewind, 1998, p. 6): The moral is both understood and followed by our own free choice and through this self-imposition humans are provided with the motive to obey, or as Schneewind puts it, "practical [moral] reason generates its own unique motive" (1992, p. 327).[5]

Most important for this discussion, "autonomous" and "self-governed" are not equivalent. Self-governance refers to the acceptance of moral principles apart from external sanctions, making no claims on the source of moral legislation. Autonomy is a more complex idea, incorporating the principle that such self-legislation is a product of individual reason and that the ethical standard itself is an appreciation of an independent *a priori* categorical imperative. Kantian practical reason enables us to conceive, for ourselves, the character of the 'ought.' In other words, each of us is not only responsible for acting ethically, we are ultimately responsible for formulating those actions rationally. And if action and legislation are generated by individual interpretation of a universal moral ideal, how does a society of free men sustain a just community? The Kantian two-part answer: 1) All men are endowed with the ability to interpret moral truth, and like the laws of nature comprehended by 'pure reason,' a unified moral order is analogously revealed by 'practical reason;' 2) our human character dictates that we follow this perceived 'ought' as best we might. In short, we are self-governing because we are autonomous

in both self-conceiving and self-imposing moral action. This is, to be sure, a radical idea of freedom and independent ethics.

The Loss of Autonomy

In a sense, the philosophical concept of autonomy – the idea that moral law can only arise from our own reason – begins and ends with Kant.[6] Presupposing a universal rationality that would afford humans a common moral understanding leading to rational courses of action has, in our own era, become a faint hope of a few stout-hearted Kantians. Most of us are much less sanguine about the possibility of revealing a democratized, universal moral/political structure. Multiculturalism, pluralism, tolerance for widely diverging moral systems is the ethos of our own culture, and the Enlightenment dreams of reason seem just that, dreams. Furthermore, confidence no longer exists in a moral imperative from which all humans might expect to find some common understanding. The Kantian idea of autonomy and its operation arose within the culturally homogeneous social and intellectual milieu of the European Enlightenment. That milieu is gone forever, and the concept, accordingly, has metamorphosed over the past two centuries.

And perhaps more critical is the loss of confidence in establishing a metaphysics upon which to build a moral philosophy. Indeed, Kant's moral posture rested on a complex metaphysical foundation, which I cannot summarize here, but suffice it to say that much of the critical reaction to Kant from his own day until our own revolves around such a construction – its character, and even its possibility (Ameriks, 2000). If we discard the notion of a universal moral imperative, what takes its place? What, indeed, grounds our own morality? A constellation of individuals without such an orienting structure may be doomed to chaos, and there are some, to be sure, who believe that we actually live with various forms of moral anarchy. The optimists think we are only philosophically confused, for we do, in fact, have stable political institutions supported by a common law. The crisis, if one exists, does not seem to be in self-governance per se – we continue to tax ourselves quite ably to build bridges and educate our children. Rather, the issue is whether such a pragmatic attitude suffices for a moral code in the absence of some comprehensive philosophical understanding.

From Nietzsche (1887) to Wittgenstein (1921) to Williams (1985), philosophers have despaired at establishing a rational basis for ethics. Indeed, we have increasingly become philosophical pragmatists, in Richard Rorty's understanding of the term (Rorty, 1999), with regard to how we determine moral action, both personally and in the public arena. I particularly like Tristram Engelhardt's formulation: "Ever more individuals live more of an

aesthetic than a moral life. . . . They are more than tolerant. They are ecumenical cosmopolitans who have framed a morality of shifting content and unburdensome obligations" (Engelhardt, 1996, p. 79). Further, I basically agree with Engelhardt's reading of ethics' modern history, a history marked by the fragmentation of moral perspectives that have doomed the

> hope of giving morality the authority of reason. . . . If one cannot establish by sound rational argument a particular concrete moral viewpoint as canonically decisive . . . then the only source of general secular authority for moral content and moral direction is agreement. To rephrase the point . . . secular moral authority is the authority of consent . . . the agreement of those who decide to collaborate. . . . The appeal to permission as the sole source of authority involves no particular moral vision or understanding. It gives no value to permission. It simply recognizes that secular moral authority is the authority of permission, [whose only] requirement [is] to respect the freedom of the participants in a moral controversy. (Engelhardt, 1996, pp. 68–69)

When referring to respect of individuals, Engelhardt must mean something other than Kant's understanding of the respect of autonomous persons, which rests on an overarching philosophical construction which defines the agent, the standard of the ethical, and the basis by which we act freely to choose moral action.[7] Without these three elements, we are bereft of a rationality-based philosophy by which freedom is defined and autonomy exercised. Now, "autonomy" means political independence: individuals acting in self-assembly and self-governance under the principle of permission, "justified in terms of the morality of mutual respect" (1996, p. 119).[8] Thus persons remain "the source of general secular moral authority" (ibid.). But this is certainly a dilute potion, as forthrightly acknowledged by Engelhardt himself, when he notes that he has

> rebaptized "the principle of autonomy" [the fundamental precept of the first edition of his *Foundations* (1986)] with the name "principle of permission" to indicate better that what is at stake is not some value possessed by autonomy or liberty, but the recognition that secular moral authority is derived from the permission of those involved in a common undertaking (1996, p. xi).

In other words, the moral focus has shifted from the individual making independent choices to the individual consenting to be part of collective decision-making. Part of this contemporary formulation is dictated by the nature of our complex culture, where we must delegate decisions too technical for non-experts to adjudicate. But irrespective of this social organization, our personal ethics seem much closer to Rousseau's social contract than to Kant's

ideas. Indeed, the Kantian elaboration of autonomy has been recast as a form of contractualism, whose deontological flavor has been retained as 'respect for individuals.' While willing to accept this formulation, I regard it from a pragmatic perspective, a minimal criterion for 'community' in our culture.

Only through tolerance will our diversity support coherence. We steadfastly hold on to the fundamental notion of autonomy as a basic value, but it has mutated into a principle of communal action. We obviously remain persons, but our individuality has been subordinated to collective bargaining. We practice a form of self-governance, but that is not the same as asserting autonomy in Kant's sense, where self-determined (self-legislated) choices are freely followed in reference to a universal moral imperative. If we agree with Engelhardt's interpretation of the present state of moral philosophy, and I do, then we must acknowledge that this Kantian autonomy has been lost. In its place we have agreed to tolerate each other and allow behavior which does not trespass upon one another – no mean feat to be sure!

Contractualism thus accommodates pragmatism. With minimal deontological constraints our moral philosophy seeks pragmatic outcomes, where we sometimes employ utilitarian criteria, at other times various standards of virtue. This pragmatism is ultimately contingent in a galaxy of moral options, each which might be assembled into a different order depending on the particular context. This adaptable system is successful, but at the same time we pursue a meliorism without the benefit of a universally shared moral compass. Because we have competing moral coordinates, our ethics are largely directed at accommodating diversity. So while we might still have self-governance, in moving beyond Kant our concerns have focused on protecting self-determination, namely, preserving the moral insularity of those living in disparate life styles. We adjust our moral compass to operate in competing force fields, each of which claims legitimacy. Optimally we seek to become fully educated to the complexities of those choices – contending matters of fact, the context of those facts, the various practical and judicial options, the diverse social and political implications, the history of the problem, and so on. In an age marked by an explosion of information, sensitive to other cultural views, skeptical of our own rationalities, we are too often left without direction. Our moral plight then is to find an acceptable accommodation to these differing interests to preserve the fragile balance of free association. After all, permission is granted only as long as persons of different moral persuasion believe that their greater interest remains within the larger group. That is self-governance, and we might regard such actions as 'free' in a certain sense, but it is not Kantian autonomy.

One last note: On the interpretation offered here, Hume's skeptical position has prevailed: He regarded moral distinctions as arising from

our subjectivity, inner drives, the emotions, which are subsequently given rationales to gain authority. Beyond the claims of competing cultural systems, we, like Hume, have a much more circumscribed view of our own rational efforts. The Kantian project falls apart not only because of our necessary ecumenism, but also because reason as the mediator of moral action simply places too high a premium on rationality, which increasingly appears, outside the natural sciences, as itself culturally and historically contingent. Ironically, relativism bestows its own moral restrictions. In Foucauldian terms, ethics become an exercise in power, and moral philosophy, as an execution of rationality, simply has left the playing field to others.

Is this a *problem*? I have contrasted our transfigured use of 'autonomy' with the Kantian notion to highlight what we do *not* have. I certainly am not criticizing Engelhardt for not attempting to re-configure autonomy as a governing principle, and the argument he makes for "principle of permission" is a perfectly respectable one. Given both the political realities of our era and our current sense of the limits and restrictions of philosophy itself, Engelhardt's minimal deontological claims are appropriate. But what has been obscured is that "the principle of permission" has little to say about autonomy, and so "freedom" is also left as a nebulous idea. With such an unstable foundation, I must ask, How are the concept of autonomy and its related notions of freedom and moral agency to be understood? Can we even hold the *idea* of autonomy or freedom without a coherent philosophical structure in which to situate these abstractions? Is pragmatism enough to guide us?

One need not be a Kantian to 'respect the individual.' From whence does that ethic originate? The idea of the inalienable sanctity and dignity of every human being seems to arise most directly from some forms of our religious culture rather than philosophy as such, and it is here we must look to understand the hold of 'autonomy' on our moral sensibilities. I have argued elsewhere (Tauber, 1999) that our regard of the ill is based on a deep metaphysical sense of response to the other, a reaction which generates responsibility. This ethical metaphysics is essentially a theological assertion, not a philosophical one (Tauber, 1998). I will again touch on this point in my concluding comments, but it frames my entire orientation regarding the place of philosophy in ethics. With all of this groundwork in place, we now are ready to discuss the place of autonomy in the biomedical setting.

Autonomy in the Clinic

Clearly, my skepticism about 'autonomy' from a general philosophical perspective colors my views of its application to patients. My discussion

relies heavily on others who have done the heavy lifting in defining the limits of autonomy as a governing principle of medical ethics (e.g., Beauchamp and Childress, 1994; Schneider, 1998), so I will simply highlight certain key points. In limiting my comments to the clinical setting, I will use Engelhardt's own definition of persons to show the weakness of the autonomy model for this group.[9]

Key to the definition of personhood is moral competence. Engelhardt offers a four-fold standard of such capability (1996, p. 139): persons demonstrate such competence by 1) being able to conceive of rules of action for themselves; 2) by exercising rationality; 3) by exhibiting moral sensibility; and 4) by thinking of themselves as free. By these criteria, Engelhardt appropriately discounts the autonomy of fetuses, infants, or retarded adults. But I would go further. The ill are not fully autonomous either, if one understands that to act rationally and freely (criteria #2 and #4), one requires the intellectual competence and emotional wherewithal to make informed decisions. Patients frequently (if not usually) lack full competence in two ways. The first is simple ignorance. Medically unsophisticated, or at least untrained, patients cannot be expected to fully understand and integrate the vast technical and scientific information required to make informed clinical decisions. Health care providers attain their professional standing precisely because they possess this knowledge, on account of which we authorize them to make decisions for us. This delegation of authority is the basis of beneficence. The second issue pertains to a more primordial level of experience, namely the dependence of the ill on doctors and nurses. Frightened and in psychological if not also physical distress, the patient is fundamentally *dis-eased*. To think clearly – rationally and dispassionately about personal life and death choices – is all too often beyond normal expectations. Indeed, fear about sickness or death is the appropriate response when we ourselves are the subject of calamity.

The argument, from my point of view, is simply where to draw the line of competence. At what point does a particular patient lose his or her ability to make free and rational choices? Tom Beauchamp and James Childress, in their pragmatic approach, offer a wise intermediate opinion: "Merely because our actions are never *fully* informed, voluntary, or autonomous, it does not follow that our actions are never *adequately* informed, free, or autonomous" (p. 101). 'Adequate' is a freely floating designation, one that may be adjusted to any given clinical setting. It is a practical accommodation to a problem that does not lend itself readily to a proscribed formula of abstract principles. I can accept this position as both a realistic appraisal of typical moral choices in the hospital or clinic and as a working model for decision-making, but in so doing I hope it is clear that autonomy has compromised its august Kantian standing,

and I am thereby left contemplating what we in fact mean by "*adequately* informed, free or autonomous."

Do not misconstrue my implicit complaint. I am not arguing for a philosophical principle that has little relation to the realities of praxis. For by and large, in the normal setting, patient autonomy is compromised and thereby becomes a theoretical problem, not a practical one, except in one situation – when trust has been broken. At this juncture, with autonomy-based law, liability too often is defined as the mismanagement of informed consent, so that the decision-making of an autonomous individual is argued as having been violated. Here I would refer back to my earlier comments and those of George Annas regarding the influence of law in bioethics. 'Autonomy,' so defined, in short, is for all intents and purposes largely a problem for bioethicists and lawyers, not patients.

I am hardly making a radical claim about the limits of the ability to choose in the medical setting. Indeed, most medical ethicists have both reduced the role of autonomy by introducing other ethical principles that must be factored into the medical moral setting (e.g., beneficence, justice, nonmaleficence) and thereby acknowledge the limits of an autonomy-based morality for medicine, and have also weakened the concept of autonomy itself within the medical scenario. As an example, allow me to again cite Beauchamp and Childress, who pursue both strategies in their *Principles of Biomedical Ethics*. I need not detail their philosophy, but will only point to two key features as relevant to my own discussion. First, as already cited, they dispense with a Kantian formulation of autonomy as both too demanding and unrealistic, and instead substitute a loose definition of autonomy-intentionality, understanding, and freedom from controlling influences – to render consequential decisions of moral agents as "substantially" autonomous if these criteria are met (1989, p. 69; 1994, p. 123). Driven by context, as opposed to some inclusive general principle, they allow a flexible approach to informed consent, where the various elements (disclosure, understanding, voluntariness, competence, and consent) need not always be fulfilled to satisfy "autonomous authorization" (1989, pp. 79ff; 1994, pp. 133ff). This is a subtle alteration, moving from assessing the moral agent to assessing his acts. In that move, they have shifted from a focus on the moral standing of an individual (patient autonomy) to a focus on competence. Sensitive to the varying degrees of competence of the ill, they measure autonomous authorization by a set of capability criteria which may be applied with varying degrees of stringency to determine whether an individual is capable of making an informed decision. Conflict then arises as to how stringent such rules should be and how judiciously they might be applied in any given setting.

This approach then opens the door to the role of beneficence in decision-making, and we immediately recognize that autonomy cannot be divorced from the responsibility health care professionals assume in the care of the patient. In fact, this is the entry for other moral principles that must operate in the clinical setting, the second mode by which autonomy's dominance has been effectively challenged.

> [M]aking respect for autonomy a trump moral principle rather than one moral principle in a system of principles, places an inappropriately high premium on autonomy. Although respecting autonomy is more important than biomedical ethics had appreciated until the last two decades [1970s and 80s], it is not the only principle and should not be overvalued when it conflicts with other values. (Beauchamp and Childress, 1989, p. 112 [similar wording in 1994, p. 181])

Increasingly, this pragmatic, multi-variant approach has gained influence, but Beauchamp and Childress lament, perhaps with some resignation, "so influential is this autonomy model at the present time that it has become difficult to find clear commitments to the traditional beneficence model in contemporary biomedical ethics" (1989, p. 210 [similar wording 1994, p. 272]). Yet their approach seems appropriate to me. Instead of pitting one principle against the other, they seek an appropriate balance of competing ethical interests, whereby beneficence might incorporate patient autonomy:

> No premier and overriding authority exists in either the patient or the physician, and no preeminent principle in biomedical ethics – not even the admonition to act in the patient's best interest. This position is consistent with our earlier claim that beneficence provides the primary goal and rationale of medicine and health care, whereas respect for autonomy (and nonmaleficence and justice) sets moral limits on the professional's actions in pursuit of this goal. (1994, p. 273)

Despite their eloquent espousal of a plurality of moral principles (1989, p. 222; 1994, p. 284), their measured and ecumenical strategy finds no happy home among factious contenders who seek to define contemporary medical ethics along other more doctrinaire lines. Why then do medical ethicists hold onto the principle of autonomy so tenaciously? To this question I address my closing comments.

Conclusion

I am struck by the deep inconsistencies of our notions of moral agency in medical ethics. We espouse the ideals of autonomy, and yet we must admit

the limits of autonomy in the clinic and hospital. We settle for varying degrees of choice, believing, from a practical standpoint, that the options we exercise are sufficient to maintain a sense of freedom. But we do so, more often than not, by employing such qualifying terms as "sufficiently informed" or "adequately understood," implicitly recognizing the limits of our understanding and freedom. Informed consent then becomes a proscribed process, much like following a dance routine. This is not 'bad' in any ordinary sense. After all, virtually every study which has examined patients' efforts to know about their disease and therapy show that they shy away from decision-making, to the undoubted consternation of those who insist that they protect themselves (Schneider, 1998).

Patients, like individuals in other social roles, allow themselves to fit into a structure in which they trust that their basic rights will be protected. By and large, they are concerned far less with their political or legal autonomy than with getting better. They prioritize their various definitions of selfhood, and autonomous individuality, at least in this setting, is almost always subordinated to other identifications. Indeed, being a patient alters our fundamental sense of personhood. Patients want to facilitate the process of healing, and to do so they usually readily admit their dependent status. In short, autonomy in the medical context is an *aspiration* of the curing process, a goal, not a starting position.

Fortunately we have honest brokers who have attempted to situate autonomy among other ethical principles, and it seems as if autonomy's tide has turned as the warnings of its limits have been increasingly heeded. But the debate will long linger, because the question of autonomy in medicine is only a case example for the more general conundrum of our age: How do we assign moral agency and what guides it in a society that has no over-arching philosophical commitment? This issue has been at the heart of medical ethics, and appropriately so, because the highly charged ethical demands of caring for the ill bring the status of persons prominently to the fore.

Our genius lies in the effective means we have devised to respect individuality and protect the rights of persons in the face of the collapse of the Enlightenment project. Pragmatism marks our political civilization, which has succeeded so effectively in offering the degrees of freedom we cherish. My position is not that we are not self-governing, but rather that autonomy as a radical assertion of self-governance is what we lack. We, in fact, do not determine our own choices as much as choose among several that are presented to us. We delegate authority, recognizing that in this highly complex world experts must guide our choices and ultimate actions. One might well argue that Kant's notion of autonomy never could fulfill the rigorous demands he made upon the idea, but that is not the philosophical point he chiseled

into history: Kantian autonomy is a philosophical creation, part of a comprehensive view of the world, encompassing a metaphysics that ordered the world and gave structure to human thought and action. We cannot expect it to serve as some kind of last word, a secular New Testament, but it stood, and for some still serves, as a working formulation, a philosophy which at the very least poses our dilemmas clearly so that we might comprehend the issues at hand. Today, the dominant theme in philosophy is not only that we have no such comprehensive philosophical system, but more to the point, that we cannot. What philosophy still effectively accomplishes is to offer us a critical perspective on what we believe we understand – or, more often than not, what we do not understand.

Yet autonomy remains, and well it should. That Paul Ramsey and Joseph Fletcher espoused autonomy as a basic principle at the dawn of contemporary bioethics reflected their basic humanism as theologians (see Jonsen [1998] for review of their contributions). Autonomy had little philosophical support in their writings, but it was a place-holder for a humane medicine, one that held the sanctity of life paramount. From Ramsey to Edward Shils to Daniel Callahan, sanctity of life – essentially a religious principle – was secularized into the moral principle of autonomy where it joined a rich political tradition (Jonsen, p. 338). To be sure, autonomy serves a vital judicial-legal function in our system of medical law, and this may well account for its continued importance, but I think it more likely that the moral depth of our notions of respect for persons reflects a deep commitment of our religious heritage. So, as many others before me, I think it more profitable to explore venues other than philosophy to fix our notions of caring for others with respect and dignity (Tauber, 1999).

We should forthrightly admit that we have failed to ground ethics; we have failed to define moral agency; we have blandly accepted the relativism of our morality; we have adopted pragmatism because we have no other conceptual edifice upon which to build a structure of standards. There is no philosophical high ground to defend. I think that autonomy has been fought over so hard among medical ethicists because at some level we know that it is but a remnant of an older metaphysics which, at some level, we pine for. Our battles over autonomy give the measure of our philosophical nostalgia. Yet we seemed to have adequately stumbled along with a patched together apparatus of moral principles, laws, policies, contracts, and regulations, and thereby worked out a means to effectively negotiate. After all, this is not the first instance where philosophy has failed and our pragmatic good sense carried us forward. As a philosopher I brood; as a physician I am too often confused; but as a citizen I remain cautiously optimistic.

Acknowledgments

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Notes

[1] Ramsey (1970) espoused autonomy as a key precept, and he wrote as a Christian. He was not alone. For instance, despite his philosophical differences with Ramsey, the theologian, Joseph Fletcher, in his celebrated *Morals and Medicine* (1949, 1954), clearly stated as his central thesis the legitimate demands of patient rights and prophetically sounded the credo of autonomy-based ethics long before the movement was in full swing: "Choice and responsibility are the very heart of ethics and the sine qua non of a man's moral status. ... In any discussion of morals and medicine, it becomes necessary to trace our moral freedom ..." (pp. 10, 12). Indeed, if we seek the genealogy of American medical ethics, especially the championing of autonomy-based ethics, we find theologians strikingly prominent among the earliest contributors.

[2] Kant inherited from Rousseau most directly the egalitarian principle, one which was formed in opposition to the advocates of natural law, who we might fairly regard as holding an intermediate position between religious authority and a democratized universal human authority. The lawyers argued that while everyone was capable of knowing the most basic principles of morality, only an elite could understand the subtlety of the law's application in particular cases. In addition, they thought that most people are unable or unwilling to follow the law without threat of punishment, and thus they substituted a secularized natural law for religious law, where judgment was given not by priests interpreting church law, but by elite lawyers interpreting natural law. They would have thought of Kant's self-motivational views as foolish, if not blasphemous (Schneewind, 1992, p. 312). In opposition to these views, the Earl of Shaftsbury and Francis Hutcheson portrayed virtue rather than law and obligation as central to morality. They invoked our naturally benevolent dispositions as substitutes for external guidance or of sanctions. Similarly, Christian Wolff argued for self-governance on the basis that we can foresee the consequences of our action, and thus with a mixture of utilitarianism and high-minded perfectionism, he argued that we are bound or required to do what we think will be for the best.

[3] "If you do not want the end, there is no need for you to do the act that leads to it. But Kant thinks it is just a contingent empirical fact that you have the desires you have. If so, then on these views it is a matter of happenstance whether or not someone is bound by any moral necessity. Obligation becomes a matter of what one wants to do. But true moral necessity, Kant held, would make an act necessary regardless of what the agent wants" (Schneewind, 1992, p. 313).

[4] "He [Kant] insisted that morality should be 'autonomous,' and that there could be no reason for being moral. A simple argument shows why, in the Kantian framework, this must be so. Any reason for being moral must be either a moral or a nonmoral reason. If it is moral, then it cannot be a reason for being moral, since you would have to be already inside morality in order to accept it. A nonmoral reason, on the other hand, cannot be a reason for being *moral*; morality requires a motive, basically moral intentionality (which Kant took to be an

obligation), and that is destroyed by any nonmoral inducement. Hence there can be no reason for being moral, and morality presents itself as an unmediated demand, a categorical imperative. . . . Kant thought we could come to understand why morality should rightly present itself to the rational agent as a categorical demand. It was because rational agency itself involved accepting such a demand, and this is why Kant described morality in terms of laws laid down by practical reason for itself" (Williams, 1985, pp. 54–55).

[5] Kant came to this idea of autonomy by a complex process (Schneewind, 1992): The critical philosophy he developed in the *Critique of Pure Reason* offered a scaffolding by which the natural world might be known. The mind, according to Kant, had certain categories whereby sensory data were organized and given various forms of order. The forms of order are not externally imposed on the mind, but are an aspect of the laws of natural phenomena, that aspect which make the experience lawful. These laws are "pure" or devoid of any empirical content in themselves, yet they contain the "structure" by which the mind discerns their order. Analogously, Kant sought a structure by which our behavior might be explained as he understood human perception, i.e., through an organizing faculty. This parallel cognitive faculty – Kant called, 'practical reason' – directs and organizes human action through its own structure analogous to how pure reason organizes experience. The perfect will, determined by its own inner lawfulness, is inherently good and perfectly rational, but unfortunately humans suffer from imperfection, driven by desires whether they are rational or not. We feel perfect will's operation, however, as a constraint against the pull of desire. The categorical imperative, like natural law is contentless (empirically empty) and is only the form of lawfulness itself.

[6] Kant may fairly be regarded at the end of a long line of moral philosophers who grappled with establishing the foundations of morality in the crisis of waning religious authority. During the Enlightenment the basis of morality was reconfigured as resting on the twin concepts that we are able to reason about the validity of moral action and that these principles held independent authority. Hugo Grotius, at the end of the seventeenth century, already understood that to invoke such independence from external (i.e., religious) authority was both the new morality's greatest strength and weakness. In a more pluralistic society, regulatory principles were to be limited in scope because of the diversity of human values and aspirations. But neither the efforts of the pre-Kantian moral philosophers, nor Kant himself, were simply to secularize ethics. Rather than completely divorcing divine presence from human affairs, the pre-Kantian philosophers sought how to keep God's company in moral discourse. "For everyone except the [few] atheists, morality and religion remained tightly linked in early modern moral philosophy" (Schneewind, 1998, p. 9). See Schneewind (1998) for a detailed history of these developments.

[7] Traditionally freedom requires at least three elements: 1) a knowing subject able to perceive choice, 2) a standard of choices, and 3) freedom of action to choose alternatives. To achieve such a formulation, Kant invented three 'solutions:' In regard to the first requirement, moral agency, the Kantian subject became an entity. Following Hume's critique of the subjectless self, Kant countered with a collective agency – a faculty, if you will, that perceives and synthesizes experience and then directs action. Kant argued that such an 'entity' – thoughtful and self-conscious – must exist in order to explain the coherence of our personhood. But he pulled a philosophical sleight of hand: Unable to 'prove' the existence of such an entity, the knowing subject became a transcendental construction, another *a priori* category, which Kant called a *noumenal* self. Regarding the standard of ethical choices, as discussed already, Kant measured our moral sense of "ought" through our perception (employing practical reason) of the second transcendental element, the categorical imperative. The final element of this triad pertains to freedom of choice, which can ultimately occur only if moral agents are autonomous by the criteria defined above.

[8] "The right of all persons to refuse to participate in any particular community makes all persons equal in their right to be left alone and to seek to fashion a community with willing others" (Engelhardt, 1996, p. 70). Moreover, "if no hierarchy of values can be established as canonical, then individuals cannot be subordinated one to the other outside of the wishes or the actions of the persons involved" (ibid., p. 70). He thus presents 'the principle of permission,' agreement to negotiate as a member of a community, for 'autonomy.' Indeed, this is Engelhardt's line in the sand – he can go no further, for as he explains, this view of community is "a disclosure, to borrow a Kantian notion, of a transcendental condition, a necessary condition for the possibility of a general domain of human life" (ibid.).

[9] This discussion is focused on the patient as opposed to healthy research subjects. I do so because these two groups do not have equivalent degrees of freedom of choice. Because their ethical contexts are so different, notions of self-governance may well have different requirements. Those essentially healthy persons who consent to becoming research subjects are potentially full persons in Engelhardt's sense. Patients, I maintain, more often than not fail to fulfill his criteria.

References

Ameriks, K. (2000) *Kant and the Fate of Autonomy. Problems in the Appropriation of the Critical Philosophy*. Cambridge: Cambridge University Press.

Annas, G.J. And Grodin, M.A. (1992) *The Nazi Doctors and the Nuremberg Code. Human Rights in Human Experimentation*. New York and Oxford: Oxford University Press.

Beauchamp, T.L. and Childress, J.F. (1989) *Principles of Bioethics*, 3rd edn. Oxford and New York: Oxford University Press.

Beauchamp, T.L. and Childress, J.F. (1994) *Principles of Bioethics*, 4th edn. Oxford and New York: Oxford University Press.

Engelhardt, H.T. (1996) *The Foundations of Bioethics*, 2nd edn. Oxford and New York: Oxford University Press.

Fletcher, J. (1954) *Morals and Medicine. The Moral Problems of: the Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization, and Euthanasia*. Princeton: Princeton University Press.

Jonsen, A.R. (1998) *The Birth of Bioethics*. Oxford and New York: Oxford University Press.

Nietzsche, F. (1887, 1967) *On the Genealogy of Morals*. Translated by W. Kaufmann and R.J. Holingdale. New York: Vintage.

Ramsey, P. (1970) *The Patient as Person: Medical and Legal Intersections*. New Haven: Yale University Press.

Rorty, R. (1999) *Philosophy and Social Hope*. London and New York: Penguin Books.

Rothman, D.J. (1991) *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*. New York: Basic Books.

Schneewind, J.B. (1992) Autonomy, Obligation, and Virtue: An Overview of Kant's Moral Philosophy. In P. Guyer (Ed.), *The Cambridge Companion to Kant* (pp. 309–341). Cambridge and New York: Cambridge University Press.

Schneewind, J.B. (1998) *The Invention of Autonomy. A History of Modern Moral Philosophy*. Cambridge and New York: Cambridge University Press.

Schneider, C.E. (1998) *The Practice of Autonomy. Patients, Doctors, and Medical Decisions*. Oxford and New York: Oxford University Press.

Tauber, A.I. (1998) Outside the Subject: Levinas's Jewish Perspective on Time. *Graduate Faculty Philosophy Journal* **20/21**: 439–459.

Tauber, A.I. (1999) *Confessions of a Medicine Man. An Essay in Popular Philosophy*. Cambridge: The MIT Press.

Williams, B. (1985) *Ethics and the Limits of Philosophy*. Cambridge: Harvard University Press.

Wittgenstein, L. (1921, 1961) *Tractatus Logico-Philosophicus*. Translated by D.F. Pears and B. McGuinness. London: Routledge