

Which Autonomy for Bioethics?

M. Wallack
Department of Political Science
Memorial University
Newfoundland, Canada

Introduction

Contemporary bioethics has seen a transition from an ethics of medical practice based on the benevolence of the medical practitioner guided by the professional obligation to do no harm – pejoratively characterized as paternalism—to practice based on procedural rules and legal oversight aimed at safeguarding patient autonomy.

According to the most influential texts on bioethics [B&C, FB, ATB] the starting point for an understanding of autonomy is to be found in the works of Locke, Kant and J.S. Mill—with Kant taking the lead in discussions by supporters of “principles of ethics” and Mill or Millian utilitarianism by others

In the words of the authors of the CMAJ module on bioethics [Etchells],

The notion of consent is grounded in the ethical principles of patient autonomy and respect for persons. “Autonomy” refers to the patient’s right to make free decisions about his or her health care. Respect for persons requires that health care professionals refrain from carrying out unwanted interventions and that they foster patients’ control over their own lives. ...

My argument will be that it is a mistake to equate Kant’s or Mill’s conception of right conduct with informed consent or to regard these two philosopher’s ideas as equivalent in any respect. I suggest that the theoretical foundation for bioethical autonomy as practiced and written into law is to be found in John Locke’s conception of consent. But Lockian consent subordinates individual express consent to institutionalized majority rule, presumes consensus on values rather than value pluralism, and expects rational prudence to produce assent even for the dissatisfied subjects of binding decisions. In return for assent, even when it is the prudential acceptance of dependency, individuals gain the protection that comes from impartial and public limits to the conduct of those acting for each person and ultimately the right to exchange one set of representative decision makers for another. Lockian consent results in legitimate dependency, not individual autonomy, but it replaces personal dependency with rational dependency based on law.

Kantian Moral Autonomy

When Kant says we must treat people as ends and never as means if we are to act morally, that the freedom of the will exercised in the power of choice is the distinctly human part of human nature we (or many bio-ethicists) seem ready to agree that this means that in medical practice informed consent is the most important guiding principle

for ethical conduct. [B& C 72, 73, Beauchamp 2003, Veatch 1999, Engelhardt 2001 and FB]

But does informed and freely given consent identify an action as autonomous? [Dworkin 1988, Frankfurt 1971] This presumption is sometimes referred to as “procedural moral realism”. [Korsgaard, SN: 35]

According to Kant the idea that our will can determine our conduct—that it is a causal power not determined by anything outside itself, -- implies that willed action can always be described as action that is in accordance with a rule or law. This is so because to recognize anything, including our will, as a cause, it must be identified as such by means of a regularity that connects an antecedent act of will and the completed action. But an act caused by the will—a free will--(rather than a will determined by a desire) has the additional characteristic that it is in accordance with a reason that would be a reason for anyone. Having a reason to act of such a kind, the will (is determined by and thus) produces the required action. Thus Kant concludes “the will... must be determined in accordance with its own law—that is, be autonomous and ...this shows that the categorical imperative is the law of a free will.” The Categorical Imperative, is -- “Act only on that maxim through which you can at the same time will that it should become a universal law. [GW 88(421)]

From his critical perspective, even a benevolent act, for example one that arises from sympathy is not a moral act unless it is in accordance with a maxim that everyone could adopt. A feeling of benevolence can cause a person to act but cannot be a moral ground for action in itself. Only a universal duty can be a moral ground. According to Kant, when we are moved by benevolence to respect another person’s desire to direct their own affairs, we do not act autonomously because our action depends on a judgment about a particular state of affairs rather than duty. [GW 66 (398)] Similarly, the informed freely given consent of a patient prior to treatment does not identify the consent as autonomous in Kantian terms unless the person acted from duty in consenting. An even more striking consequence of Kant’s moral theory is that according to this view, coercion does not limit the autonomy of the coerced person. Coercion acts on the body and on the desires, while the will remains free as long as reason remains to determine conduct within whatever range of possibility remains.

Kantian autonomy is not at stake or present in every aspect of anyone’s life nor is Kant’s moral theory a theory that is intended to provide a description of all of human conduct. Autonomy is the core concept in Kant’s description of moral part of human nature. [Schneewind] He describes this state of affairs, echoing Plato, by saying that when we see human beings as part of the “intelligible world” we must use the concepts of reason, free will and the categorical imperative. When we describe human beings as part of nature and subject to causes — Plato’s world of appearances and objects of sense--, we use desires, instincts and impulses—in short to a natural scientific account. [GW 124 &ff. (456) and Cassirer]

Honoring self-direction because it is the law, or because the rules of our profession require us to do so, is not an autonomous act. Un-coerced, informed choice by a

competent adult is not all there is to autonomy for Kant, because the grounds for autonomous choice must be duty. Duty arises only from compatibility with a categorical imperative.

Kant was not a procedural moral realist. Procedures which we see as operationalized autonomy cannot assure us of the intentions and the maxims under which they are undertaken because they cannot tell us whether the action in question (the assent or refusal) is in accord with a genuine categorical imperative. Kant's autonomy is first and foremost a morality from the first person perspective rather than a third person appraisal of someone else's conduct. Kantian principlism provides a standpoint from which to assess the moral status of procedural justice and so cannot be replaced by a procedure. For example Kantian autonomy can't be whatever a properly constituted ethics committee says it is or whatever a legally required consent procedure provides

Kantian autonomy was and remains a ground for right conduct (by those ethicists who are Kantians) and a guide to the evaluation of individual decisions and conduct that is an alternative to and in opposition to foundational grounds based on religious or cultural tradition, utilitarianism, relativism and nihilism,-- to name a few prevalent alternatives. Clearly Kantian autonomy is not to be equated with a defense of autonomy drawn from individualism understood as protection for individual judgment in self-regarding conduct. It is this latter point of view that underlies legal protections for consent found in the judgments of North American courts.

Mill: Consent in Self-Regarding Conduct

Mill's defence of individualism in his essay *On Liberty* is in part based on the premise that self-regarding conduct, at least on the part of persons in full possession of their faculties, should not be subject to constraint. For Mill, self-regarding conduct need pass no other test than consent to give rise to an obligation of non-interference in that conduct by society.

Mill argued that protection for self-regarding conduct should be a normative standard because such a policy results in social benefit by contributing to progress in the long run. Mill did not believe that such conduct, whatever it might be, deserved respect simply because it was the product of individual choice. He thought much of such conduct was reprehensible, judged from the perspective of its social utility. Thus Mill's procedural realism, so often invoked as a source of patient autonomy is simply a right not to be interfered with (an obligation not to interfere) but is not an endorsement of the protected conduct. It is not a sign of respect for that person. In examples Mill often used, a self regarding choice to drink or gamble to excess that does nothing good for any person (even for the person in question because it is lacking in a time perspective by overvaluing the present pleasure and undervaluing the future) ought to be tolerated when its effects remain individual because the social harm of regulation would outweigh the benefit of regulation.

Mill's utilitarianism was also a dramatic rejection of the Kantian ideal of moral conduct. While Kant identifies autonomy as a successful subordination of desires and habits in recognition of moral duty, utilitarianism takes happiness to be the objective correlate of moral worth. From this perspective, The Categorical Imperative appears to be little more than an empty formula. So it seemed to John Stuart Mill. Writing in his essay *Utilitarianism*, he contended that it could as easily justify universal harm as universal good. It should give us pause that autonomy in bioethics is often ascribed to Locke, Kant and Mill. Locke's laws of nature arise from experience and the fear of death—"heteronomous" not autonomous sources of conduct to use Kant's term. Mill's defense of freedom of thought and discussion and of individualism, while often said to be an alternative formulation or foundation for individual autonomy is as he understood it, not a defense of anything Kantian but rather a critique of Kantian ethics.

Results Thus Far

The Kantian autonomy that is at issue in medical treatment or research is not patient autonomy. One cannot jeopardize another person's autonomy in Kant's sense, strictly speaking. Every person remains morally free no matter what their circumstances. The Kantian autonomy that is in question is the autonomy – the moral standing—of the person or persons providing the treatment or directing the research or permitting either of these to be done. When medical ethics problems take the protection of patient autonomy as a Kantian question about patient's autonomy rights rather than care giver and social obligations, Kantian autonomy has been displaced from its Kantian origins. An ethical doctrine is being made to do the work of a political theory. When bioethicists equate respect for persons with following consent in self-regarding conduct they also ignore the argument which leads to that conclusion in Millian utilitarianism. The utilitarian ground for negative freedom does not establish or presume that self-regarding conduct is good or deserving of respect simply as such.

Political Autonomy

Autonomy came to the forefront in medical ethics as a response to a loss of confidence in care giver benevolence which was from that point called paternalism. This sequence of ideational change reminds one of the political origins of liberal conceptions of autonomy and individualism that are seen in Kant and Mill. These origins are clearly visible in the political theory of John Locke.

Locke's *First Treatise*, studied less and quoted less than his *Second Treatise of Government* is apposite to the issues raised by autonomy in medical ethics. It contains Locke's refutation of Filmer's claims on behalf of the paternal power of monarchs—that is – paternalism.

The salient points of Locke's argument may be briefly summarized. Monarchs claim the right to rule from God's grant of that right to Adam which divine right theorists maintain descends by inheritance to present lawful monarchs. Locke argues that this claim doesn't stand against the facts of the history of any actual monarch. He argues further that the natural authority of parents over their children does not resemble power claimed by

monarchs since such natural paternal power is limited in the time it is may be rightfully exercised to childhood, limited in purpose to supplying whatever is necessary to the eventual independence of the child and is shared between parents rather than exclusively exercised by one parent or the other. For these reasons, paternal authority is not political.

The *Second Treatise* gives Locke's account of legitimate political power and his defense of the right of rebellion when that power is misused. The premise of the argument is that the boundaries of legitimate rule are best understood by assuming that political societies are legitimate if their government and law are consistent with the un-coerced consent of rational people. But Locke's consent is not the express consent of each person to all the laws a government makes. It is the hypothetical consent of rational people which, he thinks, is best indicated by the agreement of some sizable number of them by means of elections in which a larger number participate. This is by no means the requirement of majority rule by universal suffrage. It only requires the assent of a few, given from time to time by a Parliament which has been legitimated by an electoral process that would be far from acceptable nowadays.

The core idea in Locke's argument is that if government must only act by law and if law is impartially applied even to those that make it, their relatives and to their friends, prudence will limit government to what is tolerable by the vast majority. While individual consent continues as a basis for the exchange of property by means of contracts, it is the law that determines what contracts are valid and what obligations beyond contract are binding. Individual consent gives way to majority consent which is understood as tacit consent (non-resistance) to obey the express will of a majority in Parliament. Individual autonomy remains only as a residual where the law is silent.

It is evident that the Lockian effort to provide an account of the legitimate exercise of power is one which subsumes individual autonomy within a theory of the autonomy of society. It is society which is autonomous and sovereign in Locke's theory. But does this theory leave any room for individual autonomy? Locke accepts the view that individual autonomy does not outlive the creation of society and that it is limited further by political society. Locke thinks that the evidence of the senses will lead to a consensus on what is harm and what is help in the actions of government. This consensus, he argues, is the basis for the stability of political societies that are based on consent and the rule of law. And it is this consensus that will leave some decisions to the individual with only a minimum of intervention by government. Lockian consent is not supervisory or even express consent as far as most citizens are concerned. Parliament acts as a trustee in granting its consent to laws. As trustees, Parliament and sovereign are bound to act only to preserve life, liberty and property by means of law. Yet citizens are obliged to obey laws despite this distant relation to their actual assent. Locke argued that the obligation to obey in such circumstances is both prudent and rational or reasonable. In fact, his view amounts to the contention that one is obligated to obey prudent and reasonable laws whether one has consented to them or not provide they have been made within a system of politics that includes consent and the rule of law.

Implications of Lockian Autonomy for Bioethics

Lockian autonomy in bioethics can thus be understood as a fiduciary relationship between patient and caregivers subject to the explicit constraints of a legal framework

that limits the relationship to the preservation and restoration of health and the alleviation of suffering. As understood by the Canadian Supreme Court in *Norberg v. Wynrib*,

A fiduciary relationship is marked by the following characteristics: (1) the fiduciary has scope for the exercise of some discretion or power; (2) the fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests; and (3) the beneficiary is peculiarly vulnerable or at the mercy of the fiduciary holding the discretion or power. A physician owes his or her patient the classic duties associated with a fiduciary relationship -- "loyalty, good faith, and avoidance of conflict of duty and self-interest". That one party in a fiduciary relationship holds power over the other is not in and of itself wrong. Wrong occurs, however, if the risk inherent in entrusting the fiduciary with such power is realized and the fiduciary abuses the power entrusted to him or her.

The individual consent of the patient is a part of a Lockian self-governing framework but only a part. The society as a whole is responsible for assessing and shaping the agreements individual patients and health care providers make. Statutes, legal decisions and international declarations of principle structure actual practice. Professional standards of care provide another set of constraints. A Lockian standard of legitimacy also requires that such individual acts of consent be considered against the standard of what any reasonable person might be expected to agree to considering that no reasonable person ought to be expected to exchange a better condition for a worse one. A social rather than a purely personal understanding of better and worse is understood and thus distinguishes Lockian autonomy from the Millian presumption that each competent adult person is the best judge of benefit and harm for her or himself in purely self-regarding conduct.

Lockian informed consent in bioethics can be understood, then, as express consent to a fiduciary relationship between patient and caregiver. The resultant decisions and their consequences are subject to evaluation by the patient and the trust placed in the caregivers is subject to revocation by the patient in the event that the consequences are found to be harmful rather than beneficial. While there is an initial act of express consent, the uncertainties and opacities of the states of affairs that are consented to are continuously subject to veto by the patient, however unlikely this is apt to be. As in Lockian tacit consent, remaining subject to treatment is taken as tacit consent. O'Neill has noted that informed consent is consent in words to a description of what is to be done and as such is not fully filled out with all the implications and possible consequences of the actions described. [O'Neill ATB] No description ever can be. But the Lockian model of consent does not assume any more than this. There need not be a list of instructions or an agreed description of everything that is going to happen as the result of treatment; but there is the duty of the caregiver to maintain an expected standard of care and there always remains to the patient the right to decide when to veto treatment. At the same time effective care creates an obligation on the part of the patient to accept the "government" of care by the caregivers while in their care when that care is regarded as legitimate by the society as a whole.

It may be noticed that the Lockian conception of political consent does not depend on personal trust between citizen and ruler. The trust mentioned in Locke's *Second Treatise* is a legal concept: a fiduciary trust. It is also worth noting that the relationship is based on prudential and rational grounds rather than moral or empathetic considerations. Thus a critique of patient autonomy based on the contention that informed consent as practiced is for the most part formal, or episodic or a ritual rather than effective or supervisory would not be apposite in respect to a Lockian conception of patient autonomy or a Lockian account informed consent. And in the same way, the contention that informed consent as practiced does not create or reestablish personal trust between patient and caregiver would not be troubling to an advocate of Lockian autonomy or consent. The right to withdraw oneself from care is fundamental in Lockian autonomy as it is in the other models of consent I have considered. But is the right to withdraw oneself from care a sufficient protection for the patient in the circumstances of illness, even if buttressed by a legally binding legal framework?

Efforts to maintain autonomy during illness have taken the form of advance care directives, binding powers of attorney, and guardianship by the courts. Assessments of these methods of extending rights of autonomy beyond the standard case are mixed. Each of them is in its way an application of the Lockian fiduciary trust model rather than being an example of Kantian moral choice or Mill's individualist self creation through individual control over self-regarding conduct since neither Millian individualism nor Kantian autonomy is possible when we are no longer able to evaluate and decide matters for ourselves. Yet Lockian autonomy also faces difficulties.

Lockian autonomy relies on the social application of rules governing the exercise of the fiduciary relation for all medical decisions regardless of the condition of the beneficiary of the trust based care. Serious illness, frailty, advanced age and some other health states call into question the Lockian model because these conditions undermine the voluntary nature of choice. Other Lockian conditions for voluntary decision making are also compromised. Lockian consent assumes all parties are motivated by hope of benefit rather than fear of death. Lockian consent assumes that in the assessment of alternatives the facts that matter are facts that any reasonable person could not fail to assess in the same way as benefits or harms. Serious illness, frailty and the complexity of medical decision making weaken the influence in the decision process of individuals who are at risk and transfer it to the reasonable majority. It is the majority for whom standards of care are devised and by whom such standards are assessed and applied by institutional decision-makers, increasingly by means of cost-benefit analysis. Do the common interests in health shared by all citizens provide a sufficient support for the particular decisions that are at stake for the frail?

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