WHAT IS AUTONOMY? WHAT DOES IT MEAN TO RESPECT IT?

In this lecture, you'll learn to:

1. Explain what "autonomy" is, and how it relates to liberty and agency.
2. Compare and contrast differing philosophical theories of autonomy.
3. Apply philosophical theories of autonomy to real-world cases.

AUTONOMY, LIBERTY, AND AGENCY

One of the four main principles of the common morality most relevant to biomedical ethics is **respect for autonomy.** In the context of this principle, **autonomy** requires both *liberty* ("independence from controlling interference") and *agency* ("capacity for intentional action"). So, normal adults are, in most circumstances, capable of making autonomous choices. They can choose where to go to dinner, who to associate with, which doctor to see, whether to buy a gun, and whether to drink alcohol. They do not have *unlimited* autonomy, though—they cannot buy heroin, chase people with axes, or go to the restaurant naked.[1]

By contrast, a person who is in prison (as punishment for a crime) lacks *liberty* and thus do not have full autonomy. They are not allowed to do many of the things that normal adults can do, though they do still have *some* room for autonomous choice (they can, for example, choose which books to read from the prison library, whether to work out, etc.). On the other hand, elderly persons with severe dementia lack *agency,* and thus do not have autonomy for a very different reason. Their diminished cognitive abilities mean that they cannot do many of the things that normal adults can do. Again, however, this does not mean that they have *no* capacity for autonomous choice. Among other things, they generally have the capacity to participate in choices regarding their diet, choice of entertainment, and so on.

Other beings that have diminished autonomy include children and adolescents, and possibly some animals (chimps, apes, etc.). By definition, beings without sentience (that cannot feel pleasure or pain) can't have autonomy, since there is nothing "good" or "bad" that can happen to them. So, a rock doesn't have any autonomy. In this lecture, we will talking about the importance of respecting patients' **autonomous choices.** While not everyone has the exact same "level" of autonomy, most patients are capable of making *some* important choices about their medical care.

IS AUTONOMY A SECOND-ORDER CAPACITY?

"To give another example, a person might desire to learn to ski. He might believe there is no further motivation or he might believe that what causes the desire is the wish to test his courage in a mildly dangerous sport. Suppose he is now led to see (correctly) that he desires to ski because he is envious of his brother who has always excelled in sports. Having recognized the source of his desire he can now either wish he were not motivated in this way or reaffirm the desire. If the latter, then he is acting authentically in that he identifies himself as the kind of person who wants to be motivated by his envy." -- G. Dworkin[2]

Dworkin's Split-Level Theory. According to the **split-level (or hierarchal) theory of autonomy,** autonomy can be defined as a "second-order capacity of persons to reflect critically upon their first-order preferences, desires, wished, and so forth and the capacity to accept or attempt to change them in the light of higher-order preferences and values" (G. Dworkin, *Theory and Practice of Autonomy*). The basic idea is that (1) an autonomous being has first-order desires for things such as food, sex, and shelter. However, (2) an autonomous is capable of *reflecting* on these desires and constraining them if need be. So, for example, both adults and toddlers occasionally look at other people's plates and think "That food looks really good. I wish I had some." The toddlers (who are NOT fully autonomous) may simply try to take the food. By contrast, the adults (who ARE autonomous) have control over their desire. In the skiing example above, Dworkin argues that the person is acting "authentically" (and with more autonomy) if he self-consciously "endorses" the desire in question. By contrast, if the person thinks "I wish I wasn't so envious" and feels regret/embarrassment over having this desire, the person is NOT behaving autonomously, since it looks like they are being "ruled" by a desire that they think of as being "outside themselves." (A more serious, and realistic, version of this problem occurs when the desire in question is the result of addiction, mental illness, severe trauma, etc.).

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[1] Both the Stanford Encyclopedia of Philosophy and the Internet Encyclopedia of Philosophy have good entries on philosophical debates concerning autonomy. John Christman, "Autonomy in Moral and Political Philosophy," in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Spring 2018 (Metaphysics Research Lab, Stanford University, 2018), https://plato.stanford.edu/archives/spr2018/entries/autonomy-moral/; Jane Dryden, "Autonomy," in *Internet Encyclopedia of Philosophy*, May 2019, https://www.iep.utm.edu/autonomy/.

[2] Gerald Dworkin, "The Concept of Autonomy," *Grazer Philosophische Studien* 12 (1981): 203–213.

The Problem. B-C claim this definition is INCORRECT because it would entail that many obviously autonomous choices are NOT autonomous. For example, alcoholics often lack the second-order capacity to "stop" themselves from drinking (in part because addiction can "skew" our second-order desires along with our first-order desires), and adulterers lack the capacity to "stop" themselves from cheating. Nevertheless, we think that alcoholics and adulterers are at least partially *responsible* for these actions, in a way that a toddler or a patient with severe dementia would not be. A less dramatic example: many of us "know" we should eat healthier, but have our willpower "break down" when we are presented with our favorite foods. This does NOT mean that we are not autonomous, or that our physician, the government, etc. needs to step in to control our diets.

INTENTIONALITY, UNDERSTANDING, AND NONCONTROL

In contrast to the split-level theory of autonomy, B-C propose a **three-condition theory of autonomous choice.** The three conditions are as follows:

- **Intentionality.** Autonomous choice "requires plans in the form of representations of the series of events proposed for the execution of an action." For example, if a patient chooses to have a surgery, they (at the very least) need to have in mind something like the *process* they will be going through, and the likely *end results* of this process). There is no guarantee that the action will turn out as intended, of course; autonomous choice merely requires that you *chose* to do this action for some *reason*.
- **Understanding.** Autonomous choice requires a "substantial degree" of understanding. In a medical context, some factors that inhibit understanding include poor communication (by the medical professional), illness, and immaturity. In some cases, a person might make an autonomous choice *not* to be told some information (e.g., you can ask your physician *not* to tell you the chance that your cancer will be terminal).
- **Noncontrol.** Autonomous choice requires that a person "be free of controls exerted by external sources [e.g., family, medical staff, insurance companies] or by internal states [e.g., mental illness, severe anxiety] that rob the person of self-directedness." There is nothing wrong with a person *voluntarily* accepting an authority, of course (e.g., choosing to follow the rules of a certain religion, or agreeing to do whatever the doctor recommends).

Intentionality is "all-or-nothing", in the sense that an action is either intentional or it is not. Understanding and noncontrol, by contrast, are matters of degree. So, you can partially understand something, or be partially influenced in your choice by external threats or mental illness. An *autonomous choice* requires that you (1) acted intentionally and (2) did so with an *adequate level* of understanding and control.

How to Respect Autonomy: Negative and Positive Obligations. The principle of respect for autonomy includes both NEGATIVE obligations (don't lie to people; don't threaten them to make them do the things you want them to do) and POSITIVE obligations (try to help them understand what is at stake; help them make their *own* choice). The principle of autonomy can sometimes conflict with the other three principles (nonmaleficence, beneficence, or justice). For example, we might restrict a person's right to autonomous choice if doing so allowed us to prevent a significant harm (nonmaleficence), provide important benefits (beneficence), or distribute resources fairly (justice).

Example: Is a 10-year old autonomous? While 10-year olds often can usually use language well enough to communicate with medical staff, we usually think that they are NOT autonomous and thus, should not make their own medical decisions. BC's theory can explain why this is. They often lack full intentionality (they can't really picture the intended long-term "result" of the treatment with great precisions) and understanding (of major benefits and risks). Finally, their emotions make it difficult for them to meet the "noncontrol" criterion. Dworkin would agree, but for different reasons: he would point out that young children have many of the same desires (for food, safety, etc.) that adults do. However, they lack the adults' second-order ability to reflect on and overrule these desires. According to both theories, moreover, children will (usually) become increasingly autonomous as they age. So, for example, the typical 15-year-old will do better by both B-C's theory and by Dworkin's theory. Correspondingly, we think that medical professionals ought to pay more attention to their wishes.

REVIEW QUESTIONS

1. Which theory of autonomy do you find more persuasive—Dworkin's theory or B-C's theory? Why?
2. Judgements about the extent to which patients are "autonomous" are especially important when these patients either refuse treatment that the medical team recommends, or wants additional treatment that the medical team would NOT recommend. To what extent would the following patients count as autonomous? Consider the potential role of intentionality, understanding, and noncontrol. How might you respond in each case? (For example, what sort of information might you try to find out? How might you go about trying to increase the patient's autonomy, if this is possible?)
    a. A patient who requests an unneeded prescription because of (false) information that he has read on the internet.
    b. A patient who refuses surgery because she has an overwhelming fear of needles.

c. A patient who has recently by diagnosed with a terminal, painful illness, who requests aid in dying.
d. A 13-year-old patient who requests cosmetic surgery, and who reveals that they are motivated primarily by the desire to avoid teasing and bullying.
e. A patient with a history of drug addiction who tells you they have been in chronic pain, but doesn't have any obvious physical symptoms.

CASE STUDY: WHAT SHOULD PHYSICIANS AND CHAPLAINS DO WHEN A PATIENT BELIEVES GOD WANTS HIM TO SUFFER?[3] (FROM AMA JOURNAL OF ETHICS)

"Dr. J, a fourth-year surgery resident, met with Mr. L to discuss his request and quickly reach a resolution, as the medical team did not want to delay the procedure for more than 24 hours. After Mr. L explained why he did not want pain medication, Dr. J stated, "You are going to feel a lot of pain after this surgery. Sometimes the pain is so extreme that patients have difficulty breathing. So the pain medication helps you be able to take full breaths, which reduces the likelihood of getting pneumonia." Dr. J then asked Mr. L if he would be willing to speak with a chaplain about his ideas of what God wants for him, and Mr. L agreed.

Dr. J consulted with the chaplain on call, Mr. K, and explained Mr. L's case. "We can't, in good conscience, not give him pain medication," she said. "It's just bad care. I respect his beliefs, but I can't be forced to give him what I know to be bad care because of his beliefs. We need to manage the pain to help him heal, if not to be compassionate." Mr. K suggested, "I'll speak with him to get a better understanding of his spiritual concerns. Why don't we talk after I meet with him?"

Mr. K visited Mr. L. They spent some time getting to know each other and, eventually, Mr. K asked, "So would you tell me more about why you think God wants you to be in pain after your surgery?" Mr. L nodded his head and lifted his hand. "I've done a lot of wrong in my life and hurt a lot of people. I haven't been a good father to my kids. And from the way I see it, God wants me to be in pain—God wants me to suffer through this so I can atone for some of my sins. And God's right—I don't deserve the pain meds and I don't want the pain meds."

Dr. J and Mr. K now meet and consider how to proceed." **What would you advise? In your response, please consider the extent to which Mr. L can be considered "autonomous" according to the theories discussed above.**

[3] Benjamin W. Frush, John Brewer Eberly Jr, and Farr A. Curlin, "What Should Physicians and Chaplains Do When a Patient Believes God Wants Him to Suffer?," *AMA Journal of Ethics* 20, no. 7 (July 1, 2018): E613-620, https://doi.org/10.1001/amajethics.2018.613.