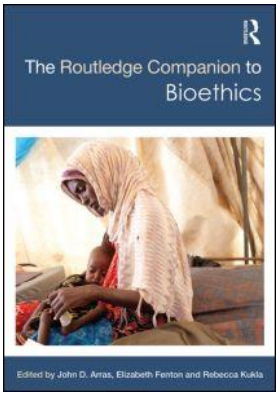

The Routledge Companion to Bioethics

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Autonomy

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Part V

AUTONOMY AND AGENCY

The concept of autonomy has played a central role in contemporary bioethics. It is not the only important moral principle relevant to bioethical debates—notions of beneficence, harm prevention, justice, solidarity, and human rights also play significant roles—but autonomy has arguably been the most salient value across a wide spectrum of bioethical debates, including the foundations of the physician–patient relationship, the ethics of reproduction, research on human subjects, organ transplantation, public health, and so on.

At its Greek linguistic root, autonomy refers to self-government (auto-nomos) or the ability to direct one's actions and life according to one's own values; it thus taps into deep wellsprings of ethical and political thought in both the Western and Eastern traditions. Notwithstanding the great value we all place on individual choice and self-determination, bioethical controversies are often driven by tensions between autonomy and other important values. Within the physician–patient relationship, the patient's autonomous decision-making (e.g., a refusal of treatment) may come into conflict with the physician's obligation to advance her patient's health. In the reproductive arena a couple's autonomous choices (e.g., to determine the sex of their offspring) can on occasion pose a threat to the values of physicians; conversely, sometimes the objectives and routines of reproductive specialists can undermine the autonomy of patients, leaving them with the impression that they "have no choice" but to continue trying to conceive, no matter what the cost in money and/or emotional turmoil. And in the area of public health, autonomous choices (e.g., to avoid vaccination or evacuation) can come into sharp conflicts with communal values of health and safety. How should such conflicts be thought about and resolved?

This section presents several tightly integrated reflections on the theme of autonomy. We begin with Catriona Mackenzie's provision of a helpful analytical framework depicting various competing conceptions of autonomy. In contrast to those who would conceive of autonomy somewhat narrowly—e.g., as restricted to the capacity to make a reasonable choice in a given situation, or to be free of external constraints or coercion—Mackenzie argues that an adequately robust conception of autonomy requires a social context sufficiently endowed with opportunities and the conditions of dignity and self-respect. In other words, in conformity with the overall goal of this volume, she connects autonomy with social justice.

Within the context of the physician–patient relationship, autonomy figures prominently in debates about decision-making capacity or competence. We all agree that autonomous patients should be able to make decisions, but who should count as an autonomous patient? What about children, adolescents, adults institutionalized with a mental disability, or just your everyday confused, anxious, scared and ill-informed patient facing a difficult and risky decision? Jessica Berg and Katherine Shaw Makielski provide both an account of the constituent elements of decision-making capacity/competency and an assessment of the various methods of ascertaining and making judgments of capacity bearing on particular patients. The major focus of their discussion is the tension between respecting patients' autonomy and protecting them from harm.

We often think of autonomous decisions as being entirely self-directed, free from external influences. This is a misleading picture. We live and make decisions within a thick social context, pushed and pulled this way and that by causes and reasons offered up by people and institutional forces within our social environment. Suppose we would like to change our health-related behavior—e.g., with regard to smoking, obesity, avoiding reproduction, accepting vaccination for human papilloma virus (HPV), etc.—but need some additional motivation or reinforcement in order to do what we wish to do. Would it be autonomy-enhancing or autonomy-restricting to offer us incentives of various kinds in order to bring about better states of health? Richard Ashcroft provides a nuanced analysis of this problem, focusing on the sorts of incentives that might be offered, their psychological impacts, and a critical assessment of the reasons often adduced for opposing resort to incentives.

Autonomy also figures prominently in discussions of privacy in the clinical, research, and public health contexts. There are many powerful rationales for the importance of privacy regarding health information, including protection from harm and social stigma, the fostering of trust, and the advancement of public health goals. Alan Rubel contends that the most important defense of privacy rests upon the value of autonomy. Even in those cases where violating our privacy might redound to our personal benefit, Rubel claims that autonomy—i.e., the ability to decide on our own with whom to share our health information—directs us to respect individuals' privacy. Rubel concedes, however, that respect for the privacy of medical information need not always trump other important concerns, such as public health.

James Childress wraps up this section with a careful discussion of tensions between civil liberties, grounded for the most part in the value of autonomy, and public health concerns. While some commentators tend to stress the conflicts between civil liberties and public health, Childress contends that these two sets of values operate for the most part in harmony—i.e., that respecting the autonomy and civil liberties of people will most often redound to the public's trust of medical authorities and thus to the enhancement of the public's health. Although he argues forcefully for a presumption in favor of respecting individuals' civil liberties in public health controversies, Childress concedes that this presumption can be rebutted under certain carefully circumscribed circumstances. Much of his subsequent analysis is addressed to the sorts of particular circumstances that might justify overriding someone's civil liberties, and suggesting ways that advancing the goals of public health might actually be achieved without resort to such violations. In this connection, Childress provides a carefully nuanced discussion of incentives and "nudges" that meshes in interesting ways with the previous reflections of Ashcroft and Rubel.

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AUTONOMY

Catriona Mackenzie

Introduction

In bioethics, the principle of respect for autonomy is widely understood as the principle that health care professionals have an obligation to respect patients' autonomous choices and decisions about their own health care. Respect for autonomy is a core principle of bioethics, underpinning requirements of informed consent to medical treatment and participation in medical research. It is also of central concern in a number of other areas in bioethics, such as in debates about reproductive choice and end of life decision-making.

Autonomy literally means self-rule or self-governance, reflecting its derivation from the ancient Greek words *autos* (self) and *nomos* (law). In its original usage, the concept was used to refer to the right of sovereign political states to be self-governing. Although this usage still remains, in the modern era the concept has been extended to refer to the authority of individual persons to make decisions of practical importance to their lives and to determine the direction of their lives in accordance with their beliefs, principles, and values. In bioethics, it is this concept of personal or individual autonomy that underwrites the principle of respect for autonomy.

Despite widespread agreement amongst bioethicists about the importance of autonomy, there is considerable disagreement about how the concept and the principle of respect for autonomy should be interpreted. This disagreement reflects, to some extent, two distinct historical influences on contemporary conceptions of autonomy: J.S. Mill's liberalism, which links autonomy to notions of individual self-expression and liberty; and Kant's notion of autonomy as rational self-governance guided by universal moral principles (for discussion, see e.g., O'Neill 2002).

This chapter discusses four different interpretations, or conceptions of autonomy: decisional, conscientious, libertarian, and relational. Each provides a different account of what personal autonomy means, of the conditions that must be met for a person or decision to be considered autonomous, and of the permissions and obligations that follow from the principle of respect for autonomy.

Decisional conceptions understand autonomy as the capacity to make informed, voluntary decisions about health care choices, such as whether to accept or refuse a specific treatment or to participate in a clinical trial. Decisional conceptions thus emphasize two primary conditions for autonomous choice: patient or subject understanding; and voluntariness, or absence of external or internal controlling influences. Respect for autonomy, on this view, gives rise to negative obligations not to unduly influence patients' decisions and positive obligations to ensure patients' decisions are sufficiently informed.

Conscientious conceptions understand autonomy as fidelity to the goals, standards, norms, or principles to which a person is committed and by which she guides her conduct. Conscientious autonomy draws attention to patients' responsibility to themselves and accountability to others, including health professionals, for their ongoing health care practice. Conscientious autonomy interprets the principle of respect for autonomy as an obligation on the part of health care practitioners to foster patients' capacities for conscientious health care management.

Libertarian conceptions equate autonomy with negative liberty; that is, the right to freedom from interference by other persons or the state in one's personal life. Libertarians claim that the principle of respect for autonomy entails obligations to maximize the scope of individual choice and minimize social interference with individuals' choices. In bioethics, libertarian conceptions are particularly influential in debates concerning reproductive and genetic technologies, physical and cognitive enhancement, contested surgical interventions, and markets in organs and tissue.

Relational autonomy is an "umbrella term" (Mackenzie and Stoljar 2000: 4), referring to a cluster of theories of autonomy motivated by feminist concerns about the impacts of oppression and social injustice on women's (and men's) opportunities to lead self-governing lives. While relational conceptions generally understand autonomy as the capacity for competent self-governance and authentic critical self-reflection, their distinguishing feature is that they seek to analyze the relational, social, and political dimensions of autonomy. Relational autonomy theory's focus on the relevance of issues of social justice for autonomy is a salutary counter in many arenas of bioethical debate to the dominance of libertarian autonomy.

The next section provides an account of decisional autonomy and discusses three criticisms of this account, including from the perspective of conscientious and relational autonomy. The following section discusses libertarian autonomy and its limitations. The final section summarizes the distinctive contribution of relational autonomy and its relevance for bioethics.

Decisional Autonomy

In bioethics, the most influential account of decisional autonomy is that of Tom Beauchamp and James Childress (2012). Beauchamp and Childress equate autonomy with informed, voluntary, and competent decision-making. Their account links autonomy closely to legal competence and to informed consent. To count as autonomous, in their view, an action or choice must satisfy three conditions. First, it must be intentional, i.e., planned rather than accidental. Second, the person must be able to understand the particular decision in question. This requires that the person has the requisite competence to understand and make the decision, has sufficient information about the nature of the decision and its import, can give reasons for her decision, and is able to communicate it effectively to others. Third, the person must make the decision voluntarily, that is, not be subject to undue external constraints or controlling influences, such as coercion and manipulation, or to overpowering internal forces, such as addiction, or mental illness.

Beauchamp and Childress stress that both understanding and voluntariness are matters of degree. Their account stipulates that, for a decision to be autonomous, the person must have adequate rather than complete understanding, and not be subject to substantial controlling influences. It follows from this account that the obligations involved in

respecting autonomy are of two kinds: negative obligations to refrain from exerting undue influence over another person's actions or choices; and positive obligations to foster the person's capacities for autonomous choice, for example, by taking steps to ensure that the person has sufficient information, is given sufficient assistance (if required) to understand the decision in question, and that the decision is genuinely voluntary.

Decisional accounts of autonomy focus on local as distinct from global autonomy (for discussion, see e.g., Dworkin 1988). To exercise local autonomy is to be autonomous with respect to a particular action, choice, or decision. To exercise global autonomy is to be an autonomous person or to lead an autonomous life. An autonomous person might, temporarily, not be capable of locally autonomous choice, due to severe pain or incapacitating illness. Conversely, a person who is unable to lead an autonomous life, whether due to external constraints or impaired capacity, might nevertheless be able to make locally autonomous decisions, such as whether to accept or refuse treatment.

Beauchamp and Childress claim that decisional autonomy, because it is focused on local autonomy and does not stipulate overly stringent conditions for a decision to count as autonomous, is both maximally inclusive and provides the most appropriate account of autonomy for health care contexts. Their presumption is that most people are able to exercise decisional autonomy in their everyday lives, and that this should also be the default presumption in health care and research contexts, except in cases where patients or research subjects fail to meet the threshold for legal competence. Nevertheless, they acknowledge that there are a number of features of health care contexts that pose challenges for autonomous decision-making. These include patient vulnerability due to pain, illness, and fear; difficulties experienced by some patients in understanding diagnoses and assessing risks, benefits, and probabilities; and differences between health care professionals and patients or research subjects in social power, knowledge, levels of education and professional status, or arising from factors such as age, race, gender, disability, or cultural background. The principle of respect for autonomy imposes ethical obligations on health care professionals and researchers to be attentive to these factors in order to ensure that the conditions are in place for patients or research subjects to make informed and voluntary choices.

The benefit of this inclusive approach to autonomy is that it provides patients and research subjects with important protections against unwarranted medical paternalism, and coercive or manipulative attempts by others (e.g., family members, health care professionals, medical researchers) to influence their decisions. However, critics have questioned whether decisional autonomy does actually provide an adequate account of autonomy for health care contexts, for several reasons. First, decisional theorists of autonomy err in equating autonomy with informed choice; second, this conception does not take sufficient account of social constraints on global autonomy and the effects of these constraints on local autonomy and individual choice; third, an exclusive focus on moments of decision-making overlooks the importance of autonomy in many areas of ongoing health care practice and misrepresents what is involved in exercising autonomy in such contexts.

Beauchamp and Childress provide a nuanced account of the conditions for informed choice. However, there is an important difference between informed choice and autonomy. Two widely accepted conditions for autonomy that distinguish it from informed choice are competent critical reflection and authenticity (for a summary, see e.g., Christman 2009). The critical reflection condition requires that the person in question

has competently and critically reflected on the beliefs, desires, values, standards, and commitments guiding her choice; the authenticity condition requires that as a result of such reflection, she regards these aspects of her cognitive and motivational structure as authentically "her own," rather than, for example, uncritically adopted due to her upbringing or socialization.

Beauchamp and Childress reject both requirements as overly onerous and restrictive. Their argument focuses on the influential "hierarchical" theories of Gerald Dworkin (1988) and Harry Frankfurt (1988), which characterize critical reflection as the capacity for second-order reflection on one's first-order preferences, values, or commitments. These count as authentically one's own if the person endorses them in light of such reflection. However, if upon reflection a person feels alienated from her preferences, values, or commitments, she is not autonomous with respect to them. Beauchamp and Childress argue that second-order reflection is not sufficient to secure autonomy because such reflection can sometimes be distorted by overpowering internal forces, such as addictions, and by powerful external influences, such as oppressive socialization. Hierarchical theories therefore lack a plausible account of the difference between competent and distorted forms of critical reflection.

Beauchamp and Childress also reject the authenticity condition on the ground that it seems to require persons to exhibit overly stable motivational and volitional patterns, making it difficult to distinguish failures of autonomy from genuine changes of heart or mind. This condition seems to suggest, for example, that a terminally ill patient, who reverses an earlier decision not to accept highly invasive treatment, is being inauthentic and hence non-autonomous. For this reason, the authenticity requirement "narrows the scope of actions protected by a principle of respect for autonomy" (2012: 103).

These and other objections to hierarchical theories have been extensively discussed in the literature (for a summary, see e.g., Mackenzie and Stoljar 2000). However, these objections do not provide sufficient reason for rejecting the critical reflection and authenticity conditions. In the final section, I discuss alternative accounts of both conditions. Suffice to say here that although it may be difficult to distinguish competent from distorted reflection, and to discern the extent to which a person's decision is fully "her own," health professionals are often called upon to make such judgments. For this reason, both conditions are important.

The second criticism of decisional autonomy is that a focus on local autonomy is overly narrow and does not take sufficient account of the historical and social context of individual decisions, and the effects of social oppression on global autonomy. John Christman's (2009) "historical" theory of autonomy helps to explain this problem. Like relational theories of autonomy, Christman's theory is motivated by the intuition that a person whose endorsement of her current values or preferences is the result of manipulation, oppressive upbringing or environment, or distorted reflection, is not autonomous. His theory highlights the importance of accounting for the historical and social processes by which a person acquired her guiding preferences and values, or came to make a particular decision. Without attending to these processes, he argues, it is often difficult to determine whether or not a particular choice is autonomous.

For example, it would be difficult to determine whether an older person has autonomously chosen to go into a nursing home or whether she has been coerced or manipulated into that decision by family members or health professionals, without some understanding of her personal history, her interests and orienting values, and the nature of her relationships with her family (see e.g., Lindemann Nelson 2001). A further important factor is her

emotional attitude to the decision itself or the process by which it was reached. Does she feel distressed, angry, resigned, depressed, or optimistic? And do these emotions persist over time? Christman proposes that a decision counts as autonomous if, in light of sustained reflection upon the decision and the historical process leading up to it, the person would accept the decision without feelings of resistance, rejection, or alienation. Acceptance, or non-alienation, indicates that the decision expresses or is consistent with the person's long-standing practical identity (her self-conception and orienting values), whereas emotions such as anger or depression in the wake of a decision, if sustained over time, are indicative of alienation and hence a decision that is not autonomous.

Decisional theorists such as Beauchamp and Childress are sensitive to the kinds of concerns raised by this example. They acknowledge that the broader context of a decision needs to be taken into account in assessing whether or not it is autonomous, even though the primary focus of their account is the conditions under which specific decisions count as autonomous. They also acknowledge that emotional pressure, manipulation, and coercion are external threats that may undermine autonomous decision-making. And the most recent version of their theory incorporates some of the insights of relational autonomy concerning the importance of social support for autonomous decision-making. Nevertheless, from the perspective of theorists of relational autonomy their theory is still limited in the extent to which it takes account of the effects of social oppression on personal autonomy.

Taking these effects into account requires expanding our understanding of the internal constraints on autonomy, beyond addiction and mental illness, to include the effects of internalized oppression, as I discuss in the final section below. As Susan Sherwin (1998) has argued, it also requires expanding our understanding of the external constraints on autonomy beyond coercion and manipulation to include social and political restrictions on personal liberty, limited opportunities, poverty, and social oppression. Sherwin also urges the importance of considering the impact of social policies, such as welfare or health policies, on the choices available to people, and hence on their local and global autonomy. In relation to the nursing home example, such an expanded analysis would require us to consider whether the lack of affordable, socially supported alternatives, such as regular home visits by a community nurse, is a social injustice that has constrained the older person's global autonomy and her ability to make a locally autonomous decision to remain in her home. Sherwin thus highlights one of the central motivations of relational autonomy, which is to develop a conception of autonomy that is attentive to issues of social justice.

The third criticism, developed by Rebecca Kukla (2005), rejects Beauchamp and Childress' focus on "punctate decisions" and their understanding of autonomy as informed, voluntary, decision-making. Using the example of prenatal care as an illustration, Kukla points out that a major part of effective health care delivery involves forms of health care practice in which patients undertake ongoing self-management in collaboration with health care professionals. To be effective, these practices require that patients exercise autonomy by taking responsibility for diligently monitoring their own health care and holding themselves accountable for doing so to the health care professionals who care for them. These practices cannot be understood, however, as a series of discrete choices or decisions, and for this reason decisional autonomy is an inadequate model of autonomy for many health care contexts.

Drawing on a Kantian conception of autonomy as being bound by commitment to rational norms or principles, Kukla (2005: 39) proposes an alternative notion of

conscientious autonomy. Conscientious autonomy "is manifested in actions that express fidelity to goals, principles, values or other normative measures to which the agent is responsibly committed." In exercising conscientious autonomy, patients will often defer to and trust in the authority and judgment of health care professionals, but this is quite different from merely complying with doctors' orders. Conscientious autonomy requires capacities to critically reflect on and articulate the reasons for one's commitments; take responsibility for one's ongoing health care practices; and exercise judgment about when deference and trust in medical authority is appropriate and when it is not. On the basis of this account of autonomy, Kukla suggests that the principle of respect for autonomy should be understood not as a matter of respecting patients' autonomous choices, but rather as an obligation on the part of health care practitioners to foster patients' capacities for conscientious health care management.

The criticisms I have discussed in this section show that while decisional conceptions of autonomy provide a nuanced account of the requirements for informed choice in medical and research contexts, the concepts of informed choice and autonomy, though related, are not equivalent.

Libertarian Autonomy

Libertarian conceptions equate personal autonomy with negative liberty. Libertarian theorists hold that to be autonomous is to be free from unwarranted external interference by other persons or the state with respect to important decisions about one's life (for classic statements of this view in political philosophy, see e.g., Nozick 1974; in bioethics, see e.g., Englehardt 1986). Libertarian conceptions of autonomy are particularly influential in Anglo-American bioethics, especially in debates about contested reproductive and genetic technologies, such as sex selection, cloning or enhancement technologies (Harris 1998; Agar 1998); markets in organs and tissue (Fabre 2006; Radcliffe-Richards 2007; Taylor 2002); and contested surgical interventions, such as cosmetic surgery or demand limb amputation (Bayne and Levy 2005). For example, bioethicists who support individuals' rights to select the sex or to enhance the characteristics of their offspring, or to sell organs, such as single kidneys, or reproductive tissue, usually support these positions on the basis of libertarian autonomy.

Libertarian conceptions are underpinned by several overlapping philosophical justifications. The first is the liberal neutrality thesis. This is the view that in a pluralist society, there is no non-controversial basis for making normative judgments about how people should lead their lives or what values ought to guide their choices. Each individual therefore has a right to live her life as she chooses and to be regarded as the best judge of what is in her interests. The role of the state, on this view, is to secure the social, political, and economic conditions to enable individuals to lead lives of their own choosing. However, the state has no business promoting or supporting particular values or imposing unnecessary restrictions on people's choices.

Second, libertarians regard the main threat to autonomy as coercive or paternalistic interference by others or the state. Such interference can only be justified by Mill's (1962 [1859]) harm principle: the principle that a person's liberty may only justifiably be restricted if the exercise of their liberty threatens to cause harm to others, where harm usually means direct physical harm. Third, libertarians regard freedom of choice as central to autonomy, where choice is understood as satisfaction of a person's subjective preferences, no matter how arbitrary, prejudiced, manipulated, or self-destructive these

might be in the eyes of others. On the basis of these justifications, libertarians hold that personal autonomy is best promoted by maximizing the range of choices available to individuals and minimizing regulatory and other forms of constraint on individual choice. Respect for another's autonomy involves refraining from interference with that person's choices, unless those choices threaten to cause harm to others.

The libertarian conception of autonomy seems attractive on a number of grounds. It articulates one of the key ideas underpinning the concept of personal autonomy: that of individual sovereignty with respect to one's own life. At the same time, via the harm principle, it sets clear limits to this sovereignty, thereby distinguishing justifiable (to prevent harm to others) from non-justifiable (coercive or paternalistic) forms of interference. The libertarian conception of autonomy also highlights the important connections among autonomy, freedom, and individual choice. These ideas have played a crucial role in securing political freedoms, such as freedom of religion, or freedom of speech and assembly, that most people in western liberal democracies regard as crucial to their ability to lead autonomous lives. In some jurisdictions, these ideas have also been used to support more controversial personal freedoms, such as women's rights to abortion; the right of terminally ill patients to request voluntary euthanasia; and the rights of those with non-standard sexual or gender identities, such as gays, lesbians, and transgender persons to lead lives of their own choosing, including being able to express their sexual preferences and gender identity without state sanction.

Relational theorists uphold the importance of individual sovereignty with respect to one's life. They also agree that political freedom, personal freedom, and individual choice are important for autonomy. However, they disagree with libertarian interpretations of freedom and individual choice, and reject libertarian conceptions of autonomy on three connected grounds. First, they maintain that negative liberty is insufficient for autonomy. Second, they claim that libertarian autonomy overlooks the social constraints on individual choice. Third, they contend that it pays insufficient attention to exploitation and social injustice.

Why is negative liberty insufficient for autonomy? To exercise autonomy requires both liberty and opportunity. Liberty, or freedom from undue interference, is required because it is difficult for a person to lead a self-governing life if political or personal restrictions prevent her from making choices about matters that are important to her, such as being able to practice her religion, express her political opinions, pursue a career or personal projects, and decide with whom she will have intimate relationships, where she will live, or whether she will have children. However, living an autonomous life or a life of one's own choosing intuitively seems to require more than being free from undue interference by others. It also seems to require access to genuine opportunities, or to a range of significant options (Raz 1986), which means access to social goods such as education, health care, housing, and social support; adequate nutrition, sanitation, and personal safety; opportunities for political participation and paid or unpaid employment; and some degree of mobility. These goods require complex social, economic, and political infrastructures. Relational theorists charge that libertarian autonomy places too much emphasis on the importance of negative liberty or freedom from interference, while overlooking the importance for individual autonomy of access to these social goods and the opportunities they make available.

The second objection, which follows from the first, is that libertarian autonomy pays insufficient attention to the social distribution of opportunities and the social constraints on individual choice. The extent of a person's access to significant options

depends both upon their social availability and also on that particular individual's social environment and social relationships. For example, even in societies in which access to a university education is a significant option for many young people, such as Australia, it is unlikely to be a significant option for a young person from a socio-economically disadvantaged background, particularly if he is Aboriginal, who, despite having the native ability to study at university, may have received a poor high school education, may come from a family or community that does not place much value on education, and is unlikely to have been encouraged by his teachers, parents, or peers to consider university as an option (see e.g., Australian Government 2012). In other words, even if there are no formal discriminatory barriers preventing this young man from gaining a place at a university, and even if targeted access programs and financial assistance are available to Aboriginal students, the option to study at university is unlikely to be a significant option for him. One reason for this is what is known as the problem of adaptive preference formation (Elster 1983; Sen 1992). This is the phenomenon whereby persons who are subject to social oppression or deprivation adapt their preferences and goals to their circumstances, eliminating, or failing to form, preferences or goals that cannot be satisfied, and even failing to conceive how these might differ in different circumstances. A young Aboriginal man growing up in circumstances such as those described above, for example, may have little conception of the kind of options that might be available to him or the kind of life he might be able to lead were he able to gain a university education, and so never even forms a preference to undertake university study.

The third objection is that because libertarian autonomy endorses expansions of choice but fails to account for the social distribution of opportunities and the social constraints on individual choice, it can entrench social injustice and overlook exploitation. This is because in contexts of highly constrained choice, it might be rational for persons with significantly reduced options to enter into exploitative personal relationships, or exploitative employment or other commercial arrangements. Bioethicists who endorse libertarian autonomy usually justify such arrangements as freely chosen, advantageous to both parties, and as enhancing the autonomy of the disadvantaged by expanding their option sets. Such justifications therefore assume that any expansion of a person's choices that meets the harm condition (construed minimally) enhances their autonomy. However, according to relational theorists, what such justifications ignore is that some options are unjust and function to entrench or extend existing inequalities, such as inequalities arising from socio-economic status, gender, disability, or citizenship. Rather than enabling a person to lead a more self-governing life, adding these options to her choice set may simply increase the opportunities for others to exploit her. The fact that the option is available may also function as a further constraint, pressuring a person to pursue an option she would not otherwise have chosen, and furthering her disadvantage.

An example from bioethics will help to explain this third objection. Some bioethicists have proposed that in order to meet the increasing demand for organs and shortages in supply, a current market in nonessential or renewable body parts, such as single kidneys, liver lobes, blood, bone marrow, or corneas, should be established (Fabre 2006; Radcliffe-Richards 2007; Taylor 2002). Such proposals are defended on grounds of libertarian autonomy, via two main arguments. First, that people have an autonomy right to determine what happens in and to their bodies, and this includes the right to use their bodies however they choose, including selling body parts and organs for material gain.

Any attempt to limit this right constitutes unjustifiable paternalism. Second, that such markets simply provide prospective donors with extra options. Since nobody is under an obligation to sell their organs if they do not want to, then the availability of this option can only enhance donors' choices and hence their autonomy.

Critics have responded to such arguments by highlighting both the risks to individuals and the broader social harms of organ markets. The trade in body parts is now a global enterprise and those who are most likely to have an interest in selling their organs are the global poor. Since surgical procedures to procure organs are often undertaken in unsafe conditions, individuals who sell an organ such as a single kidney are at risk of suffering a range of harms, including poor health (both short and long term), resulting in consequent loss of employment, and being shamed within their communities (see e.g., Scheper-Hughes 2007). Organ markets, critics claim, therefore exploit people who are vulnerable, disadvantaged, and often desperate, while advantaging the wealthy. Moreover, in doing so they entrench global inequities in the allocation of health care resources (Zutlevics 2001). Critics have also claimed that whereas organ donation involves an altruistic gift of life to another person, organ markets treat the human body and body parts as commodities, thereby undermining respect for human persons (Titmuss ([1970] 1997); Radin 1996).

Bioethicists who defend markets in organs and tissue often acknowledge that such markets may involve the making of exploitative offers to poor, vulnerable, and disadvantaged people, and that those who take up these offers may thereby risk their health and livelihoods. However, these bioethicists argue that if the offer is perceived by the seller as advantageous, if genuine consent has been given in full knowledge of the risks involved, and if the offer makes the seller better off relative to their current situation, then prohibiting the poor from pursuing this option or from pursuing other high-risk opportunities for earning income is unjustifiably paternalistic (see e.g., Radcliffe-Richards 2007; Taylor 2002; Wertheimer 2011). While it is beyond the scope of this article to provide a detailed response to this kind of argument (for a subtle response, see e.g., Radin 1996), one of my concerns is that it effectively ends up defining exploitation away. On this account it is difficult to see how arrangements that seem obviously unjust, such as sweatshop labor, could be classified as exploitative.

The central problem with the libertarian conception of autonomy then, is that it starts from the mistaken premise that autonomy is equivalent to negative liberty and fails to take sufficient account of the effects of social injustice and oppression on individual choice. Despite the influence of libertarian autonomy in bioethics, therefore, I have argued in this section that it does not provide a satisfactory account of personal autonomy.

Relational Autonomy

Relational conceptions hold that autonomy is a complex competence, the development and exercise of which requires ongoing interpersonal, social, and institutional scaffolding. Relational theorists seek to analyze the nature of this competence; to understand the kind of social scaffolding required to develop and exercise it; and to show how autonomy can be thwarted by social oppression and injustice. Relational autonomy theory therefore shares the decisional autonomy theorist's focus on the competences required for autonomy, but develops a richer account of these competences. It shares with the libertarian conception of autonomy a focus on the connections between autonomy, freedom, and

individual choice, but develops a more complex social analysis of these concepts and their interconnections. And it shares the conscientious autonomy theorist's focus on the importance for autonomy of critical reflection, responsible judgment, and accountability to others, seeking to analyze the ways such accountability relations are sometimes embedded in oppressive social relationships and institutions.

Relational autonomy theorists such as Diana Meyers (1989) propose that autonomy competence requires a complex repertoire or suite of reflective skills, which may be developed and exercised to varying degrees and in different domains. These skills include but go well beyond the requirements of legal competence—understanding, minimal rationality, and the capacity to communicate one's decision—that are central to Beauchamp and Childress's account of decisional autonomy. They include volitional skills, such as self-control and motivational decisiveness; emotional skills, such as the capacity to interpret and regulate one's own emotions; imaginative skills, required for understanding the implications of one's decisions and envisaging alternative possible courses of action; and capacities to reflect critically on social norms and values. According to Meyers, a person is autonomous, and her choices are authentically her own, to the degree that she has developed these skills and can exercise them in understanding herself (self-discovery), defining her values and commitments (self-definition), and directing her life (self-direction).

Meyers' skills-based theory provides a plausible way of responding to the problem identified by Beauchamp and Childress, concerning how to distinguish authentic from distorted forms of critical reflection, such as in the example of the terminally ill patient who reverses an earlier decision to refuse treatment. Reflection is authentic if a person possesses and can exercise the full repertoire of cognitive, volitional, emotional, and imaginative competences required to direct her life and make choices that express her authentic self-conception. Reflection may be distorted, however, if these competences are under-developed or their exercise is impaired, for example by volitional disorders or social oppression. Meyers' account of critical reflection is procedural or content-neutral. Judgments about whether or not a person's decisions are autonomous do not turn on the specific content of that decision, but on whether or not the person exercises the necessary reflective skills to make a decision that expresses her authentic self-conception.

Meyers' account of autonomy competence, and other relational conceptions of autonomy are relational in four main ways. First, relational autonomy theory emphasizes that autonomy competences emerge developmentally and are sustained and exercised in the context of significant social relationships. Hence, autonomy competence is a relationally, or socially constituted capacity. In contrast to popular conceptions, which equate autonomy with self-sufficient independence, relational theorists stress that an adequate conception of autonomy must be responsive to the facts of human vulnerability and dependency. For this reason, on a relational view, there need be no inconsistency between autonomy and interpersonal relationships of dependence and interdependence. Because relational autonomy starts from a conception of persons as vulnerable and dependent, to varying degrees, it is particularly relevant to health care contexts, where obligations to respond to vulnerability must be balanced with respect for patient autonomy.

Second, relational autonomy theory is premised on a social conception of the self, according to which we constitute our self-identities in relation to social relationships; the specific historical, political, and geographical contexts in which we live our lives; and intersecting social determinants, such as race and gender. This social conception of the self has implications for the notion of authenticity, or what it means for a decision,

choice, or action to be "one's own." The notion of authenticity is sometimes interpreted as implying that each individual has a true, deep, or ideal self (see e.g., Wolf 1990). Relational theorists reject such interpretations of authenticity. Autonomy is not a matter of discovering who one essentially is, free from social influence. It is rather a matter of exercising socially acquired reflective skills to determine what one values and how one wants to live one's life. Although this requires some degree of self-knowledge, it is not a solitary exercise, but requires sustained interpersonal and social scaffolding and ongoing dialogical interaction with others, or what Christman (2009) refers to as "socially-mediated self-reflection." Moreover, although some degree of motivational and volitional stability is required for authenticity, relational theorists emphasize that our self-identities are dynamic and changing. Hence the terminally ill patient's change of mind need not impugn her autonomy, so long as she has exercised the relevant reflective skills, has considered the implications of this decision, often in discussion with others, and can give reasons for her decision.

Third, while emphasizing the crucial role of social relationships in shaping our self-identities and developing the skills involved in autonomy competence, relational theorists argue that some social relationships, such as those characterized by domination, abuse, coercion, violence or disrespect, provide hostile conditions for autonomy. These kinds of social relationships, whether in intimate personal and family relationships, institutional care contexts, work environments, between neighbors or friends, and so on, can thwart the development or constrain the exercise of autonomy competence. In accounting for the autonomy-impairing effects of oppressive social relationships, some relational theorists claim that autonomy is both a *capacity* and a *status* concept, and that these two aspects of autonomy are closely intertwined. To lead an autonomous life requires not just possessing and exercising the relevant competences, but also regarding oneself, and being recognized by others, as having the social *status* of an autonomous person (Anderson and Honneth 2005; Benson 2005; Mackenzie 2008; McLeod 2002; Lindemann Nelson 2001; Oshana 2006). Regarding oneself as having the social status of an autonomous person, according to these theorists, requires having positive and appropriate self-evaluative attitudes, in particular attitudes of self-respect, self-trust, and self-esteem. Self-respect involves regarding oneself as the moral equal of others, as having equal standing to have one's views and claims taken seriously. Self-trust is the capacity to trust one's own convictions, emotional responses, and judgments. Self-esteem or self-worth is an evaluative attitude towards oneself, which involves thinking of oneself, one's life, and one's undertakings as meaningful and worthwhile.

McLeod (2002), for example, argues that justified self-trust is required for autonomous choice, judgment, and action. Making autonomous choices requires that a person trusts her own abilities to choose well, to understand the information relevant to that choice, and to discern when it is appropriate (or not) to trust the purveyor of that information. It also requires that she trusts her own judgment that this is the right choice for her to make, given her beliefs and values, and that she trusts in her ability to act on the decision she has made. Similarly, Kukla (2005) argues that justified self-trust is required for exercising conscientious autonomy, that is, for taking responsibility and holding oneself accountable for one's health care practices.

Self-evaluative attitudes such as self-trust, however, are vulnerable to the attitudes of others; that is, to social relations of recognition. Refusals or failures to recognize another person as an autonomous agent, and as deserving respect, are quite typical in social relations involving domination, or inequalities of power, authority, or social and economic

status. McLeod (2002) and other relational autonomy theorists claim that the internalization of oppressive social relations and stereotypes can corrode a person's sense of self-respect, self-trust, and self-esteem, thereby impairing her autonomy.

In health care contexts, patients' self-evaluative attitudes are particularly vulnerable not only to the effects of illness or disability, but also to the attitudes, judgments, and styles of communication and interaction on the part of clinicians. For example, a parent's sense of self-respect and confidence in her judgment can be undermined if health care professionals dismiss her concerns about her child's health or ignore her reports of the child's symptoms; convey attitudes of disrespect or disinterest; make stereotypical judgments based on the parent's gender, religion, occupation, or cultural background; or communicate using medical terms she does not understand without explanation. As a result, she may feel (rightly) that her autonomy has been overridden and her judgment impugned if she ends up agreeing that there is nothing wrong with her child when she knows that he is ill, or agreeing to treatment plans that she suspects may be useless or harmful.

Finally, relational autonomy theory focuses attention on the impact of social oppression and injustice on individuals' capacities to lead autonomous lives and to make autonomous choices. Relational autonomy theorists agree with libertarians that there is an important connection between freedom, choice, and autonomy, and that constrained option sets can compromise a person's ability to lead an autonomous life. However, they argue that what matters for autonomy is not the mere proliferation of choice, but the range of significant options that are available to a person or social group. If we are interested in promoting autonomy we therefore need to be concerned with the social distribution of opportunities; that is, with questions such as whether there are significant inequalities in the opportunities available to members of different social groups, and whether these inequalities perpetuate injustice and enable exploitation. For relational theorists, then, an interest in promoting autonomy goes hand in hand with an interest in promoting social justice.

This aspect of relational autonomy is particularly pertinent to public health ethics (Baylis et al. 2008; Faden and Powers 2006). Public health is focused on what societies collectively can do to promote the health of the population and to reduce health inequalities and inequities among individuals and social groups. It is fundamentally concerned with issues of social justice, in particular with the social determinants of health. This refers to the impact on health, at both the individual and population levels, of patterns of systematic disadvantage, due to factors such as socio-economic inequality, geographical location, gender, race, or disability. Relational conceptions of autonomy are particularly relevant to public health because their attention to the social constraints on individual choice and the social distribution of opportunities can help focus attention on the background conditions that shape individual health choices. For example, in poor communities, food choices, such as high levels of consumption of fast food, are often shaped by factors such as the low cost and ready availability of fast food compared with fresh fruit and vegetables, insufficient education concerning nutrition, and time poverty due to long working hours. Relational conceptions also focus attention on the way that health and social policy decisions can limit or expand the options available to people and may affect different social groups in different ways (Baylis et al. 2008: 202).

An objection that has been raised against relational conceptions of autonomy is that highlighting the social constraints on individual choice and the autonomy-impairing effects of social oppression may invite disrespect towards persons who may already be

socially marginalized. As a result, relational conceptions may sanction unwarranted paternalistic interference with their choices (Christman 2005; Holroyd 2009). In response, I would argue that this objection misidentifies the critical target of relational conceptions, which is unjust and oppressive social relationships and institutions that impair individuals' capacities for autonomous agency and choice. The kinds of interventions that relational autonomy theorists would sanction are regulatory interventions aimed at preventing exploitation, coercion and abuse, or expanding the significant options available to individuals from oppressed or disadvantaged social groups. However, it does not follow from recognizing that a person's autonomy may be impaired to some degree that disrespect and paternalistic interference with that individual's choices are thereby licensed. Rather, relational autonomy theorists emphasize the importance of providing forms of social support that scaffold individuals' capacities for autonomy. In clinical contexts this might mean adopting approaches to clinical care that facilitate dialogical interaction between clinicians and patients, or providing assistance to patients who find it difficult to implement treatment regimes. In public health contexts it might mean developing targeted programs to improve knowledge about nutrition, or how to avoid infection, while taking care to avoid stereotyping of targeted social groups. For relational autonomy theorists then, respecting autonomy requires more than respecting an individual's autonomous choices; it means promoting the kinds of social relationships and institutional structures that enable people to lead self-governing lives.

Related Topics

Chapter 24, "Privacy, Surveillance, and Autonomy," Alan Rubel
Chapter 25, "Public Health and Civil Liberties: Resolving Conflicts," James F. Childress
Chapter 33, "Alzheimer's Disease: Quality of Life and the Goals of Care," Bruce Jennings

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