University of Nevada, Reno

RESPECTING RELATIONAL AUTONOMY

This thesis submitted in partial fulfillment of the requirements for the degree of
MASTER OF ARTS in
PHILOSOPHY

By

Brittany Paige McAllister

Dr. Christopher Williams/Thesis Advisor

May, 2021

THE GRADUATE SCHOOL

We recommend that the thesis prepared
under our supervision by

BRITTANY PAIGE MCALLISTER

entitled

Respecting Relational Autonomy

be accepted in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

Christopher Williams, Ph.D

Advisor

Simon Gubler, Ph.D

Co-*advisor*

Colleen Murray, Ph.D

Graduate School Representative

David W. Zeh, Ph.D., Dean *Graduate School*

May, 2021

Abstract

Patient autonomy is one of the central moral principles practicing health professionals have been prompted to respect, owing to the development of technology and widespread critical examination of previous paternalistic conduct. Respecting patient autonomy was meant to affirm the individual's right to decide about their health care. The present work rejects the claim that autonomy—as it is understood individualistically—is an adequate concept for judging what is important about patient decision-making. Respecting patient autonomy in a relational manner will better deal with the individualist's own conditions for decisional capacity since the expectation of self-governance actually undermines the benefits of mutual dependency. Because people are socially embedded and interdependent to a degree which affects their cognitive abilities, respecting relational autonomy is an approach which acknowledges the individual's inseparability from personal relations. For these reasons, the family unit is a salient site for considering how patient's decision-making is developed and fostered; thus families will prove to be more important for theorizing about autonomy than previously accepted.

Acknowledgments

The success of this project has greatly been supported by numerous colleagues, professors, family members and friends. The academic element was in large part facilitated by the composed oversight and sage intelligence of my advisor Christopher Williams, Ph.D. I am also grateful for the feedback of my committee, Simone Gubler, Ph.D and Dr. Colleen Murray, Ph. D. Another pillar of this project's success was my daily, mutual accountability partner and peer Naomi Kandarian. My significant other, William Ellsworth, has been my mainstay of emotional and financial support though these past two years, even when he was hundreds of miles away. And of course, my family has empowered me in a vast variety of manners which I hold close to my heart.

Table of Contents

1 Introducing Autonomy

The central topic of this work is autonomy in medicine. To make clear what is flawed about this concept for medical application, I will first spell out a general background of the concept. Utilization of the term has shifted from applying to the self-rule of a state to the sovereignty of the individual human. What once was simply a political conceptualization—in parts of the world—has been further adopted by fields where risk of duress or coercion to an individual person is legally objectionable. To observe the self (*autos*) rule (*law/custom/rule*) of a sovereign agent does not simply require that individuals be protected from others' ill intentions. A grounding thought is that persons have inherent dignity as well as objective duties. Engaging in self-sovereignty refers to operating or living according to one's own rules—so long as the autonomous person does not harm others. Beyond the mere esteem for autonomy, there are palpable conditions needed to be satisfied for respecting autonomy. The concept and related philosophies have advanced revolutionary ways agents see and interact with their circumstances. Autonomy is a powerful principle that has altered what is traditionally regarded in persons' existence.

The primary way autonomy can be understood has to do with the valuing of individuals' rights over duties or rules imposed by social structures. Recognizing individual autonomy has a direct link to persons' real or potential capability for reasoning. This approach values an agent's self-governance is in and of itself, with no reference to any reasons supporting the demand. Otherwise stated, as a demand, there is worth in upholding the sacrosanct dignity of persons by respecting their self-determination. People must be viewed as individuals. These individuals have the quality of being individuals as opposed to being viewed as being a part of a group that is defined by certain decisions that the individual may have little to no say about. Moreover, autonomy is about simply regarding individual's potential ability to self-govern by rejecting

paternalism. By freeing persons from being submerged in another's—group or authority—judgment or reasoning, the agent will stand as an equal to others morally and rationally. While I will discuss more about historical underpinnings of autonomy in a later section, the particular position I am referencing is that of Immanuel Kant, who believed that persons should not be merely means in themselves. Respecting persons' autonomy is one, albeit primary, way of dignifying the treatment of persons as ends in themselves. Thus, this view of autonomy is less concerned about what benefits or consequences are conferred by acknowledging the right to self-government and more about upholding the right to autonomy because it is the correct thing to do for individuals. Yet, there are distinct reasons, related to historical occurrences, which galvanized the attention to the concept of autonomy.

Historically, the paternalistic limitations to economic freedom, media, political engagement, religious practice, etc. have suffered many persons. The response to these limitations, as well as authoritarian rule over people’s interests, engendered arguments for being liberated from what was viewed as an oppressed position.

To comprehend the use-value of autonomy, I think it is helpful to consider what a lack of autonomy generates. Most often, oppositional forces that threaten human agency include subjugation by the forces of authority, coercion, imprisonment, as well as manipulation. These are all forces of influence which limit an individual's freedom of expression, speech, and thought. Some suppressive forces manifest as enforcement, others intimate or pressure someone to do or refrain from doing something or thinking some way. Controlling actions may be overt or disguised, purposeful or latent. The most clear-cut course for how self-governance is revoked actively is when an agent/agency has an autonomy-limiting intention for another, uses action to revoke or limit their liberty, and realizes the intended results. Controlling an individual’s actions generally will command how they can interact with things external to them or even themselves.

So then lacking autonomy implies a loss of physical or even psychological control over one's own actions.

It would be a stretch to claim that *any* or even *all* limits on liberty impede autonomy in total. To be autonomous, an individual will not be totally free from concrete situatedness. Concrete situatedness will inadvertently and inescapably fix how much freedom there is. In particular, securing social organization of persons' self-government requires some amount of limitations. Otherwise stated, societies pragmatically protect the kinds of liberty it deems just and good. This inevitably results in controls curtailing undesirable actions, especially if they impair agents' "good" free actions. What this all means is that humans restrict the merit to some kinds of autonomous action while others are punishable or shame-worthy. It is not always the case, but many accounts of autonomy deny that social controls, such as coercion, are essential for sustainable societies. Although viewing all social controls as sinister is an extreme position, the value of autonomy is more about leaving people alone to exercise their own faculties. Plainly, self-government over one's own cognition is at the base directly related to the control over an agent's own moral universe. For proponents of autonomy, this sense of individual control grounds their understanding of existence.

Simply remarking on the utility of autonomy when it is unimpeded or what is lost when there are limits, sketches only some of the overall value we give autonomy. There are indirect conditions that must be met for autonomy to reach or retain value and usefulness. For one, an agent must have quality choices. Also, the capacity to be autonomous conveys information about their decision-making state.

Choices of quality matter because when an agent has nil, artificially limited, or worthless options to decide from, effectually there is nothing to select from. Being able to choose about something is fundamental to autonomy. Most basically, a certain quantity should be available for 'choices' to even exist at a minimum. And those choices must exhibit characteristics relevant to

an agent's moral universe. This means that agents should not be limited to inconsequential or irrelevant choices. Thus, the choices available often interface information about the capability of the decision-maker. Preserving the right to apply one's own moral principles appeals to postures about rational choice.

The last element of autonomy is having the capacity to make choices. Capacity, at its most basic, refers to an agent's potential. But it is also used to refer to a present state of aptitude. Actualizing the capacity to be self-governing is in part defined by that agent developing themselves. Capacity need not be just about developing oneself, because it can also refer to a person's potential actualization of autonomy. When done constructively, an agent can become more valuable to themselves. What makes the concept of autonomy political, even though the focus is on the individual agent, is that freedom to *be* is the only means for ruling powers to enable all participants to be critical, self-improving persons. Only when introspection and self-government is allowed to flourish will an agent's capacity similarly be free to develop.

2 Autonomy in Medicine

In the medical field, acknowledging the autonomy of patients is one of the more recent additions to moral values for health workers delivering care. Health care professionals satisfy this moral principle by respecting patient autonomy. As mentioned in the previous section, acknowledgment of this principle will involve giving competent patients the information and opportunity (choices) to make their own decisions. No absolute regard for this ethical principle can be guaranteed, because there are other conflicting moral values in effect, such as beneficence, non-maleficence, and justice. But an adequate effort needs to be made to let patients direct their own lives, despite being in compromising, confusing, or technically foreign medical situations. In this section, I will describe how the valuing of autonomy came to be adopted by the medical complex. Autonomy was not a concept welcomed by practitioners however, a number of events and common practices

prompted criticism about immoral treatment of patients. I will suggest that while addressing the ethical treatment of individuals has been desirable, the medical establishment has placed too much emphasis on one version of autonomy which has undermined other important values and given rise to a different sort of problem for medical practices.

One obvious approach to satisfying autonomy involves some amount of transparency between the physician and patient. Truth-telling is a practice that care professionals have adopted contemporarily. Transparency was not a standard amongst physicians because they abided by principles of beneficence and non-maleficence alone. Gaining authorization too was not a common practice. As time and societal developments have progressed, the medical field has recognized different values due to the regular criticisms from patients, their kin, academics, and justice systems. According to Fabrizio Turoldo, autonomy gradually came to be valued in approximate lockstep with the increasing use of technology. Use of surgical anesthesia, for instance, "was initially used not only to avoid pain but also to combat patients' resistance to operations." Turoldo goes on to say that "physicians in the 1800s, as is well known, believed that opposition to an effective cure was a clear sign of incompetence and were, for the good of that patient, permitted to proceed against his or her will."[1]

One of the most publicized critiques of revoking individual patients' consent to procedures is that of the Nuremberg Trials of 1946. The International Criminal Court was in large part generated to prosecute prominent Nazi leaders for gross violations of human rights. Among the atrocious acts carried out by Nazis, the trials revealed innumerable horrific "medical" experiments carried out on persons without their expressed, informed permission. The international community reacted to these gross violations first by making it clear such morally deplorable actions would not be tolerated and would be punished. These actions on the

---

[1] Turoldo, Fabrizio. 2010. "Relational Autonomy and Multiculturalism." *Cambridge Quarterly of Healthcare Ethics* 19 (4): 542-549.

international stage loudly declared that all medical personnel and researchers should mandate voluntary, informed authorization from all human subjects, for any procedure or therapeutic. Systematization of respecting patient autonomy in medical settings has however been a slow process for some state actors.

State-specific, there are populations in America that have been skeptical about trusting the medical field due to gross past (and present) abuses of positional power, withheld information and misinformation. The dehumanization and notoriety of these treatments contributed to strong calls for informing patients and attaining authorization pertaining to procedures or therapeutics. For instance, governments and organizations have used sterilization as a control over woman's fertility, with the goal of restraining racially and economically profiled populations from growing. These programs began operating in the early 20th century and continued, mostly unabated until the 1970s. Halting the continuation of such unauthorized, manipulative and irreversible procedures only occurred once independent oversight groups advocated against and began monitoring sterilization practices.

Medical incidents such as these have revealed that not only did the medical field need a more robust account of acting benevolently and doing no harm, but we also needed other ethical principles to counterbalance the power dynamic between health care professionals and individual patients. Before 'respect for autonomy' was embraced, decision-making was largely up to the physician who not only took it upon themselves to make such decisions, but they were widely trusted as experts who not to be questioned. This was the case because care workers poorly understood the value of activities such as honesty or obtaining consent, and how lack of informed authorization directly affected the patient and their extended relations. Without respecting patient autonomy, decision-making by the physician alone is paternalistic. Bioethics—and correspondingly medicine—embraced a theory of autonomy because it appeared to be the ethical

manner of treating patients, as opposed to paternalistic modes. This different way of viewing patients advanced patient privileges in medical decision-making.

Paternalistic action in medicine is the practice of limiting a patient's freedom of action by the care provider. The term alludes to the benevolent oversight a father would (in the past) have over the child wherein control leaves little room for the child to act as they please. Care providers are perceived as having expert insight into knowing their patient's best interests and knowing how to keep them from harm has justified this abstraction. According to this perspective, physicians were justified in withholding information from patients and justified to decide about things for patients. Also, along these lines, manipulation and coercion has taken place. To be clear, arguments for and about so-called "paternalistic action" have not disappeared and are contemporarily apparent. A full explanation and treatment of paternalism will be scant in this project, but I should note that it is exigent to justify paternalism—soft or hard—when invoking liberty as a guiding principle. What drove critiques about the presiding paternalistic view was that patients were beings treated as though they lacked the adequate ability to deliberate about their options or consider consequences. Surely, people did not want to unnecessarily be harmed or die or be subjected to life-altering treatments. Altering the patient-physician relationship and dialogue about information so that physicians would systematically respect the will of the patient developed as a priority. Despite there being pressure from bioethics to require physicians to recognize individuals' right of self-government, persistent and popular moral justifications for paternalism exist. And even though justifications for moral paternalistic action continue to surface, clinical practices have systematically shifted to correct for the serious ethical problems caused by constrained or coercive interventions on behalf of patients.

Usurping decision-making power from patients in most usual situations typically is inconsistent with how care professionals treat patients in modern times. Institutions, such as clinics or hospitals, are impelled to accommodate the interests of those it serves, which includes

structuring care to respect an individual's will. Patients are not unfeeling things that simply need to be fixed. Nor are they *merely* the receivers of care or therapeutics for their own benefit. Rather, a person's right to decide about their health care without coercion or manipulation by others is to be respected. *Who* defines *which* and *what* benefits matter has been amended to include the patient's input. An individual is entitled to utilize their own knowledge and agency to act, even in the case they harm themselves. Guided by ethical considerations, medicine has worked to incorporate principles codifying autonomous patient action such as informed consent, transparency, and confidentiality.

There has however been an overcorrection, despite the respectable progression made in the way of regarding patients dignifiedly. A significant amount of responsibility for risks, uncertainty, and understanding bears on individual persons, assuming their reasoning capacity. Shifting away from being simply patrons of managed care *to* being receivers of care with respect for one's decision-making capacities has been remarkably laudable. The heightened awareness of patient autonomy, nevertheless, has rested on a certain conception of autonomy that I will show to be problematic. The problem lies in the foundational conception of a patient chimera which is separable from their community, past, emotional pressures, ingrained habits, cultural interests, etc. In trying to avoid coercive or forced clinical actions, a defense of decision-making has been afforded to patients as solitary, isolatable figures. Protection of patient self-governance rests on a theory which fails to adequately capture how persons make decisions sufficiently, especially for the medical field. These issues will need to be addressed but, prescriptions will not include returning to the paternalistic medical decision-making of the past. Instead, at least correcting the identifiable issues when respecting autonomy is how I think clinic practice should deal with this overcorrection.

3 Individualistic Conception of Autonomy

One conception of autonomy typically defines the biomedical principle of *respecting patient autonomy*. Recall that the broad concept of autonomy originated as a political reference to a state having self-governance. Evolution of syntax and common use has shown the variance of the term's uses. Today, references to autonomy also apply to individual persons. A person acting on their own will, according to reasoning, is the cornerstone of self-government. Because of this perspective, much of the medical ethic literature about autonomy focuses on the patient as a freestanding individual. A subsection of the literature has put forth another version of autonomy, called relational autonomy, that contends with premises the majority position holds. To qualify the overcorrection, it is necessary to grasp how the application of autonomy in medicine is theorized about and how it is applied to patients.

The version of autonomy that I have so far described is what I will call *individualistic autonomy* or *atomistic autonomy*. This version is specific to individualist philosophy. In the following subsections, I will explain more particulars about what individualistic autonomy is, how the concept is influenced by its historical foundation, and how it is understood contemporarily. Specifically, I will introduce the conditions used by care providers when assessing how autonomous a patient is.

3.1 Historical Roots of (Individualistic) Autonomy

Individualism is closely associated with natural rights, freedom of action, and freedom from external influence. Associated liberal doctrines were the product of various philosophers of the eighteenth century who sought to replace governance of God with being governed by one's reason alone. The sovereignty of the individual and their reasoning abilities replaced the sovereignty of God. This philosophical movement, impelled by social-political unrest, the rise of

capitalism, and outright disparagement of religious authority, advanced the individual's claim to moral recognition.

3.1.1 Influential Philosophy

Many events, prevailing ideas, and people influenced the rise of Enlightenment ideas, starting in the 17th century, spanning the 18th century. Overwhelmingly, the self that Enlightenment philosophers such as Immanuel Kant and Jean-Jacques Rousseau focused on was individualistically conceived. The individual is viewed as an atomistic social element of society. According to many intellectuals contributing to and succeeding the Enlightenment period, it was the duty of the individual to use their own rational faculties, to claim their right to be free from tyrannical oppression and manipulation, and to demand their rights be minimally infringed upon by governing bodies. Tapping into one's rational capabilities meant judgement about arbitrary authority could occur, as could the development of one's own moral principles. Thus, taking moral responsibility for one's well-being became a relevant burden intellectuals championed. Government institutions were reimagined as serving the interests of its individuals as well as being the protector of their natural rights. Conforming to religious doctrine, state dictum, or sociocultural traditions were viewed as constraints holding individuals back from realizing an auspicious, adaptive human will.

Kant even went so far as to assert that the lack of self-enlightenment was because of persons being lazy, uncourageous, submissive, which subjected them to unscrupulous control by others.[2] Being the sole influence of one's intention or will was considered a duty in this line of thought. Again, seizing authority over one's mind was the only course of action to liberate the self from ill social confines. Enlightenment philosophical ideals were predicated on utilizing one's rational endowments, developing deliberate motivations, and generating coherent actions.

---

[2] Kant, Immanuel, 1724-1804. *Foundations of the Metaphysics of Morals: And what is Enlightenment?*. Vol. 113. New York: Liberal Arts Press, 1959.

As is very clear in Kant's writing, utilization of one's rationality was to originate from an individual or an individualistic standpoint exclusively.

3.2 (Individualistic) Autonomy in Modern Medicine

Recalling the rough annals of philosophers' popularized appeal to individualistic autonomy is essential for understanding why the individualistic paradigm has evolved in medicine, especially in the United States. After all, it was that state actor who has embodied Enlightenment principles on a foundational, systematic scale that few countries have replicated. Governmental policy and legal documents have enshrined the concept of self-governance. The concept has correspondingly been popular in cultural observance. For instance, the conception about a good American life implies security and privacy; rights, respect, and fairness; honest work, peace of mind, and a fair shake. Gaylin and Jennings add that "what links these diverse hopes and values is an underlying notation of personal liberty, self-expression, self-reliance, and noninterference… Through thirty years of jurisprudence and legislation that has weakened state authority and strengthened individual rights, privacy, and entitlements, autonomy has bored deeply into the laws of the land."[3] A strong cultural impulse to be free of authority, free to reason unimpeded continues today in the United States of America.

So when deeply troublesome, medical-related events occurred—as I covered in §2—implementation of respecting individuals' autonomy made sense. Then the default version of treating patients involved the respecting of individuals' will—so long as they had or could communicate that will. In enacting the espoused principle of autonomy, fulfillment of another standard came into view. Competence—the *ability* to do something according to the will—became a central benchmark for judging the rational, cognitive independence a patient exhibited.

---

[3] Gaylin, Willard and Bruce Jennings 2003. *The Perversion of Autonomy: Coercion and Constraints in a Liberal Society*. Washington, D.C: Georgetown University Press. 47.

In medical ethics, these two concepts bear on one another, and will repeatedly surface. This section will produce the grounds for which atomistic autonomy in medicine is contemporarily argued from.

3.2.1 Psychological Separateness Grounds Medical Autonomy

An imperative feature to the grounding of individualistic autonomy has to do with the ability to be rational. I will not define what 'rationality' is here, but what theorists agree about is that rationality has to do with performing cognitive skills. Rationality is typically associated with neuron activity of the frontal lobe, of the brain. Persons' ability to be 'rational' proceeds from a set of ideas. I have pointed out that individualism claims people should be free to think for themselves, to have their own moral principles, to speak for themselves (e.g., democracy and free speech), and to be free of arbitrary authority so they can be free to be free. Without the psychological component underlying individualism, it would be unlikely that any of the previously stated acts would be possible. Even though the psychological component is nonmaterial, it is the seat of humans' moral experience and concept formation from which "adequate and perspicacious" objective answers about existence can be arrived at.[4] Impartiality and universality about esse is correspondingly possible. Cognition then is very important to individualism's claims. The relevance of cognition will surface repeatedly as I cover the conditions for satisfying autonomy in medicine.

An obvious, but understated connection here is that the separateness of an individual self from other selves or institutions has to do with the separateness of where psychological processing takes place. The brain—and related neurological elements—processes individuals' internal world as well as the external one they engage with. The separateness makes it possible

[4] Putnam argues that the difference between fact and value statements is not absolute. One element of his argument is that just because ethic and concept statements lack material existence does not render them subjective. He also says that pluralism also does not undermine how truth can be realized by 'standards of rational acceptability' as well as grasping perceptual knowledge. See Putnam, Hilary. 1981. *Reason, Truth, and History*. New York; Cambridge University Press. 127-49.

for them to have their own psychological functions. Because of the separateness and basic physiology, individuals can harness control over their cognitive functions. So then, the idea of self-government can be contextualized as an intentional intra-human activity. Thus, mature agents are autonomous when they are intentional. John Christman articulates that the cognitive functions which matter for autonomy include "competence in reflection and decision making and (on some views) authenticity of the values, desires, and so on that constitute the person and motivate choice".[5] This base definition which bridges the psychological aspect of autonomy to the concept of autonomy has been termed the 'proceduralist view.'[6]

Proceduralism matters to autonomy in medicine because it explains why certain conditions matter. For Beauchamp and Childress, there are three distinct conditions that need to be met for a singular action to be autonomous (in the medical field); for others the third condition can be bisected based upon the subject of focus. I have focused on their conditions because they are an adequate semblance of differing approaches used in judging a person's decision-making. They say that "normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences [by external sources or internal conflict] that determine their action"[7] suffice for being seen as competent persons. Elsewhere in the literature and for methodologies, other conditions hold, but I will interweave these amongst the identification and critique of Beauchamp and Childress's conditions.

---

[5] Christman, John. 2004. "Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves." *Philosophical Studies* 117 (1): 143-164.

[6] The term 'proceduralism' or 'proceduralist' is not my term. Various theorists use it and other corresponding terms, such as internist. Specifically, John Christman uses this term in the manner I seek to employ it. We can use the term in either the individualist sense, and later I will use it for the relational view.

[7] Beauchamp, Tom L. and James F. Childress. 2019. *Principles of Biomedical Ethics*. New York: Oxford University Press. 102.

3.2.2 Intentionality

Judging how actions result from a plan is a mainstay of theories about individualistic autonomy. Granting that an agent has choices and can act, the intentionality of their action involves having a representation of a motive or outcome internally, then doing an action(s) to (try) realizing that intent. Intentionality only makes sense when the outcome of an action is traceable to an agent's purpose. Several standard views of understanding and evaluating the relationship between motive and action obtain. These views will roughly introduce the elements of coherence, appreciation for one's own reasons, and cerebral conditions as being important to judging whether an individual's intention accords with their will, and if it does not, why that is. Discerning intention will show whether or not someone is, in part, autonomous.

One thing discrete about intentionality, compared to the other conditions, is that the condition is to be satisfied or not. What complicates the definitiveness of the condition for autonomy is that several ways of testing the authenticity of intention populate the literature. Such differing ways of judging intention say less about the discordance between theorists and more about what is valued in the way of judging. The underlying conceptual connection of these views—of coherence, appreciation of reasons, and cerebral conditions—is that either value is given to the unity of an agent's psychological state and/or value of an agent's unity of self is characterized by time periods.

The most common way for assessing intentionality has to do with coherence. Coherence is very much a cognitive, and correspondingly a behavioral, value which lends to sureness of consistency, reliability, and somewhat aimed-at order. Reference to coherence means there is little to no divergence between an agent's motivation for action with their idea for what action should be taken. A person's actions then are understood as necessarily aligning with the attitudes they hold, where attitudes apply to the action. Beauchamp and Childress also say "foreseen but

undesired outcomes can be part of a coherent plan of intentional action."[8] Of course, a person can be mistaken about what plan they can take for the intended act, aligning with their motivation.

So, it could be additionally said that we should include an element of reasoning when judging what action or actions are most worth effectuating. Evaluating one's own intent-action relationship when faced with self-held reasons will involve paying attention to those reasons as well as appreciating the significance and nature of the decision at hand.[9] Both concepts involve weighing the costs and benefits of consequences related to action. Persons will need to have the mental ability to reason about their intentions, as well as genuinely appreciate that what a physician is saying to them *matters* to them. While consequences may be a relevant feature of evaluating intentions, autonomy does not bear on taking *responsibility* for consequences of actions, because many outcomes (after other medical value requirements are meet) in medicine are incidental because of medical risks or are the fault of care professionals.

The categorizations of the listed positions are admittedly incomplete and highly abbreviated. Ultimately, proponents of atomistic autonomy state that the intentionality of an act is not subject to degrees, like understanding and voluntariness are.

3.2.3 Understanding

Principle to *how* decisions are made, an agent should have an understanding about their circumstances, the prognosis, their available choices, prospective outcomes concerning those choices as well as their physician's recommendation. When persons do not adequately understand various elements about their clinical situation, their decision-making ability should be questioned. Then, depending on the circumstances as well as the tools being used to determine decision-making status, a patient may have access to various elements of decision-making revoked. For a

[8] This statement is an admission that the doctrine of double effect carries some moral weight for Beauchamp and Childress. See Ibid. 102.
[9] Grisso, Thomas and Paul S. Appelbaum. 1998. *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. New York: Oxford University Press.

patient to fully give their agreement to a procedure or therapeutic, understanding first needs to be met. Thus, this condition is basic and necessary to moving from a deliberation *to* authorizing an elected course of action. Settling on a clear definition of understanding is highly debated. But by increasing the quality of understanding patients have about material information concerning their medical situation, *respect for autonomy* is a plain goal. Most basically, understanding has been defined by Buchanan and Brock as being the most *basic* element of competence and relatedly autonomy.[10] I will cover the concept of competence and how it relates to autonomy. Also, the capacities to be competent will be explained, as will the tests that evaluate such capacities. The nature of understanding too is important, but I will set that aside for a later section.

Autonomy and competence are not obviously thought to be analogous. Autonomy, as has been iterated, is defined as self-government. Competence on the other hand is *about* doing something. To do that 'something' with relative success will require standards as well as the functional capacities for related action. Functional capacities are those that led to rational thought, abstract conceptualization, perceptual awareness. Specifically, the standards for both autonomy and competence bear on cognitive skills. Here again, proceduralism is represented.

For one, the base assumption of all patients is that they are in fact self-governing agents. It is the obligation of the health care professional(s) to let people make their own decisions. To intuitively include the bulk of people as able choosers, such an assumption must take place. If on the other hand, people had to prove their competence in medical settings, settling persons' decision-making capacity would not only be time consuming but it would also affront *respect for autonomy*. Autonomy is venerated by not coercively inferring that individuals who are incapable of being rational decision-makers. These people are considered 'normal choosers', who of which grasp the central facts about the nature and consequences of their action. Patients are not expected

[10] Buchanan, Allen E., 1990 and Dan W. Brock. *Deciding for Others: The Ethics of Surrogate Decision Making*. Cambridge: Cambridge University Press. 23.

to know all the details about their medical situation, but they should know *enough* to make an informed decision.

The activity of knowing and understanding 'enough' to decide has and continues to be complex. To mitigate the economic, legal, and social hazards of misunderstandings or a patient's insufficient understanding, determinations about competence has been systematized. Established standards range from timesaving methods to extensive empirical tests. Whether or not tests are in place, there is a divergence of opinion about whether an all-or-nothing approach obtains, or a weighted continuum of understanding should hold.

First, some have argued that there are verifiable thresholds that can be established, deeming a patient all-or-nothing in understanding something. Otherwise said, either a patient has the capacity to make a medical decision, largely because of their understanding, or they do not. To draw this capacity line, reference is made to clear and identifiable thresholds. Several versions of tests which establish empirical thresholds are used clinically. The thresholds do not test the global competence of a person, rather the person's competence about the medical issue at hand is being tested. It is most typical that these evaluations seek to identify for *incompetence* or *incapacity*.

There are at least 9 formal evaluative instruments that assess incapacity. The three most easily performed evaluations that have functional test characteristics include: The Aid to Capacity Evaluation (ACE), the Hopkins Competency Assessment Test, and the Understanding Treatment Disclosure.[11] What makes these evaluations suited for being all-or-nothing tests is their reliance on empirical criteria for whatever capacity is basing the competence judgment. Although verifiability of the thresholds is subject to value criteria and judgments, these tests provide health care professionals with a structure for determining a patient's understanding.

---

[11] Sessums, Laura L., Hanna Zembrzuska, and Jeffrey L. Jackson. 2011. "Does this Patient have Medical Decision-Making Capacity?" *JAMA : The Journal of the American Medical Association* 306, no. 4: 420-427.

And there is a shorthand way of recognizing incompetence that is commonly used. It is much simpler and is less focused on reaching an empirically significant degree of certainty. Under the umbrella of assessing a patient's level of consciousness upon first contact (usually in the emergency room), there are heuristic tests used to assess what level they are at. The closest level to autonomy is called 'alert and oriented X4'. The test involves four simple open-ended questions, such as 'who are you?' or 'what just happened to you?'. The goal is to determine the relative consciousness and capacity of a person being able to answer questions about reality. Of course, this shorthand test does not reveal a patient's understanding in a complete manner. Usage of this less demanding competence test helps a care provider know quickly whether a patient could even have the capacity for autonomous decision-making or not.

What has not been explicit yet, is that healthcare professionals apply threshold tests depending on the situation. In the emergency room for instance—among the many questions that need to be answered about a patient in a short time—assessing a patient's level of consciousness and basic cognitive function (related to bodily sensitivity) tells care workers the capability baseline. Beyond being tested for basic cognitive capabilities, tests are not typically performed for most patient interactions. There are distinct situations, many are familiar with, where medical personnel evaluate decisional capacities for a particular purpose. For instance, being cleared for euthanasia requires a set of satisfied conditions, including evaluations about a patient's authorization for ending their suffering ahead of a natural passing.

So then, even though these various tests could theoretically be useful for patients globally, there is an intuitively accepted standard of adjusting application of tests to the particular situation. A similar line of argument has been offered when deciding *how much* understanding a patient needs for procedures or therapeutics of differing risk to their own welfare. Subsequently, there is a difference between having a global set of standards about capabilities and having

differing standards for differing interventions considering of the patient's welfare.[12] This is effectively a sliding-scale strategy which would have to add a situation's level of severity and the deliberation of consequences to judgments about competence. Otherwise said, if the risk to welfare is significant, then the thresholds of capacities will be higher compared to a situation in which risk to welfare is low. In the minimal risk scenario, the standard of understanding would be lowered. This approach speaks to the relativity of making a particular decision in particular circumstances. The strength of this approach, in utilizing the tests I touched on earlier, is that people are truly assessed on an individual level about the numerous medical decisions they may need to make. The strength is also the weakness of this approach. The sliding-scale strategy is confusing because it adds potential consequences into the equation about a patient's decision-making competence. When potentiality is considered, riskiness could vary widely depending on how the prediction is being made.

Typically, the formal incompetence tests mentioned earlier are only utilized when care professionals doubt a patient's competence including or when the stakes of deciding about a particular treatment are considered to be highly significant. More likely, thresholds are referenced when someone is perceived to be highly inattentive, inconsistent about values and concern for their own interests, lacking consciousness, or especially chaotic. Otherwise, most physicians rely on their own intuition in confluence with shortcuts to judge competence.

When the thresholds or a physician's intuition identify that a patient fails to meet competence standards, then a proxy decision-maker (or decision-makers) must be appointed. Proxies too are subject to satisfying the thresholds for being an autonomous chooser. Additionally, however, the proxy must also demonstrate that they can make decisions according to the best interests of the incompetent patient.

---

[12] Ibid. 116-18.

3.2.4 Voluntariness

The last condition necessary for a patients to be considered autonomous involves their being able to act on their own free will, which implicitly requires them to be free of controlling conditions. In being able to make meaningful decisions for oneself, authorizing medical actions can be satisfied in full. Individualism principally defines voluntariness because it prescribes that patients are *able* to exercise absolute authority over their decisions. This condition is particularly interesting because of its moral judgments. An important element to guaranteeing voluntariness for patient decisions involves active protections.

Two elements dominate how voluntariness is understood. For one, voluntariness, like the condition of understanding, falls on a graduation. However, the thresholds defining the scale of voluntariness is less developed in the literature compared to competence, so threshold talk will not be present. Second, autonomy is compromised when either a patient is else coerced, persuaded or manipulated by another person(s), or when the patient is themselves compromised by disordered or debilitating psychological phenomena.

Beginning with the compromising behaviors of *others*, the "controlling conditions" will be discussed followed by additional notable considerations. For external inputs to be understood as influencing atomistic autonomy, generalized theory says that any influence may count. However, in medical ethical literature, discourse about external controls focuses on how *some* influences are harmful to autonomy and how other influences are elsewhere on a continuum of ethical justifiability or general effect on those persons. Most treatments about voluntariness clarify what kind of external influences are unwanted or objectionable threats to a patient deciding about something according to their will.

Three categories are identifiable in terms of external influences which *threaten* individualistic autonomy are: coercion, persuasion, and manipulation. A variety of definitions for

these terms abound, but I am going to deploy Childress and Beauchamp's definitions of the terms:

> Coercion occurs only if an intended and credible threat displaces a person's self-directed course of action, thereby rendering even intentional and well-informed behavior nonautonomous... In *persuasion* a person comes to believe something through the merit of reasons another person advances. Appeal to reason is distinguishable from influence by appeal to emotion… The essence of manipulation is swaying people to do what the manipulator wants by means other than coercion or persuasion... For example, lying, withholding information, and exaggeration with the intent to lead persons to believe what is false all comprise autonomous choice. The manner in which a health care professional presents information—by tone of voice, by forceful gesture, and by framing information positively… rather than negatively…—can also manipulate a patient's perception and response.[13]

These categories of influence are considered to be threatening to autonomy because they are not resistible or ably warded off. While I think Beauchamp and Childress have done well at defining these terms, in the next couple paragraphs, I will go into a bit more detail about how these concepts, since a deeper understanding of these concepts will be important for my later arguments. Specifically, the external influences are distinctly of moral relevance because of the distinctions being made between goodness and badness.

The threat of force is most clearly a category to protect patients from injury. Validity of this influence hinges on the realness of the threat itself. However, not everyone agrees on whether the threat of force is an accurate definition of coercion, in that coercion does not seem to change how people alter purposeful and meaningful behavior. Instead, the *potential* threat itself is what influences how the future is imagined. Fear of an anticipated future need not be based in reality for that fear to feel real. Regardless, for Beauchamp and Childress, coercion is *only real* when the nature of the other person's behavior genuinely threatens patient autonomy. This distinction makes clear a situation wherein a consenting person voluntarily gives up their self-rule to be under the dominance of a designated other. There is no threat to this "traditional" relationship if,

[13] Ibid. 137.

upon reflection free of oppression, that person accepts that oppressive position. An example of this situation would be the submissive or subservient housewife.

The other two manners patient understanding, intent, and choice can be contaminated are through manipulation and persuasion. Determining how these conditions manifest is tricky. Innumerable factors may contribute to why these pressures are engaged in—knowingly or not. So instead of trying to untangle possible situations that are "contaminating", it is more useful to go in the way of identifying how the wide graduation of autonomy-undermining actions are rationalized. Individualistic autonomy tells us that moral knowledge about wrongness and rightness should be self-constructed, as this is one (of two) method(s) for realizing independence—the other being acting according to the will. Manipulation and persuasion are moral threats because they are insincere expressions of rationale, opinion, facts, or play with emotions. Even the most menial received things such as tone, implicit messages, or unwarranted stoking of fear can steer a patient's understanding or motivations in an uncharacteristic direction. Thorough and critical self-reflection are necessary to avoid misrepresentations of knowledge or corrupted interpersonal events.

Another manner of constraining an individual's self-rule has to do with internal phenomena. Earlier, I introduced the grounding of agent reasoning and individualism as being psychological. It is possible for a person to in fact act in opposition to their well-being or against their autonomy-related interests because of self-generated hazards. In other words, internal constraints can cause a departure of how a person would "normally" make a particular decision in a neutral condition. Most always, the person is doing something untoward *to* themselves. Otherwise put, agents may indeed act according to their will, in line with their motivations, but actually have limited or lack control of said action because of their altered state. Familiar phenomenal occurrences of internal sabotage or constrain include addiction, certain mental defects, intense fears, acute pain or persistent discomfort. This can be explained by the references

made earlier about coherence and relation to one's beliefs. Once the external facts are set aside, such as how someone came to be and how they situate their beliefs and attitudes about reality, then observing a patent's ability to conform to her own judgment will be clearer.

Persons taking responsibility for avoiding moral errors is important for individualistic autonomy. The error here is that their own internal phenomena results in sinister or obscuring behavior. Moreover, because developed individuals are responsible *to* themselves for their own morality, their addressing of moral issues in altered or uncharacteristic ways is not tolerated by individualistic autonomy.

4 Burgeoning Problems with Bioethical Autonomy

In the previous sections, I have canvased the shift from medical decisions being made solely by physicians to an ethical framework respecting patients' authority in the clinic. The approach elementally treats patients as self-constituting agents that should be protected from the coercion, persuasion, and manipulation perpetuated by others. There is also a moral responsibility for medical personnel to make sure the elements of understanding are satisfied so that patients can appreciate, comprehend, and reason through their medical decision. I will make clear in this section how essential elements of individualism will ultimately undermine respecting patient autonomy.

To begin, individualistic autonomy rests on various assumptions. With my limited space, I will only deal with the most important assumptions.

Looking to the historical idea of individualism, individuals are prompted to use their rational capabilities in acting based upon their own will. On first glance, this does not appear to be an extreme position, however the presumption is that competent persons can do such an activity on their own, at all times, and that it is the best method for avoiding manipulation or tyranny. The capacities which make up competency itself are an imperative feature here.

"Patients or prospective subjects are competent to make a decision if they have the capacity to understand the material information, to make a judgment about this information in light of their values, to intend a certain outcome, and to communicate freely their wishes to caregivers or investigators."[14] Beauchamp and Childress go on to say that "standards of competence feature mental skills or capacities closely connected to the attributes of autonomous persons, such as cognitive skills and independent judgment."[15] And while I agree with their assertion, I will reveal that the standards have unsettling consequences for the individualist, on their own empirical terms.

The consequences will undoubtedly be related to the historical roots from which medical individualist autonomy was borne. Considering that the shift from agency of the state or religious authority *to* agency of the individual allows us to see whose claims are to be centrally respected. Protections according to individualism manifest as heeding claims about various rights and privacy. Moral and civil discourse about these claims is supported by continual reverence of liberty, choice, autonomy, personal rights, and voluntarism.[16] Paradoxically, the very foundation of order these freedoms require also require institutional power and social order. Otherwise stated, to demonstrate the moral valuing of individual autonomy, coercive powers of certain kinds are accepted and even welcomed. The demands that come with upholding civic organizations have been argued against by the individualist because of their stifling conditions, but they are very effective at responding to conditions of need and vulnerability. This insight is not revolutionary, but what has occurred is that nurturing and safeguarding structures which enable individual autonomy have been deluged by attacks against their serviceability. Repetitive and escalating rhetoric has led to dismantling acts against civil institutions. Whether or not such

[14] Ibid.
[15] Ibid.
[16] Ibid. 7.

assertions are true, there are consequences for seeing social associations or institutions as nothing but sites of power that threaten one's autonomy.

On my view, protecting individuals *from* the very structure that bore their autonomy and continues to mature their autonomy has impeded further progress for improving decision making for patients. Willard Gaylin and Bruce Jennings' corresponding critique is helpful for my purposes. While we disagree about how to resolve defects of the atomistic framework for autonomy, what they say on the matter of 'whose agency matters?' advances my position. In their book *The Perversion of Autonomy* it is said that there are two reasons which identify how expansion of autonomy-focused rights is increasingly dangerous. For instance, those rights have included patient privacy rights. For one, by eroding the very political and enforcement structures protecting peoples' liberty, liberty itself would no longer be efficacious. They go on to say "equally dangerous, but more subtle and insidious, is the possibility that it [further expansion of autonomy-concerning rights] will come to undermine the very social and psychic infrastructure upon which social order, and hence the conditions for autonomy itself, rests."[17] Social structures refer to families primarily, as well as other "civic institutions." The psychic infrastructure they refer to includes "processes of childrearing, socialization, and moral development that create the motivational basis for responsible conduct in the social emotions of shame, guilt, pride, and conscience."[18] According to this critique then, the activities and influence of stabilizing social structures should not be arrogantly diminished because threats are possible. 'Whose agency matters?' will be the question I answer in a later section, but for now I will focus on continuing the critique.

The overcorrection then is that autonomy have been over-valued. Efforts to respect patient autonomy, as a medical value, has been paved with good intentions, but its perversion of

[17] Ibid. 6.
[18] Ibid. 6.

the historical account has negatively affected clinical interactions. The real problem at stake is the enduring pseudo-estrangement from rules, structures, and relationships that have built and supported the self.

Too much importance has been assigned to the individual who in fact requires the social order, influence, and sacrifice of other persons. But most importantly, individuals need to use trust to deal with modern complexities. Denial of the instrumentality of moral and social constraints defies the closest manifestation of someone detached from the world of morality, Bernard Williams' gangster.[19] One of the base aims of individualism is to construct one's morality after departing the guidance at their mother's knee. I will show that persons do not demonstrate adequate levels of cognitive abilities needed to satisfy the individualist's conditions for respecting individualistic autonomy according to its own conditions. Moreover, the awareness of these facts will reveal that modern medical moral responsibilities are far more burdensome and cumbersome than individualism can appropriately deal with. And thus, humans are less rational as individuals, than individualists would like to believe. Throughout the following subsections, I will show that several assumptions of individualistic autonomy turn out to be significant conditions which ultimately leave the opposed position incapable of being satisfied.

4.1 The Condition of Inclusivity

Before I flesh out problems with the conditions for atomistic autonomy, it is necessary that I make an additional condition visible. The other condition is that of inclusivity. The condition of inclusivity derives from an underlying but cardinal assumption for a satisfactory treatment of the

[19] Williams fleshes out various ethical perspectives in his book. One that is notable here, is the amoralist. This person is presumed to exhibit practically no sense of morality and associated moral responsibilities. The understanding is that this person will unavoidably have to abide by some moral attitudes and actions to realize self-regarding things. The mob gangster appeals well to the reader's imagination to qualify the kind of person who would be highly self-regarding but would need to treat some close others (family) in a way that they do not abandon him and his projects. See Williams, Bernard. 2012. *Morality: An Introduction to Ethics*. New York: Cambridge University Press.

theory of autonomy. The condition is directly related to proceduralism. That is, in the case persons have developed cognitive functions, they are in fact autonomous people, unless they prove otherwise. "Developed cognitive functions" refers to the kind of brain functions needed for thinking, reasoning and using language. The "mature" cognitive agent will demonstrate decreases in neurological development along with a shift to increases in frontal lobe activity. Of course, much infighting centers on *who* should be considered to be a part of this group, which amounts to giving protective rights of the individual depending on potential or present cognitive function.[20] Whatever the reference point ends up being, the assumption the condition is based on is that virtually all persons who have developed cognitive functions are in fact autonomous. I will not identify a quantity of what 'virtually all members' is, but I hypothesize that the theory of autonomy demands that inclusion should be at nearly one hundred percent of persons—of those qualifying members, of course.

The inclusivity condition will continually surface in elements of my critique, because *how many people will end up* being considered autonomous after empirical studies are carried out, will be concerning for the individualist's argument in medicine. The individualist assumes all persons can make their own decisions, even if those decisions are morally repugnant. This is because persons must have the authentic opportunity to determine their own morality, be free from coercive influences, and be able to do all the things individualism specifies. It is understood that even those who are semi-autonomous should too be given access to those things they can be autonomous about. Giving as many people the opportunity to be autonomous has been widely argued for because that freedom is surmised as yielding: truth, more freedom, and many other beneficial results. For these reasons, inclusivity is an important benchmark for identifying the

[20] The infighting is happening, unsurprisingly, between proponents of liberal or atomistic autonomy. A straightforward example of individualists disagreeing on *who* is merited self-governance is that of the abortion debate. Depending on how the developing *child in utero* is defined will ultimately produce differing burdens of proof and argumentative outcomes.

adequacy of conditions used to judge autonomy capabilities. If the majority, or even too large of a minority, of people cannot meet a particular benchmark, then that standard is not sufficiently inclusive enough. More specifically—but not too specifically—inclusivity is characterized appropriately when most ordinary adults are included or accounted for.[21]

For medicine especially, the inclusivity assumption might appear to be a worthwhile goal to fulfill, but it will be unattainable as it stands on the individualist's theory. The outstanding issue is that when autonomy is in in fact tested empirically, regularly too many people prove to be incompetent for the conditions to be considered inclusive. Empirical studies are of service not only because they are a manner of understanding reality, but the Enlightenment-based individualist will be keen to rely on the scientific method. For them, the scientific method is, but another means of discovering truth in what many deem as rational.

With the assistance of empirical studies, I will make clear that a surprising number of people will regularly fail to meet basic threshold requirements; of which disqualify or degrade their decision-making status. It will be apparent that if standards for autonomy cannot be met by 'most ordinary adults' something is faulty. So, either the empirical thresholds need to be lowered to accurately reflect distinguishable thresholds at the day-to-day clinical level. Or a revision of *what* thresholds are tested is in order. Regardless, an adequate theory of autonomy must address the inclusivity condition. The evidence I will put forth for my critique will be aimed at the conditions: understanding and voluntariness.

4.2 Achieving Understanding

Decisional capacity is far more cognitively weighted than the other two conditions for making judgments about autonomy. This means that judgments about someone's decision capabilities

[21] Arnold, Robert M. and Lachlan Forrow. 1990. *Deciding for Others: The Ethics of Surrogate Decision-Making*. Vol. 11 Taylor & Francis Group.

will mostly concern their cognitive abilities. In the earlier section about understanding, I only explained the definition of capacities as well as how such capacities could be tested. Four capabilities have been identified and are widely used for judging understanding. One of the four notable decision abilities simply concerns a patient's demonstration of communicating their choice about treatment options. Of course, this capability engages cognitive skills, but the others employ a more serious intrapersonal analysis. Predictably then, of the four abilities, the one most easily satisfied in the clinical setting is about communicating preferences. The other listed capability includes the patient appreciating their own situation, and how it relates to their underlying values along with the medical reality. Also, patients need to grasp pertinent information regarding treatment options as well as proposed diagnostic tests. An additional capability involves the patient giving reasons for making some decision.[22] What is relevant about these abilities is that they can be empirically measured, because of the centrality on cognition. When empirical data is taken, irrespective of physician's tendency towards a sliding-scale strategy, it is apparent that an appreciable amount of people lack understanding—on average this affect appears in 25% of those tested, depending on their disease or care setting.[23] Patients failing to meet the condition of understanding happens at an appreciable rate of 82% in intensive care units.[24] But since the condition of 'understanding' is regulated by the inclusivity clause, 25% of 'normal' people having their decision-making revoked due to incompetence seems unreasonable. I will parse out this issue here.

The first place we could look for answers in how competence is defined. Competence depends largely on cognition. Recall that cognition is those processes needed to perceive, learn,

---

[22] Appelbaum, Paul S. and Thomas Grisso. 1988. "Assessing Patients' Capacities to Consent to Treatment." *The New England Journal of Medicine* 319, no. 25: 1635-1638.
[23] Ibid.
[24] Bertrand, Pierre-Marie, Bruno Pereira, Mireille Adda, Jean-François Timsit, Michel Wolff, Gilles Hilbert, Didier Gruson, et al. 2019. "Disagreement between Clinicians and Score in Decision-Making Capacity of Critically Ill Patients." *Critical Care Medicine* 47, no. 3: 337-344.

and reason about their experiences. For the individualist, such a requirement of a patient is both expected and required. If the patient is incapable of processing the information they are given or should know (e.g., their values or outcomes for their situation), then the patient has no claim to making their own decisions. However, what is missing here is the stability and maturing of a person's reasoning, situation appreciation, and grasp of pertinent information. People are expected to potentially understand a range of information coupled with the experience of whatever halting realizations become of the clinical visit.

Another approach is available. We can analyze the standards of the capacities being judged. According to my earlier mention and the associated literature about levels of incompetence, concerns can be raised about what is happening. Either the standards for competence or incompetence are inappropriate in the tests being used. Or incompetence levels are accurate, but the assumption of inclusivity imposes something unattainable for a substantial number of individuals.

If standards are too high or specific, many persons will not satisfy the capacity test, which may be the case. Many tests have shown that many persons are poor forecasters about what a future course of action will feel like.[25, 26] Since an important element of deciding on a course of action has to do with imagining *how* we will feel once that course is taken, the tendency to misestimate our own emotional reactions as well as the speed of emotional recovery makes clear the poor appreciation and self-awareness persons have commonly. This sub-set of empirical work snapshots the fine data details that reveal extensive and high demands for autonomy thresholds. Upon doing a meta-analysis of the various competency tests, Laura L. Sessums, Hanna

---

[25] Smith, Dylan, George Loewenstein, Christopher Jepson, Aleksandra Jankovich, Harold Feldman, and Peter Ubel. 2008. "Mispredicting and Misremembering: Patients with Renal Failure Overestimate Improvements in Quality of Life After a Kidney Transplant." *Health Psychology* 27, no. 5: 653-658.
[26] Wilson, Timothy D. and Daniel T. Gilbert. 2005. "Affective Forecasting: Knowing what to Want." *Current Directions in Psychological Science : A Journal of the American Psychological Society* 14, no. 3: 131-134.

Zembrzuska, and Jeffrey L. Jackson have concluded that it is common to encounter incompetent patients.[27] Agreement about the commonness of incompetence with these more comprehensive tests—in likeness with the 'gold standard'[28]—similarly motions to an affront of inclusivity. But what separates these tests from what happens at the clinical level—that being most patients do not have their autonomy revoked—is that patients *have* to be assumedly autonomous. When matched against the empirical consistency of competency tests, physicians miss incompetence diagnosis in nearly 60% of patients.[29] But when physicians assess competence, their assessment does correctly identify those who do lack capacities. Of course there amount of patients identified between these judgers is different. Then I will tentatively assert that physicians do in fact intuitively align with systematized standards, but physicians are inconsistent at upholding those standards. Valuing *respect for autonomy* spurs such inconsistencies amongst physicians, I believe. Analysis has supported my supposition about physicians perception of patient capabilities compared with empirical cognitive tests. Physicians commonly overestimate the decisional capacity because they conflate consciousness with ability to decide.[30]

It now seems appropriate to take the position that standards identified by various competency assessments are valid. Such that, just because standards are ignored does not invalidate their evaluative outcomes. For physicians observing patients who do not meet empirical standards for competence, but are overlooked clinically, it is likely that that patient occupies some gray zone of competency. Because atomistic autonomy calls for an individualistic cognitive basis, unsurprisingly, measures of cognition dominate how physicians identify

---

[27] Ibid.
[28] The gold standard of deciding about an individual's capacity for understanding surrounding a medical decision, typically involves a forensic psychologist or a multidisciplinary competency panel.
[29] Ibid. 420-427.
[30] Ibid. 337-344.

competency.[31] This data inclines me to assert that physician's intuitively and deliberately try to respect a patient's autonomy, but this overestimation could a serious pattern of maleficence.

I think that if we are going to take the empirical data seriously, even if we believe standards are in some measure too specific or high, we need to explore how we can better satisfy inclusivity. Considering so many patients occupy a 'grey zone' of understanding and their diminished decision status goes unnoticed, what can be done? Instituting widespread use of competency tests is out of the question, if we are to continue *respecting patient autonomy*. Increasing understanding would appear to be the other option for resolving grey cases. 'More' understanding will most likely not take place in the clinical setting. The cognitive capacities needed to satisfy standards can be nurtured and repeatedly engaged in order to develop a cogent perception of the medical situation. If reasonable, time too is needed in order to digest information, appreciate the options and their outcomes, as well as develop reasons for a decision. I believe it is a mistake to think that just because patients are in a 'grey zone', that that signals they should have their autonomy taken away. By supporting cognitive processes, physicians can do better by their patients. An assortment of tools exists for this purpose. The most undervalued and underutilized of tools are additional cognitive sources—beyond the physician's own counsel. Physicians can send patients home with all the reading material they want or offer electronic tools, but understanding is produced by long term, thorough cultivation. Nurturing and cultivating understanding is an exercise that I do not think can or really should be done alone. In the next section, I will reinforce why I take the position of prescribing trusted others—especially those who are intimately or domestically fixed in that patient's life—as a distinct moral support for individual patient decision-making.

---

[31] Ibid.

4.3 Paradox of Voluntariness

The section on voluntariness introduced a definition as well as the two undermining sources to individuals' autonomy. Voluntariness means that a patient is able to act according to their intentions when they are not acting out of ignorance or compulsion. Compulsion is the focus of my discussion. It was also made apparent that state of voluntariness can be compromised by certain external or internal powers. I also mentioned the moral nature of this condition for individualistic autonomy. It is not a stretch to imagine how violated a person feels upon realizing they were sterilized forcibly or they were manipulated into choosing an expensive therapeutic because a physician said there were no further options—when in fact neither of these situations need occur. However, I believe the condition 'voluntariness' is not only too ambiguous to be helpful for clinical application, but clinical acceptance would likely result in not satisfying the 'inclusivity assumption.' To demonstrate this, I briefly canvas how opaque the field of coercive or oppressive forces are. I will also argue that individuals will have some responsibility for developing their morality, but to a lesser extent than the individualist advances. Instead, I will assert that moral testimony from trusted others throughout all stages of life can and should supplement the making of good moral agents. According to individualism, voluntariness will mean that someone's ability to choose will be unabated and that this is best achieved by only sourcing evidence or claims from experts or one's own experiences. However, the paradox about voluntariness is that decision-making is commonly supported and even improved by the involvement of external sources.

4.3.1 External Influences

I will begin by describing and expanding substantially on the earlier account of external influences patients will contend with while they confront medical issues. Now, I said I would not do this earlier. However, I am going to employ external (and internal) influences in a way the

individualist does not. Recall that the influences I mention here are not simply physical, but moral threats to constricting an individual in action according to their will. Considering the external, any legitimate threatening forces that are beyond interpersonal coercion, manipulation, or persuasion will deeply complicate identifying suppression to autonomy. This is why Beauchamp and Childress and others attempt to keep the conversation about influences focused on "real" threats, not perceived ones.

To be certain, I agree that the actual forcing of someone to do something they don't want to do, is morally wrong and should be protected against. Coercive forces are not however limited to individuals acting untoward other individuals. Incentives for instance are often viewed positively, but they can no doubt act as an insidious source of skewing perceptions about why persons should do something. Oppressive and persuasive forces can also be systematized, with individuals simply enforcing significant pressures on individuals, such as those in nursing homes, psychiatric facilities, prisons, etc. Furthermore, actual or potential medical costs intersecting with secondary implications because of other systems put patients under financial duress, which no doubt constrains or guides choices. This situation is especially poignant in countries lacking universal healthcare in which scores of people must choose between life-saving treatment, paying large monthly sums, or declaring bankruptcy. There appears to be a universal existence of the condition for which people are "*made vulnerable* by the environments in which they live and by how those environments are shaped by the decisions and actions of agents of various types, typically in ways that serve the interests of dominant groups."[32] Ultimately, examples of extrinsic pressures are diverse and have the potential to (covertly) dominate the vulnerability of an individual's understanding.

[32] Doan, Michael D. and Ami Harbin. 2020. "Public Health and Precarity." *International Journal of Feminist Approaches to Bioethics* 13 (2): 108-130.

Obviously, many of the threats I have touched on are civic or systematic. Here, we could say "change the system", which would be fair. However, I want to say that nurturing and contributing to the kinds of relations where moral commitments are reproducible will be the most tangible manner of dealing with such threats.

4.3.2 Internal Phenomena

The threats to autonomy by internal phenomena also are more extensive than have been espoused by the individualist. An examination of such a list has been taken on by Laura Weiss Roberts. Her categorization and development of impairments to internal capabilities includes illness-related considerations, developmental factors, and psychological issues, and cultural and religious values.[33] The definition of addiction or mental defects could also be more considerable too in how authentic motivations of an individual can be constrained. My legroom for describing the various factors is marginal, so I will say this: for some of these autonomy-reducing phenomena, it may in fact be appropriate to revoke autonomy and allow the physician or psychiatrist to act authoritatively. However, the withdrawal of autonomy does not correspond with the exercise of self-authority as patients move along the gradation. For instance, victims who are in power-related traumatic or psychologically disabling circumstances, may overturn their autonomy to the authority figure which has both morally and psychologically worrisome implications.[34]

The sprawling detriments to voluntariness are concerning. It is possible that Roberts goes beyond what are plausible internal threats to autonomy, for which I do not condone the view that anything and everything threatens an individual's autonomy. But her work makes clear the depth of possible genuine impediments to voluntary choice.

---

[33] Roberts, Laura Weiss. 2012. "Informed Consent and the Capacity for Voluntarism." *The American Journal of Psychiatry* 159, no. 5: 705-712.

[34] Such situations are not worrisome in certain circumstances, however. According to John Christman in "Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves", if someone is in an oppressive social situation, they are considered autonomous only if upon rational consideration of their circumstances, they would not reject those conditions.

4.3.3 Moral Matters

I do not think that all these threats mean people are incapable of choosing on their own. By roughly revealing the spread of threats to voluntariness, I am stressing that modern persons exist in a world full of moral threats. If I am able to present convincing evidence from my assertions, the argument will have demonstrated why the moral basis from voluntariness ought to include trust in testimony.

To me, it is very dubious that people are capable of developing and preserving their own moral principles, as the individualist requires. The individualist will acknowledge that moral lessons are learned at the parent's or guardian's knee. The moral beginner will need to be taught how to evaluate and *give reasons* concerning moral views. But as the course of cognitive and behavioral development proceeds, development of one's own ethical principles becomes their sole responsibility. For those no longer tender footed, borrowing of moral knowledge or reliance on other people's judgment is to be rejected. Additionally, an individual is responsible for avoiding moral mistakes and actions uncharacteristic of their morality. There may be some truth to these prescriptions, I think the individualist's view is both myopic and too narrow.

Karen Jones details in "Second-Hand Moral Knowledge" how developing one's own moral sensitivities that are locally and globally relevant is an ill-conceived endeavor.[35] For Jones and myself, developing morality in a global sense, will need counsel from others, whether or not they are moral experts. For the individualist, there are moral experts. This is because the individualist concedes that depending on moral experts to comprehend what arguments and positions about morality exist, the individual can be aware of the approaches to morality. Moral experts must then exist for this assertion to be viable for persons developing their comprehension of moral principles. The individualist knows that the process of self-education about morals can

[35] Jones, Karen. 1999. "Second-Hand Moral Knowledge." *The Journal of Philosophy* 96, no. 2: 55-78.

be time consuming, even for mature persons. To gain competency at the very least, significant study would need to be dedicated to such an examination. In the sense that giving reasons for moral beliefs is layered as Douglas Walton says that "there seems to be no clear method or due process for justifying a claim or resolving a difference of opinions on what is right or wrong."[36] To deal with incongruence of sorting out moral issues even in everyday practical debate, various levels of deliberation take place. Walton adds that definitions for conceptual starting points varies widely between schools of thought, which complicates rhetoric of argumentation. Furthermore, how facts and values are elaborately combined for ethical reasoning attests to the abundant number of virtues, combinations of virtues, and ways to expressing virtuous activity. If time is short, some proponents reluctantly agree that accepting another person's moral reasons for something still requires the agent to evaluate their reasons for belief. Despite the various ways moral argumentation is complicated enough for those who engage in it professionally (such as philosophers), the individualist holds that it is an agent's responsibility to develop their moral capacities through examination. But it seems to me that adequate enquiry and argumentation falls short of being convenient enough for mature agents.

Another notable way moral knowledge is generated on Jones's argument is through 'perceptual capacities'. Perception, as Philippa Foot has argued, tells (us) humans about goodness and badness as it relates to the conditions of human life.[37] Perceptive capabilities may be universal, but Foot's work demonstrates how the context and purpose of moral experiences will affect how those perceptual experiences are understood. Foot rightly points out that human goodness of morality and correspondingly living is at the base dependent on both chance and one's own qualities (cognitive and physical). I am drawing attention to 'chance' because moral experiences are subject to local fluctuations. Where a person lives their life will affect how they

[36] Walton, Douglas N. 2003. *Ethical Argumentation*. Lanham: Lexington Books. 71-118.
[37] Foot, Philippa. 2001. *Natural Goodness*. New York: Clarendon.

perceive ‘what makes a person flourish’, and this is a product of luck. Reliance on perceptual capacities raises concerns about the limited nature of such experiences. So then, if perceptual capacities are a relevant manner for constructing personal morality, the associated suppositions about locality will bring into question whether *any* person is capable of moral expertise.

I expect that the individualist will acknowledge existence of localized moral experiences. After all, agent’s self-guided moral acumen will be limited to their individual experiences since other’s testament should be rejected. They may arrange their global code to reflect the compilation of moral experiences with a sensible moral theory from their evaluations.

Is this assemblage of a personal morality adequate for construction, or even taking full moral responsibility of action? I do not believe so, because I have avoided a crucial element in moral knowledge up until this point. That point won’t necessarily disarm individualism, and for this I will be forced to accept some amount of the individualist’s position as legitimate and undeniable.

But I believe that these two critiques from Jones’s work do some heavy lifting in terms of cracking open the self-making position. The critique is important because I not only want to show how advocating voluntariness will be mistaken if the individualistic account defines it totally. What has been missing is the role of moral testimony amongst moral agents, who are adults. Accepting the evidence or witness about moral matters inevitably involves trust. Unearthing the domain of trust will retrospectively inform what influences are actually most threatening to autonomy. As for trust itself, most auspiciously (for nervous individualist apologists) “the standards for wise borrowing are stringent indeed and so offer no comfort to the morally indolent”[38] according to Jones. More importantly for my goals, apprehending the involvement of trust renders insight about *how* and *who* can be relied on for their testimony.

[38] Ibid. 67.

4.3.4 Trusting Testimony

Similar to the previous section, here I will further my criticisms of how an underlying assumption about voluntariness is mistaken, on the individualist's account. The amendment I will propose to conceptualize voluntariness will generate a better understanding of the concept itself, as well as suggesting what can be done to diminish decision making issues in medicine, *even when voluntariness is not in question*. The amendment I refer to is the incorporation of testifying about moral and non-moral knowledge from one mature agent to another.[39] We can further understand testifying in the context of a "testifier herself [vouching] for the truth of"[40] a moral principle. As mentioned in the last paragraph, the amendment will involve borrowing moral knowledge from others while keeping some of the individualistic account intact. To make the amendment, a brief account of trust will be introduced. Ultimately, trust in testimony is risky, but in dealing with the vulnerable states medical situations and disability, trust will prove to be a beneficial risk.

Earlier, I put forth several challenges to the individualist's assertion that agents can and are responsible for creating and evaluating their reasons for moral beliefs. The resources for this endeavor are limited to assessment of moral arguments and local moral experiences. Jones has outlined constraints to actually achieving the "ideal" self-crafted morality. Specifically, time constraints and a significant skew in perceptual capacities end up being self-limiting. Jones also draws attention to the blurriness between testifying and arguing, which is what I will expound on next.

Recall that testifying has to do with reasons being given for moral knowledge, which is related to the testifier themselves. Argument is similarly understood to be the reasons given in

---

[39] Similar to Karen Jones, I believe the line between moral and non-moral judgments is indistinguishable. For most of this section, I will use the argument for moral judgment, but I will also show that valuing of good and bad things does not necessarily have moral ties as we expect from moral principles.
[40] Ibid.

support of a position, but the credibility is based upon the justifications alone. These concepts are not the same, certainly. Yet, in certain contexts, presentation of an argument is indistinguishable from testimony. Jones has illustrated this blurriness between referencing the given reasons versus the person a couple ways. First, we can look to an expert witness (in a court setting) who presents reasons for a view that may be fact-based, but their professional role speaks to their capacity for 'knowing the facts' to those less familiar with the situation particulars. Another example used is that blurriness in the distinction of terms presents when marginalized persons put forth their viewpoint on civic functions—as is argued by standpoint theories. Marginalized civilians often have a much richer understanding about certain moral issues pertaining to their social position. That is to say, there is a diversity of roles or standpoints of a person—who is giving reasons for some conclusion—for which argumentation and testifying are not easily untangled. This rough muddying of the waters shows that character attributes *can* play an important role in giving reasons about adopting or rejecting a moral belief, whether we understand a moral witness to be giving testimony or arguments.

Trusting is a risky activity because it involves a special kind of vulnerability. For my focus, the vulnerability will involve risks but also benefits to body and relationship(s). Trust is a phenomenon that persons may not even be aware they are engaging in or what form it is. The form I will stay focused on here pertains to judgments in the matter of voluntariness.

Several risks present when persons engage in trusting activities. I have limited space to explain these risks[41], but here I think it better to point out what is lost by not taking such risks. Earlier, I argued that moral arguments and local experiences don't prepare persons sufficiently for the great variety of moral judgments to be encountered throughout all life stages. And for dealing with threats to health, the vulnerability to compromise autonomy increases. But compromises to

[41] As I imply here, I have limited room to discuss the risks to trust, but Annette Baier's book "Moral Prejudices" extensively fleshes out all the risks. See Baier, Annette. 1994. *Moral Prejudices: Essays on Ethics*. Cambridge, Mass: Harvard University Press.

autonomy also occur if we do not acknowledge the dependent nature of persons due to their medical conditions. It could be claimed that I am making a false equivalency here, and yet developing one's agency requires that persons recognize their shortcomings or position of vulnerability and lean on others to assist in making moral judgments. Alasdair MacIntyre supports my position about such an acknowledgment when he says:

> ...if we are to develop from our initial animal condition into that of independent rational agents, and the virtues that we need, if we are to confront and respond to vulnerability and disability both in ourselves and in others, belong to one and the same set of virtues, the distinctive virtues of dependent rational animals, whose dependence, rationality and animality have to be understood in relationship to each other.[42]

Vulnerability and disability of health will require the reliance on others for both moral and non-moral judgments. When persons go toward sustaining distrust of those they should be vulnerable with, self-isolation manifests in order to sufficiently reduce external threats. Isolation not only diminishes one's own richness of life, but also their access to testimony contracts.

Checking the credibility of testimony can be done a number of ways. Again, we don't always have time or resources to look at the facts and validity of someone's argument; there are other pronounced manners of checking on credibility. For one, the character of the testifier says something about that person, and thus says something about the trustworthiness of their testimony. Since an individual's character is defined by their moral and mental qualities, we can make predictions about how they may conduct themselves in positions where trust is needed. Also, any prospective acceptance of testimony "will require the confident expectation that the one trusted will be directly and favorably be moved by the thought that one who trusts is counting on them"[43] Knowing that *as the testifier* you are dealing with someone who is being supported by

---

[42] MacIntyre, Alasdair C. 1999. *Dependent Rational Animals: Why Human Beings Need the Virtues*. Vol. 20. Chicago, Ill: Open Court.
[43] Ibid.

your arguments (morally or non-morally), responsibility comes to be a shared burden. Being believed *again* is an element of trust, too. Much is to be said about this, but for Annette Baier "the truster, who always needs good judgment to know whom to trust and how much discretion to give, will also have some scope for discretion in judging what should count as failing to meet trust, either through incompetence, negligence, or ill will."[44] Checking up on those testifying is by no means faultless, and it is especially not an empirical endeavor like checking cognitive skills can be. But it is a sufficient tool for gaining moral or non-moral knowledge from those whom we can check up on.

4.4 Instability of Preferences

When we go beyond the discussions about cognitive skills, the other important skill patients must demonstrate is communicating their preferences. Preferences are to be the 'rational' result of three cognitive skills I touched on earlier. Here, I want to bring attention to the instability of preferences because such issues continue to reveal the ephemeral, insidious assumption of inclusivity for respecting patient autonomy. In particular, I will focus on end-of-life directives, which guide decision-making in the case the patient proves incompetent. Here, I will utilize advance directives to demonstrate problems with individualistic autonomy being applied to the medical field. The use of this example is not a signal that I promote their use, but when planning for someone's end-of-life, it will be clear that even the most advanced members do not wish to engage their individualistic autonomy. This will be indicated by the fact that older folk frequently change their preferences about end-of-life directives. Changing one's final life preferences does not appear to be problematic at first glance. Rather, it is surely acceptable for autonomous decision-makers to alter their preferences.

[44] Baier, Annette. 1994. *Moral Prejudices: Essays on Ethics*. Cambridge, Mass: Harvard University Press.

However, the pervasiveness of this phenomenon raises questions about whether these persons take their end-of-life situation seriously. Also, an authentic awareness of one's values—considering possible medical realities—would seemingly generate consistent directives. This is not the case. The likelihood that end-of-life preferences change across surveys given within a time period will range between 20%-40%, according to social science data.[45] Approximately 20% of those with unstable preferences are unaware that their preferences had changed at all.[46] This smaller group further shows that the reasoning about decisions does not always occur, since the reasons are not reproducible. Here again, I have presented data that is an affront to the assumption of inclusivity. The affront occurs, because is it not expected that over 25% of people will change their minds about how they ultimately want to be treated therapeutically if they cannot make their own decisions. If older adults' morality is in fact developed and they are as well studied about moral arguments as individualism prescribes, then making choices about future preferences should be straightforward, especially if they are informed about their options.

More hazardous to requirements for understanding, is that data about preference instability may be under-representing the persons who do not value or reason about how their final days ought to play out; over 10% of survey respondents answered all the questions about preferences as 'don't know'.[47] Values, options, reasons apparently don't matter for this group. The lack of preferences about end-of-life decisions is widely reflected in the greater population, as many older folk do not compose advance directives. As people progress into more serious health situations—from home health care to hospice care patients—the rates of directives

---

[45] Kim, Scott Y. H. 2014. "Improving Medical Decisions for Incapacitated Persons: Does Focusing on "Accurate Predictions" Lead to an Inaccurate Picture?" *The Journal of Medicine and Philosophy* 39, no. 2: 187-195.

[46] Gready, R. M., P. H. Ditto, J. H. Danks, K. M. Coppola, L. K. Lockhart, and W. D. Smucker. 2000. "Actual and Perceived Stability of Preferences for Life-Sustaining Treatment." *The Journal of Clinical Ethics* 11, no. 4: 334-346.

[47] Smucker, William D., Renate M. Houts, Joseph H. Danks, Peter H. Ditto, Angela Fagerlin, and Kristen M. Coppola. 2000. "Modal Preferences Predict Elderly Patients' Life-Sustaining Treatment Choices as Well as Patients' Chosen Surrogates do." *Medical Decision Making* 20, no. 3: 271-280.

increase. Various explanations are relevant for these figures, but absence of clear guidelines expressing one's wishes and preferences leads me to my last point.

A background narrative emerges when persons are asked why they completely lack preferences: why they are not 'set' on particular preferences, or why their directives are vague. One popular expression of self-government is giving trusted others the leeway to make decisions for them, trusting they will do so in the patient's best interests. This course of choosing prevails because a great deal of trust is in fact given to those who have earned that trust by merit or by mastery. In most cases, those who are 'trusted' include family member(s), and secondarily the attending physician may be selected as the surrogate. And it is often expected that the physician will neutrally collaborate with the patient's family to fulfill the incapacitated patient's best interests. 'Choosing' this option for expressing one's autonomy—even if it turns out to be the default expression—speaks to the value persons give to the collective goods and interests involved in these morally demanding circumstances. The disconnect of this situation is the frequency at which family members themselves express their contempt or discomfort for the decision-making burden because of their uncertainty about the patient's values, intentions, reasons, etc. I think this development is pivotal and will necessitate further evaluation. There are more detailed problems about advanced directives, but I will address those in a later subsection.

4.5 Shifting the Questions being Asked

So far, I have worked to show that there is an argument against what empirical measures tell us about peoples' autonomy in medicine. I have reason to believe that by valuing individualistic autonomy we have mistakenly had to accept conditions that are not achievable, in the way the inclusivity assumption prescribes. Should something else be part of showing respect for patient autonomy in order to better satisfy the condition of inclusivity?

The capacities which make up understanding and voluntariness specifically have proven to be difficult to satisfy. I have also shown that physicians may satisfy the inclusivity assumption, but their assessment of capacities is unstructured and lacks uniformity. But when instruments level reliable standards, the tests categorize too many people as incompetent. By revealing physician inconsistency and overestimation about competency, researchers rightly suggest wider use of such testing, which would offend the autonomy of individuals. What happens next? Do we continue to use the tests while tolerating their flaws? Do we endeavor to improve them by making competency tests more empirical or user friendly? Or ought we be honest and admit that a good portion of people will not meet competency standards? I think competency testing is helpful in the way of steadying the judgments made by physicians. There is more to the concept of understanding, however. It is apparent that other factors play a significant role in understanding besides the immediate cognitive skills a patient displays clinically.

Too, for the condition of voluntariness, individualism foundationally dismisses the validity and value of trusting others for moral and non-moral testimony. The elements that make up personal morality for individualistic autonomy only get us so far. Again, I think we are mistaken to ignore the role trust plays in confronting disability and animalistic vulnerabilities—that are conventional to medical situations.

To me, it is apparent that our dealings with medical issues are awry due to referencing individualistic autonomy. A limited set of options could obtain for attending to the outstanding decision-making mattes. For starters, respect for autonomy could be disestablished all together and paternalistic decision-making could be reinstated. As stated before, rolling back all the modern improvements individualism tackled would be unwise.

The contrasting position for individualism could be entertained—of which is relational. To be relational means that there are “various ways in which humans are socially embedded, intimately related to other people, groups, institutions, and histories, that they experience

themselves and their values as part of ongoing narratives and long traditions, and that they are motivated by interests and reasons that can only be fully defined with reference to other people and things."[48] The relational embeddedness can be understood as imprinting onto human cognitive function. If this 'constitutive' approach is accepted altogether, a new set of conditions for decision-making would need to be introduced. There is much to be desired in terms of developing such an account from proponents of the relational approach. I am not so ambitious to make a thorough argument or explanation for relational autonomy to replace the standard atomistic approach here. However, I will take to utilizing some conditions of individualistic autonomy that are worth preserving to forward my argument in re-conceptualizing how patients acting according to the will. The will, in my view, is a balance of the participants' agency along with their moral responsibilities, which arise from their intimate association(s).

5 Relational Autonomy

The conceptual response to the fraught version of individualistic autonomy has been antithetical. Instead of being governed by individualism, which is tied to impartiality and universalizability, as Hilde and James Lindemann Nelson point out, an ethic for valuing a different version of patient governance is needed.[49] For them and many others over the past several decades, an improved ethical account will consider the complex of necessary relationships which includes features such as collectivity, favoritism, particularity, non-consensuality, and a premodern sensibility. It is these encompassing features that constrain humans to be embedded socially, which directly affects the cognitive capabilities. Social embeddedness is a phenomenon of dependence, which is integral to human life. Although individuals "look" to be separate, they are inextricably and undividedly connected due to how they need one another, for a wide range of reasons biologically, socially,

[48] Ibid.
[49] Lindemann, Hilde and James Lindemann Nelson. 1995. *The Patient in the Family: An Ethics of Medicine and Families*. New York: Routledge. 55-82

psychologically, etc., but the main driver is that these relationships are mutually beneficial. The antithetical term I will be using is relational autonomy, which has to do with social embeddedness. This version of autonomy asserts that individual persons are not self-sufficient reasoners alone, rather that because of social-embeddedness—which will have a psychological element—persons are interdependent in reasoning and decision-making.

Just because psychological separateness is a physical reality does not mean that cognitive processes can actually be controlled by an individual who is engaging in intentional cognitive activity. It would be foolish to say that individual-controlled rational activity is not possible, because the physical separateness makes such activity viable. Instead, I will make an ambivalent claim in saying that we cannot fully realize an absolute level of control. Intentional cognitive activity will always rely on and incorporate the mutual dependencies and constitutive role played by humans' need for continuous socialization. Then, relational autonomy is government of the self as a complex, socially situated person, inseparable from their constitutive nature.

As for the conditions which define individualistic autonomy, they will not be scrapped. The conditions hold merit for judging the decision-making ability of a person or persons. But the conditions for individualistic autonomy are both paradoxically a minimalist conception of autonomy *and* a failure at satisfying the inclusivity condition. It is reasonable and worthwhile to require that persons are intentional, lack cognitive impairment, and are free from direct coercion when making medical decisions. It is also reasonable to think that these conditions will need to be restructured for the relational view, but I will not do that here. Nevertheless, I have exposed some significant weaknesses for individualistic autonomy being considered the standard approach to *respecting patient autonomy* in medicine. The empirical tests about understanding and the nuances of voluntariness have revealed that individuals do poorly at satisfying the surreptitious condition of inclusivity. Without dramatically altering the conditions for decision-making, I want

to instead alter the conception of autonomy with the aim of satisfying the inclusivity condition better than the individualist.

On my view, unintuitively I will show that what matters for helping more 'normal choosers' satisfy all the conditions adequately, will proscriptively include trusted shareholders.

This section will detail what grounds the relational approach[50] as well as the differing philosophies which use this version of autonomy, despite their divergent agendas. I will also cover *which* relation matters. To better satisfy the inclusivity assumption, the family will be the site best suited for addressing individual's shortcomings in decision-making. Introducing the family's interests will undoubtedly demand a different kind of physician-patient interaction. However, such weighing of shared benefits and burdens is already occurring behind closed doors. Even in the case a family does discuss health topics, discussion is poorly structured and often proves to be inadequate. To ultimately improve patient decision making, the common good of an individual in relation to their family's interests will require a robust treatment of the ideal outcomes as well as the notable obstacles.

5.1 Persons as Psychologically Embedded

Theories of relational autonomy recognize the integral-ness of "relationships of giving and receiving through which our individual and common goods can be achieved".[51] What this version of autonomy proposes is that the social and interdependent nature of persons is recognized for contributing to the fabric of the individual. Humans exist within a web of relationships and develop important features based on the influences of those relationships. Not only can personal relationships be an essential feature of an individual, so can traditions and institutions.[52]

---

[50] It should be noted that there are three aspects to the relational account. I focus on relational autonomy. But relational social justice and relational solidarity are affiliated areas of study.
[51] Ibid.
[52] Ibid. 143-164.

Individuals are inseparable from such relations, this is made clear when persons try to isolate themselves wherein, they experience severe risks to the very things supporting their atomistic autonomy.

Individualism is hollow for relational proponents, because it claims that persons are sovereign beings able to be free of reliance on external influences for thinking, and especially for reasoning. In *Re-visioning Public Health Ethics*, it is further said that "traditional bioethics treats persons as self-contained, self-interested, and self-directing creatures".[53] The individualistic position is untenable because we are not such creatures, especially when in vulnerable situations of illness and disability. The authors assert three salient features that contribute to persons' lives. Obstacles shape people, as do the opportunities they are conditioned by. Furthermore, "relational persons develop and deploy their values within the social worlds they inhabit".[54] According to this view, there are features and conditions which develop persons. This 'causal' approach captures how external factors affect an agent's autonomy, and how those factors reflect into the interpersonal environment.

Individuals are indivisible from their social worlds, even if a *proceduralist* viewpoint is accepted. Even though physiological processes occur at the individual level, I posit that interpersonal interaction is a constitutive element of a person's psychological states and processes, even if the individual keeps some cognitive control. Christman points out that the psychological claim the relational approach makes is "about a person's self-concept, value structure, emotional states, motivational set, or reflective capacities."[55] About the features that contribute greatly to one's self-concept, the social factors include gender, race, religion, class, and ethnicity. Others go further and claim networks shape an individual's perception, belief,

---

[53] Kenny, Nuala P., Susan B. Sherwin, and Françoise E. Baylis. 2010. "Re-Visioning Public Health Ethics: A Relational Perspective." *Canadian Journal of Public Health* 101 (1): 9-11.
[54] Ibid.
[55] Ibid.

emotions, values, habits of interactions, and connections of the social and natural world.[56] Thus, achieving individual choice will bear on social dynamics throughout all developmental stages of life.

Here, I have favored defining relational autonomy in terms of social dynamics constituting the psychological being of an individual, that is not so individual. To amplify the understanding of cognitive interdependence, I will give a brief survey of various philosophical approaches. These approaches will all incorporate relational autonomy in a pronounced degree, although they develop the notion in different ways.

5.2 Philosophical Theorizing of Interdependence

Feminists and communitarians have been the most visible proponents of the relational view of autonomy. The relational aspect of human nature is a foundational element for both philosophical views. Virtue ethicists do not so much propound the relational view, but they forward a notion of agency that concurs with relational autonomy when agency is put at risk due to vulnerable states involving the body-mind. To some degree, these theory positions agree that persons are not completely irreducible from the constitutive nature of social dynamics, despite their physical separateness as individuals. For them, it is self-evident that the social embeddedness of persons presents a plausible challenge to the prominent ethical theories rooted in individualism.

5.2.1 Feminism

By and large, feminists have contributed the most to the growing arguments for a relational view about autonomy. Feminist ethics has been characterized—by Thomas Mappes and David DeGrazia in their anthology on “Biomedical Ethics”—as being (1) “firmly committed to the view that the moral experience of women must be taken seriously but often with a critical eye to the

[56] Sherwin, Susan and Katie Stockdale. 2017. "Whither Bioethics Now?: The Promise of Relational Theory." *International Journal of Feminist Approaches to Bioethics* 10 (1): 7-29.

role that subordination of women may play in shaping that experience. (2) It [Feminism] is deeply committed to the overriding moral importance of ending oppression—with special emphasis on the subordination of women."[57] To capture the moral experience and oppression, Jennifer Nedelsky was one of the first to assert that the individualism-based version of political autonomy needed revision. The revision that was called for by Nedelsky involved generating a language of freedom and self-determination for feminists to achieve their objectives.[58] For many feminists, language is important because it has the power to repress or uncover what essential characteristics and conceptual frameworks influence identity. More broadly, feminist analysis has been dedicated to centrality of women's self-identity, which has to do with embracing relations. Relations are clearly important to women, but on Nedelsky's thinking—and many feminists who followed her—the irony is that such relations have been or are commonly oppressive. Systems that possess power are influential and thus have the potential to abuse such power. The power of influence most acutely results from uneven power dynamics, as well as pervasive social expectations associated with particular identities. Nedelsky adds that an agent's social relationships and position will influence their development of autonomy in that "if we ask ourselves what actually enables people to be autonomous, the answer is not isolation, but relationships…"[59] An enduring tension between collective and individual benefits is that there are burdens of action and responsibility which have asymmetrically burdened women.

Other feminist authors have taken another course of argument for dealing with the grievances women and dependents have with unequal or repressive powers. A notable approach argues that too much emphasis has been placed on certain virtues while undervaluing others. For

---

[57] Mappes, Thomas A. and DeGrazia. 2006. *Biomedical Ethics*. New York: McGraw-Hill. 30-33.
[58] Nedelsky, Jennifer. 1989. "Reconceiving Autonomy: Sources, Thoughts and Possibilities," *Yale Journal of Law and Feminism* 1: 7-36. Nedelsky, Jennifer. 1990. "Law, Boundaries, and the Bounded Self." *Representations* (Berkeley, Calif.) no. 30.
[59] Ibid. 7.

those who argue this, such as Diana Meyers, socially embedded persons will flourish when competency conditions pertaining to the atomistic account includes capacities for social interaction, caring, intimacy, etc.[60] Particular to medical systems, feminists critically evaluate the systemic oppression in matters of reproduction, surrogates, motherhood, the profession of nursing (which is dominated by women), and the discounting of 'caring'. Only when femininity and relations of dependence are no longer diminished, the relational approach will hold water. The significance of affective components continues to be understated, both society-wide and medically, despite their moral merits. This account emphasizes the dyadic, dependent relations between family members, particularly between mother and child, but it is extendable to other "caring" roles. On one end, moral merit comes from the admirable trait of caring (most often role of women) and other merit from the "appropriate" stereotypical feminine gender qualities that are associated with fulfilling that role. As long as *caring* continues to be given marginal status, the value of relational autonomy will lack moral grounding. Feminism thus requires that we monitor how the constitutive factors (language and valuation) concerning how interpersonal conditions covertly or overtly oppress women's psychological capacities.

5.2.2 Communitarianism

Commonly, communitarianism is defined as being the diametric to individualism. In that, the favoring of individual rights and attitudes are unwelcome in achieving community goals; goals that are directed at improving the general welfare of everyone. This position posits that the perceived tension between individual liberty and the security of community goods or interests is mistaken. The mistake the individualist makes, according to the communitarian, is that one must be favored over the other. Communitarians do not deny the existence of individuals and some of their rights. Instead, communitarians argue that more respect and higher value should be given to

[60] Meyers, Diana T. 1989. *Self, Society, and Personal Choice*. New York: Columbia University Press.

the defining structures communities create and preserve, be it moral or political through traditions and practices. For proponents like Charles Taylor, individualism has failed to adequately conceive of the human good (e.g., the good of autonomous agency), because individuals are not divisible from social life or civil institutions. Taylor adds that autonomy-based theories prompting independence of the self are unacceptable so long as the structures and interests of the family and community are neglected.[61]

This is a burdensome demand, because familiarly the individualistic position denies or does not acknowledge that there is a common good. Atomistic-esc success of persons depends on each individual addressing their own interests. For the individualistic political sphere, for instance, it is assumed that by honoring individuals' rights and needs, a corresponding goodness will be expressed in society. The issue here however is that benefits and burdens of persons are shared; this need not be limited to the political area, of course. It is not simply the case that afflicting effects are borne by individuals alone. And then to overcome burdens, the reaction of an injustice to one person, by that person, will not cause change. Other people need to hold similar *care* for addressing the violation of an individual's rights. So, the reification of individuals' rights—which involves not only defending but also preemptively managing rights conditions—is absolutely reliant on the community.

Applying the relational view to medicine is a comprehensive manner of clarifying "the complex ways in which individuals are inseparable from communities and build on the fact that the interests of both are interrelated"[62] for securing health. The interrelation of interests will favor community and the common good and incorporate individual rights when they do not sabotage the community interests. Since the community will establish the common good, this approach

---

[61] Taylor, Charles. 1979. "Atomism." *Powers, Possessions, and Freedom,* by Alkis Kontos, 39-62. Toronto: University of Toronto Press.
[62] Baylis, F., N. P. Kenny, and S. Sherwin. 2008. "A Relational Account of Public Health Ethics." *Public Health Ethics* 1 (3): 196-209.

deals with concerns about safety, benefits, and distribution of goods in a manner distinct from the other relational-concerned views.

5.2.3 Virtue Ethics

The affiliation of communitarians and feminists with relational arguments is straightforward. Less obvious is how virtue theorists corroborates embeddedness of individuals. By default, defenders of virtue theory have been sympathetic to relational autonomy, because both philosophies object to consequentialism and deontology.

To a degree, however, virtue theorists and neo-Aristotelians will diverge from relational proponents about *how* independent individuals can be. Philosophers such as MacIntyre conceive that rational interdependence is possible and virtuous. This means that despite oppressive external or interpersonal conditions, the individual can maintain command of their choices, preferences, or desires. To attain and maintain rational agency, MacIntyre holds that the adequate exercise of independent choices requires the coexistence of virtuous agency with recognizing dependence.[63] Without recognition of this tension-loaded coexistence, we will fail in comprehending various features of agency.

On MacIntyre's account, a virtuous feature for developing into independent rational agents from an 'initial animal condition', has to do with taking measure of our human vulnerabilities. He says the virtue of confronting and responding "to vulnerability and disability both in ourselves and in others, belong to one and the same set of virtues, whose dependence, rationality and animality have to be understood in relationship to each other."[64] So, there is a distinction MacIntyre is making between one's own psychological capacities and the capacities of one's social environment in being able to address premodern vulnerabilities. Human's premodern sensibilities are good in and of themselves when dealing with bodily vulnerabilities, because

[63] Ibid. 1-9.
[64] Ibid. 5.

defects of bodily health impede one's power and authority over their choices and actions. MacIntyre does not think this physiological dependence on others is a hostile state like the individualist does. Such is only the case if persons are restricted in contributing to the very systems that constitute the political and social conditions of their autonomy.

5.3 The Family Relation

Feminists, communitarians, and virtue ethicists agree on the fact that individualism has wrongly dismissed the extent and moral significance of social embeddedness. While these positions disagree on the extent to which external influences affect the cognitive functions of an individual, they do agree about the nature of interconnectivity and its role for person's identity and dependency. The individualist too may say that a group of people can produce benefits for the individual. But on the individualist's view, the only reason that an individual should contribute is because the individual has something to gain. Whereas the three philosophical approaches that apply relational thinking consonant that agents are inseparably susceptible to others. Dependency of persons due to their social and psychological inseparability means that there are not simply benefits or threats related to addressing vulnerabilities, but there are also burdens which come with being a part of a network of persons. And because of this, there is a certain circularity between vulnerability and dependence. These concepts are so profound that entire philosophies—such as feminism—have set out to disarm the deep psychological hold interrelations demonstrate, be it threatening or not. Persons may appear separate, but the constitutive nature of persons means that ourselves and our surroundings are understood in a value-laden way.

There are many contexts these philosophies can and are applied to. But most profoundly, the family is the quintessential site for which vulnerabilities are created, addressed, or taken advantage of. Families bring exceptionally vulnerable members into the world and must decide from day to day, even minute by minute, how they will respond to those vulnerabilities. Much is

at stake for members who are involuntarily vulnerable (when persons are very young or they are disabled). It is easy to imagine how the relational perspective applies to the family, in part because young progeny have not developed their rational capacities yet. The standard version of autonomy would agree that children need to be looked after by their adult caregivers. However, relational proponents go beyond a child's upbringing in saying that persons are socially embedded throughout all stages of life. Such is exceptionally apparent in how families imprint and constituent individuals. Even though the viability of adults needing their family diminishes with things like physical separateness (eg. moving out of the family house) or the rejection of family values or interests, individuals are incapable of complete separation.

In the sub-sections that follow, I will explain the relationship family has with medicine. Then a clear definition about what family *is* will be advanced. And finally, I will reveal a more philosophical reason why I have chosen a particular definition of family by explicating the consequences of adhering to another, more popular definition.

5.3.1 The Family as a Site of Shared Decision-Making

One method of a physician interacting with their patient is in the way of 'shared decision-making.'[65] This patient-centered theory tries to neutralize the role of the physician, so they are less of a paternalistic figure and are more of a collaborative participant who simply has expert knowledge about medical particulars, choices and outcomes.

I too am interested in collaborative decision-making but am of the belief that the family should be the site of decision-making instead of relying on the physician. That is, the family performs a similar role as the collaborative physician but brings another outlook to the patient's

[65] The term 'shared decision-making' is used almost exclusively to explain a kind of decision process between a healthcare professional and their patient. I will use this term for family engagement in a patient's decision making here and onward. Some ethicists, such as Pauline E. Osamor and Christine Grady, have however used 'joint decision-making' as an alternative for families sharing in decision-making processes.

bedside. Family participation is overlooked and undervalued I believe, in part because it is usually framed as a complicating obstacle for an individual's medical decision-making.

The family is the most primary and most consistent social unit which addresses various forms of human vulnerability. In the past, families were the only source of prevention of illness and care for ill individuals. But with significant expansion of technology, political power, and most importantly authority of being trusted with people's vulnerable health states, the source of care has shifted to formal health care institutions. The shift has not displaced the entire burden off of the family, nor was complete displacement the intention.

Care responsibilities between the family and clinical setting have been informally distributed. Even though families no longer assist in reproduction, curing sickness, caring for dying persons, etc. to the same degree of centuries past, does not mean the family unit is no longer valuable to suffering individuals. It is quite the opposite. Families continue to bear the burden of prolonged care duties, (potential) financial ruin, deciding whether to seek professional care, etc. Families bear more than just medical burdens too. Unsurprisingly, families must consider more than medical ends when making medical decisions. Contemporarily, families continue to be the most effective and efficient social network for caring for those members who cannot care for themselves. Because the medical institution holds *respect for individualistic autonomy* in such high regard, respect for the 'goods' and interests of families is systematically overlooked.

5.3.2 How is the Family to be Understood?

To further my case for family being a necessary party in medical shared decision-making, I need to clarify how the concept of family is to be understood. I will begin by employing a framework for family functions, according to the Nelsons. The other portion of this subsection will specify what version of family is coherent with the relational approach. The nature of the family has morphed in recent decades from a narrow version to a more inclusive, flexible one. While

aligning with a more inclusive version of family has its merits, I will distinctly prefer deploying the narrow conception. As the analysis proceeds, it will be clear why such a choice makes the most sense if I am going to circumvent agreeing with the individualist.

Structural characteristics of 'family' designate particular ethical frameworks, which in turn suggests what functions family ought to perform. An ethical framework for the family, consisting of seven principles, has been proposed by Hilde and James Lindemann Nelson.[66] This framework will assist me in supporting the nature of family.

To begin, care workers may in fact be better qualified for making or guiding medical decisions; however, (1) family members are not replaceable in their role of understanding, supporting, or addressing the interests of relevant members. When I spell out the narrow version of family, it will be clear that (2) family members are far less able to disconnect from the family unit. There are a number of reasons for this, but there are both benefits and unavoidable encumbrances because of this feature. A certain collective sensibility about the morality of these relationships is the product of being nearly incapable of separating ties. The difficulty of disconnection means that (3) over much of members' lifetimes, they contribute to the ongoing chronicle of meaningful or salient relationships. A present-day family may make different choices than their ancestors, but the extended legacy of a family helps its members with moral guidance. Combining the clauses of irreplaceability and near inseparability with continuous family narrative contributions, there are many occasions for which trust can be generated or destroyed.

Trust too is a structural characteristic of an existing family unit. Of course, a basic function of family is (4) the passing of values and skills from the more experienced generation onto those less adept. Trust given by children is not something they decide to do, as they have no alternative but to trust their survival and socialization to those looking after them. Such is the

[66] Ibid.

consequence of family members recognizing the fact that (5) causing someone to exist in fact produces responsibilities. Failure to care for one's child may result in severe harm or death of the youth. Many other responsibilities come along with causing someone to exist.

The imperative to derive trust from family does not end after one has come of age and has the capacity to their own authority over their life. To (6) increase connection and closeness between members throughout adulthood, certain responsibilities present. What happens amongst unchosen—and hard to separate from chosen— relations affect how we know ourselves and mediates how we might engage intimately with others outside the family. An awareness of members' mutual vulnerability combined with knowing the common good or how to foster the common good of the family are the conditions which sow trust. Baier adds that "trust is acceptance of vulnerability to harm that others could inflict, but which we judge that they will not in fact inflict."[67] Once someone is a part of the family web as an adult, distrust-inducing behavior does not bode well for members. Checking up on family members' character—to judge the truthiness or serviceability of what they are saying—is subject to the collective memory as well as the other ordinary means strangers or co-workers might check up on others.

Finally, (7) the intentions of an action or attitude or series thereof matter a lot for families considering there are burdens or benefits of actions which are shared between members, symmetrically or not. To continue being a part of the unit, consequences are not unimportant, but intentional threats to the common good will most likely render everyone more vulnerable in some capacity.

From these family-concerning principles, it is more apparent why a fundamental function of family will involve caring for its' vulnerable members. The functions of the family unit are what drives individuals to seek and commit to kin despite their ambivalence towards their only

[67] Ibid. 152-182.

family member or the various individuals. So, while I believe the function of family does well in characterizing what family *does*, I don't think this characterization can stand alone. I need to also explain what the relation boundaries of this social unit are.

There are two identifiable versions of family. The narrow, 'traditional' definition sees families as being limited to blood relations and formalized legal or economic (family-specific) relations. Far more broadly, Karen Bogenschneider defines families as not being "a universally defined entity, but rather a collection for people (two or more) that can be identified by its structural connection, or by its functional connection."[68] For Bogenschneider, structures could include blood ties, residence, or a legal relationship. For function, a family member could be someone who cares for vulnerable members—the young, elderly, disabled, or ill—and shares economic resources.

It is tempting to be in favor of the wide version, since it captures 'new' conceptualizations of families owing to increases in the employment of mothers, non-marital childbearing, cohabitation, and divorce. But I will assert that the narrow version is the version of family that will best advance my argument. Limiting who can be considered family will no doubt marginalize some, but the formality of relations is and should be requisite for making routine but also life-affecting medical decisions. Limiting shared decision-making to blood and legal ties reveals how related or committed persons are to one another. Despite having to confront potentially persistent interpersonal conflicts, the narrow definition crucially reserves medical engagement to those that have far fewer opportunities for being reluctant and permanently detached members.[69]

---

[68] Bogenschneider, Karen. 2014. *Family Policy Matters: How Policymaking Affects Families and what Professionals can do*. Third ed. New York: Routledge, Taylor & Francis Group. 1-15.

[69] Of course, it is possible for family ties to in fact be extinguished completely. However, at an exceptionally high rate, kids from destructive, broken homes—from which they were removed from—seek their birth parent(s). Such common incidences, albeit emotionally perplexing, show that family separation is not the preferred situation and people will put themselves at risk to recover these deeply intimate ties.

5.3.3 How Not to Understand the Family

A very distinct benefit of aligning with a narrow view of family, is that it prevents any covert applications of individualistic autonomy. I will show how the individualistic autonomy position has been imposed on the family. The imposition will have an intimate application of Kant's work in the way of a theory of justice. I use John Hardwig's work to sketch both the mal-outcome of his view for family in medical circumstances and how his Kantian conditions spoil his own conclusion. Susan Okin has similarly argued on this basis and concluded even more radical conclusions.[70] Whatever the conclusions these philosophers have about dissolving the asymmetries amongst family members, they will not only be overlooking important elements of the family, but they will constrain themselves to a certain definition of the family.

Kant holds that *individuals have responsibilities unto themselves*. According to Kant's viewpoint when the obligations to one's well-being are ignored or slighted, their autonomy is at risk. In the work "What About the Family?" John Hardwig points out that conceivably the impact of poor medical decision-making (by an individual) may negatively affect their family (1990). Hurting the well-being of the family reciprocally has negative effects on the individual. Thus, Kant's position asserts that responsible utilization of freedom as needed to weigh all the relevant interests when one's own well-being may be at risk. To be our most autonomous selves, persons should treat their family members' interests equally to their own since the family unit contributes to the patient's well-being. Here, the presumption of equality—because that guarantees some kind of fairness—between member interests for the sake of one person's autonomy is not a conception I agree with.

Recognizing the fairness of interests is in fact a symptom of taking a wide definition of family, which is what Hardwig does in his article. Expressly, by taking the individualistic

[70] Okin, Susan Moller. 1989. *Justice, Gender, and the Family*. New York: Basic Books.

approach, all members of a family are their own individual units that add to the summation of a family. Since all individuals contribute to the summation of the family matter, Hardwig has to take the wide version of family. Anyone could contribute to bettering the social unit and in return bettering themselves. That is because anyone who is close enough to be regarded as family will have interests in the well-being of the family, and reciprocally their own well-being. There are no constraints to who such contributors could be. Then, it is unsurprising that Hardwig defines family as "those who are close to the patient", which includes family members, friends and companions.[71] Thus, the individualist must both accept that fairness between members' interests must occur while accepting the less definable family boundary.

According to my argument, persons within a family are not seen as individual agents simply aggregating a family. The family *itself* is its own social being. By utilizing the narrow family definition, I regard separately the interests of the family from the individual. This approach means that fairness between individual members is much less of a concern such that unequal treatment of members' interests is acceptable. While the effects of one person's medical decisions can come at substantial costs or burdens to other family members, this does not require that *all* interests are regarded in a fair manner or even acknowledged. I am not endorsing any protections for power-holding members 'right' to exploit and abuse the weak. My feminist counterparts provide ample resources for diffusing power relations. In particular, trust will play a significant role in how to protect the vulnerable. Affirmingly enough, Hardwig himself concedes that on a case-by-case basis the patient's interests ought to be advanced, but at other times consideration for a mix of member interests is necessary, and at other times the patient's interests should be ignored altogether.

[71] Hardwig, John. 1990. "What about the Family?" *The Hastings Center Report* 20, no. 2: 5-10.

The reality is that family dynamics are not easily subjected to principles of fairness. But by defining which kind of intimate relations should be acceptable for shared decision-making, I have revealed that only clear familial boundaries are accepted, that the family is not simply a summation of individuals, and that this version allows power inequalities to exist. Also, by aligning with this view, family members are constituted by individuals in a manner that does not require they act well unto the family for their own benefit.

5.4 How Individuals Need Families

In the last subsection I separated my view, as a version of the relational perspective, from the persistent individualist. Families make significant contributions to the cognitive constitution of individuals. This much is unavoidable, whether or not individuals accept such a reality. The psychological manifestation of social embeddedness is powerful, so powerful that we must be sensitive to how persons are influenced by those especially close in relation. Such is especially the case for persons in states of disability or illness. However, the worries about families wantonly harming or handicapping people's physical and voluntariness states are much louder than those who philosophically validate the benefits.

Disability and primitive vulnerability are circumstances that may happen to anyone, at any point in their lives. And while all persons must depend on others for responding to medical situations at certain points (early youth and senescence), the chance that anyone could become dependent (for medical reasons) is unpredictable and common. I believe that not only are patients better off when their disability or illness is addressed by family members, but that coordinating with trusted others amplifies the agency of individuals. I have shown that the adult segment of the population commonly does not meet the conditions of being viewed as autonomous according to the individualist's own standards. Instead of revoking individual's access to medical decision-making—which has been systematically and intuitively avoided in observation of the inclusivity

condition—I am arguing that qualifying related persons should always share in the decision-making process of the patient. I will prove this point by utilizing examples of intentional nondisclosure and advanced directives, of which will further substantiate my argument for relational autonomy.

Integral my account is addressing the condition of inclusivity, similar to the individualist. This condition is undeniably important, because revoking people's authority over decision-making, correspondingly denies them any input into the future of their bodily health, for as long as they are considered non-autonomous. Trusting a physician's adherence to benevolence, non-maleficence, and justice is not enough to justify denying so many person's access to decision-making according to threshold tests. If I am going to do better than the individualist at satisfying their own assumption, I need to show how the family is always relevant to medical decision-making, even if the patient does not want them involved.

On the relational view, the controlling or persuasive influences of external sources and internal phenomena is not only foreseen, but is understood to be characteristic of power imbalances, emotional experiences, cognitive defects, etc. It is unsurprising that patients' "lives, values, and preferences are likely to interact with treatment."[72] Rather than alleging that various barriers diminish or block voluntary action, care systems should adopt strategies to enhance voluntarism. For instance, Roberts prescribes that "clarifying personal values through dialogue about cultural and religious beliefs, psychological issues and personal history, and documents... may dramatically enhance the subject's ability to identify preferences in key decisions…"[73] Bringing patient's social situatedness into plain sight while engaging those others in decision-making will manifest what Roberts recommends. In the case the family engages with the decisions of their vulnerable members, risk of negative attitudes, isolation perpetuation, and

[72] Kashaf, Michael Saheb and Elizabeth McGill. 2015. "Does Shared Decision Making in Cancer Treatment Improve Quality of Life?" *A Systematic Literature Review*. SAGE Publications 35.
[73] Ibid.

detachment from suffering can be faced. Minimal family and social support will cause unnecessary suffering, which in part undermines the very conditions for individualistic autonomy. Resilience and growth are features a family will need for coping with medical events. The communal good of these features will engage the very things needed to build and maintain trust. Then, to increase the amount of persons who qualify for making decisions, the mutual influence of physical illness, disability, and family functioning will need to be courageously faced.

5.4.1 Moral Responsibilities

Another unspoken element of respecting patient autonomy is that patients have moral responsibilities associated with their agency. Moral responsibilities are those *outcomes* that feature the capacities that a person has, along with the actions arising from the exercise of those capabilities. The medical establishment ignores such responsibilities to a considerable extant. There are a variety of reasons for this, one of which being: no matter how 'good' a decision is, there are many things that could go wrong since there are many other mechanisms which likewise need to go well. Choosing the 'right course of action' will have outcomes that the patient and their intimate relations might have to deal with in both quality and quantity. A straightforward example of how medical health professions avoid burdening patients (normal choosers) with moral responsibility is that of in intentional nondisclosure. Intentional nondisclosure is a deliberate act of not communicating or misrepresenting some information necessary for a patient to reach adequate understanding. Notable topics of intentional nondisclosure include: therapeutic privilege, "medical confidentiality, informed refusal, placebo treatment,.. genetic counseling, and the duty to warn third parties."[74] Physicians will take it upon themselves to shield patients from decision-relevant information that might harm them. What physicians are trying to avoid includes the triggering of irrational decision-making, endangering someone's life and avoiding creating

[74] Ibid. 125.

stress or anxiety—in the case the patient was already showing signs of depression, emotional exhaustion, or showing signs of being unstable.

Even though there is some amount of gradation patients can occupy when it comes to conditions of understanding and voluntariness, my account does better at dealing with *why* physicians engage in intentional nondisclosure of information. There is confusion here about what then the physician is doing when they engage in actively hiding, avoiding, or misrepresenting facts and particulars about what is being deliberated about. Are they trying to protect the patient's autonomy at the expense of the patient's interests? It does not appear to be the case for intentional nondisclosure. So, are they protecting the patient's interests out of beneficence? For me, the accurate question is the latter. The physician may situate themselves in a position to "know" the interests of their patients, but I think family is in a much better position to know and address the interests of a patient in concert with the interests of the family itself. The practical conditions of contemporary medicine set up physicians for not actually knowing their patients well, in addition to the fact that physicians are trained to respond to medical interests. Physicians will often do their best to care or not cause harm to their patients, but family members have more opportunities for knowing the interests of the patient and how those interests relate to the family's interests. Occupying this insightful position makes the family more adept at keying into the intentionality, understanding, and potential threats to the patient's voluntariness. This especially would be the case if collaborating member(s) were to attend clinical appointments and treatments regularly.[75] There are other ways family can or should engage in shared decision-making.

[75] It is not my stance that we should let member(s) into the surgical theater. But it would be reasonable for patients' families to view the procedure through a streaming service, so that everything the patient consented to is in fact respected. For instance, the express lack of obtaining informed consent to perform pelvic exams on women under anesthesia during surgical operation (for something non-pelvic related) has occurred well into the late 2010s. Once these unauthorized pelvic exam occurrences became public knowledge, a wave of political bills addressed this deeply unethical and normalized practice. The normalization is characterized by Dr. Silver-Isensctadt who has "surveyed over 401 students at five

Family members embody a problem for physicians. Members and the interests of the family impose a demanding burden of treatment, recognition, and explanation on physicians. These pressures are highly uncomfortable when members advance inappropriate treatment or demands, especially when the member situates *their* interests as being more important than the patient's interest. Facing conflicting interests will be an obstacle. There are many examples which speak to why medical practitioners try to deny or minimize family involvement with decision-making. Medical professionals are stressed enough. Which is in part why they take it upon themselves to make decisions for patients at times, depending on how they see the situation. However, just because the burdens of incorporating family interests in the clinical setting may be fraught with complicated dynamics—that set up decision-making to be an excruciating process at times—does not remove the moral relevance of a family's interests, it simply avoids the complex of interests. Like chronic disease, prevention of dealing with a cascade of participation and conflicting affairs will mean taking management efforts.

The family too has moral responsibilities. These responsibilities do not simply arise because families are necessarily well equipped or capable of responding to the detrimental conditions affecting its member(s). They will have to confront the asymmetries of power and caring responsibilities amongst themselves. Responsibilities also arise because each member is irreplaceable and their contributions to the unit occur across the lifespan. And because relational autonomy mandates their involvement, the privacy of who has what responsibility and interest will need to be uncovered. In the family, an infinite number of moral dilemmas can take place throughout their continuous narrative. Because of this fact, maintaining trust in the clinical setting will be far more influential than it will for the sparse interactions with the physician. The trust having to do with the physician-patient is of a different sort. Knowing that these persons cannot

---

Pennsylvania medical schools and found that 90 percent had performed pelvic exams on anesthetized patients." See Goldberg, Emma. 2020. "She Didn't Want a Pelvic Exam. She Received One Anyway." *New York Times (Online)*. Accessed 03 2021.

easily be disconnected from the unit at most any point in life, they will care about the future near as much as they care about the present.[76] Members care in part because each has contributed to the defining conditions of the other's autonomy. Also, by being able to address the threats to family functions and projects will make room for better negotiation of (potential) burdens rather than leaving it to the physician to sort through their own bias and assumptions about the patient. Caring about the future of the family as its own social condition-creating unit motivates cooperation even amongst conflicting or confused interests. Thus, moral responsibilities balance the obligations and values of today with the conduct between members in the future.

5.4.2 Advance Directives Reveal Trust Rather than an Expression of Free Will

Notoriously in bioethics literature, end-of-life decisions engage the moral responsibilities I roughly discussed in the previous sub-section. Also, I have demonstrated in §4.4 empirically and socially what advanced directives tell us about people's desire to engage in relational autonomy. It is possible that advanced directives could be a tool for those engaging in relational autonomy; however, this sub-section will show how directives are individualistic and thus I cannot champion them as they stand.

First, I will briefly explain why families are involved in member's late life. These circumstances are particularly intriguing because it is not always clear when someone, who once had a healthy and matured agency, loses that agency. Also compelling is that persons in this position have had ample time to study about and refine their moral principles as well as knowing their interests and preferences. The ability to communicate these things written or verbally should be straightforward, but that is not the case. By evidencing the problems with advance directives or lack thereof, I will further my case for involving the family and their interests long before

[76] This situation directly corresponds with the 'infinite prisoner's dilemma.' Peaceful and mutually beneficial behavior is both demonstrable and ideal for maintaining trust.

advance directives are committed to paper. Throughout, I will show how the account of relational autonomy can be applied in order to make better sense of the position.

It is common and somewhat expected that as persons age or approach their end of life, medical attention also increases along with the possibility of decreasing decision-making capacity for that person. There are many afflictions that impede cognitive capacities, especially as persons age. So, expectedly as these people's cognitive skills diminish, so does their autonomy. This is expected. Unless legal documentation or court orders say otherwise, the surrogate decision-making most often falls to family.

Advanced directives are helpful because they are a pathway for an individual to unlimitedly identify what they do or do not authorize, who the proxy decision-maker is, etc. The goal of living wills is to provide instructional and substantive information about what a person desires in the event incapacitating circumstances occur. Ronald Dworkin remarks that decisions about life and death are a means "for forming and expressing personality" so long as their character genuinely aligns with the decision.[77] For Dworkin, patients' individual freedom to make their mortal decisions is an expression of self-respect, which is the very thing that drives persons to see their lives as having importance of an objective and intrinsic nature. The expressions of preferences and values in document form also provides a consistent framework which can be referenced. It may seem like a forward-thinking idea to compose one of these documents, but there are substantial issues with instructions that are provided.

Instructions may specify what actions should be taken if a person reaches a state of incapacity for deciding as an autonomous agent. Often, there are no instructions at all. Despite the accessibility of composing such a document, many people do not do so. In the case a person does compose a living will, the oversights can be truly endless because there are innumerable medical

[77] Dworkin, Ronald. 1994. *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom*. First Vintage Books ed. New York: Vintage Books. 218-241.

decisions which will be circumstantial. The variety of choices and means of staying alive or being let go of abound, especially with new technology. “Patients while competent often could not have reasonably anticipated the precise circumstances they actually encountered when they became incompetent”,[78] say Beauchamp and Childress. A lack of specificity does not say much about autonomy, but the fact that many persons choose not to pen such a document has much to do with trusting that proxy decision-makers will act in the patient’s best interests. Without specificity, surrogate decisions will be necessary.

Surrogate decision-making is a marked topic, but the assigning of a surrogate is a formality in living wills that are also subject to being unusable. Commonly, only one person is designated as having the ‘power of attorney’. That designated person may themselves lack competence, fail to be available when called upon, be emotionally unstable, or they maintain a conflict of interest or state of being controlled by another agent that undermines any commitment to abiding by the patient’s interests.[79] So then, it may be necessary to include multiple additional surrogates into the document. However, it would seem more proactive to have had at least one of the prospective surrogates *already* involved with medical care and decision making so that disqualifying factors would have already been identified, and encouragement for another surrogate selection could be addressed.

Even when a person takes the time to write out a directive, it is surprisingly common that they change their mind about what quality and quantity of care they desire. And it is even more common that they fail to update their advanced directive to reflect such a change. As I touched on in the section on preference instability, people may additionally lack awareness that their preferences about decisions concerning incompetent states have changed or that inconsistencies exist. Underlying the commonality of preference instabilities is the enduring worry that too much

[78] Ibid. 193-197.
[79] Ibid. 193-197.

emphasis has been placed on self-government. The expectation that patients know what is right for themselves—whether the care provider agrees or not—pervades medicine, because individualism has imprinted the assumption of inclusivity. It is possible to overcome inconsistencies, which involves the regular investment of structured, pointed communication about values and preferences. No one 'likes' discussing matters of death, but to avoid coordinating such conversations speaks volumes about how other, more negligible medical decisions are being disregarded due to the discomfort topics effect.

In a similar vein the instabilities are not only apparent prior to medical events when a directive is in place, but also once the event is taking place. Beauchamp and Childress say that "living wills provide no basis for health professionals to overturn a patient's instructions; yet prior decisions by the patient could turn out not to be in the patient's best medical interest."[80] Dworkin similarly claims that there are rare occasions where overriding the written wishes of a now-incompetent person is morally acceptable. Beyond what happens after a patient has fallen from their autonomous state, the fact that their preferences changed once they were steeped in a medical situation, it is unsurprising. People may change valuations of their preferences as new circumstantial considerations surface. With new information comes new considerations. However, it is also common that people do not update their advance directives. Typically, the directive is written and then it collects dust until the document is implemented for a decisional framework. To be more employable, updating the hard copy to reflect changing interests—while still capable—strikes me as practical. However, this is not the case when we assume persons will have solidified their moral foundation and associated interests. One draft of an advanced directive would be enough for the individualist, provided that there is flexibility for new technologies. But,

[80] Ibid. 193-197.

simply updating the set of actionable medical orders according to alterations in a person's current preferences has somewhat proven to be insufficient and unpracticed.

In §4.4., I introduced the notion that focusing on advanced directives is not only confusing for those trying to base medical (and non-medical) decisions from, but that most people trust their family members will make decisions in that person's best interests, along with the family's. The trust in intimate others is a given for many patients, but the family is often left to roughly surmise what they knew about that member as a translation to medical decisions. There is a distinct disconnect between knowing the values and projects of family members and knowing these same things in the context of medicine. My relational approach would observe this disconnect as foreseeable, because as long as we continue to deny adults' social embeddedness—especially in the family—the benefits and burdens will continue to be shared amongst members, but those members will have limited opportunity to express family interests.

Prior to dealing with end-of-life decisions, families would benefit from periodic open, structured, and detailed discussion about relevant interests. By exploring all the different medical events that could take place, members are given the opportunity to understand and refine their fellow intimate's deliberation. We need not limit this discussion to someone's repose or sudden passing. Engaging in shared decision-making with family throughout all stages of life and medical situations will dissolve the kinds of worries that medical ethicists have about expressing free will in medicine. This is in part because I have shown that free will in the medical sphere is more of an enigma than theorists would like to admit. A new set of worries will present, particularly about this approach to advanced directives, but I will set those aside for now to discuss more crucial challenges to my position.

5.5 Practical Limits of Relational Autonomy

No doubt, addressing individual patients as constituent persons while incorporating the interests of their family will be an arduous task. There are notable weakness to my position, some of which I will cover here. Considering the brevity of this project, I will name some of these problems while not providing any responses. These problems are not unexpected, as I have covered them in some form earlier in my work, but here they will be specific to the family social unit.

5.5.1. Buying-in and Relational Ambivalence

Frankly, there are various practical fears health care providers have about bringing family members into the clinical setting. For instance, bringing more people into the decision-making situation invites more opportunities to have more unmanageable persons involved. Additional persons may to amplify misunderstandings (such as a family who are anti-vaccination) about medical therapies or strategies. These and other concerns are not limited to medical providers, as evidenced by the various philosophers who champion relational autonomy but specifically have misgivings about the family.

Most often, relational advocates[81] believe the family is subject to the relative conditions of their surroundings. This means, for example, that families will inevitably be as bad off as the community they occupy. Local communities, for them, will be a better site for making real, systematic change, for the good of the family (in this case). This position is not wrong, but we are trying to achieve two different results. The collective action of a community will construct and maintain the infrastructure for addressing disabled or ill persons. But decision-making will still be up to the family, because ultimately shared benefits or burdens of medical interactions will be most intense at this site.

---

[81] The list of relational advocates who dismiss the capability of the family includes, but is not limited to the following: Susan Sherwin, Hilde & James Lindemann Nelson, Alasdair MacIntyre, Willard Gaylin & Bruce Jennings. The Nelsons can be differentiated because they are aware that it is common for family members to not know the values and preferences of their own loved ones in terms of medical decisions.

For the family, to gain the benefits of my position—despite their social situation—they would have to regard shared decision-making as worth-while, even when it spurs more interpersonal harm than perhaps not engaging would. With that said, forcing families to show up to clinical appointments, to both deal with their interpersonal issues while sharing in decision-making, is a burdensome expectation. Thus, the most notable weakness of my view is that a good many people will not submit that they are better off including family members in decisions, that seemingly only concern their own body or economic situation.

In a similar manner, Christman keenly warns that "relational views that see social conditions as not only supportive of autonomy but *definitive* of it carry with them a danger that autonomy-based principles of justice will exclude from participation those individuals who reject those types of social relations demanded by those views."[82] Instituting the relational version of autonomy would in fact level a social demand on persons this is scant applied elsewhere in contemporary society.

Another weakness is that some persons do not have intimate social connections, let alone relations serviceable for my prescriptions. There are identifiable groups as well as relationships statuses that fall into this state. Such a state does not have to be permanent however. And even in the rare case that blood relations do not exist at some point in a person's life, there is always the option to "choose" family or "make" family. For this reason, no one can say for certain if anyone exists without someone regarded as their family, especially across their entire life. But for many, the existence of family members is not equivalent to "having" family. For instance, in the latter years of life (over the age of 60) between 20% and 43% of U.S. adults experience *frequent or intense loneliness*.[83] Additionally it has been observed that loneliness is heritable at a rate of 40%,

---

[82] Ibid.

[83] Perissinotto, Carla M., Irena Stijacic Cenzer, and Kenneth E. Covinsky. 2012. "Loneliness in Older Persons: A Predictor of Functional Decline and Death." *Archives of Internal Medicine (1960)* 172, no. 14: 1078.

suggesting a genetic component is at work.[84] I will not go further in showing how people might occupy a seemingly isolated state. This work is worthwhile and useful for my project, but what is being revealed is that social disconnection is a common feature in the United States. Instead, the work that would need to be done for ameliorating family disconnections or occurrences of extended loneliness involve activating social and moral responsibilities of members. Taking up this assignment to establish trust-worthy relations for the sake of relational autonomy in medical contexts is burdensome, but not out of reach.

The social connectedness of family will affect how, when, and why persons will in fact feel about engaging with the family's moral framework. Intuitively, people are aware that relations with intimate unchosen and chosen—but hard to separate from—ties can induce regular or outstanding strains. Ongoing, inseparable relations for which family-specific responsibilities are inherently tied to, will produce positive, negative, or a mixture of behavioral mechanisms. The range is not necessarily static of course. Amongst the quality of relations however, the most common are those that are both voluntary and stress-inducing due to fluctuating perception of behaviors. This is a mixture of salient levels of both positive and negative interpersonal aspects characterize ambivalent relationships.[85] It is likely that this version of relationship is more detrimental than those that are simply negative or indifferent. Amongst couples for instance, between 47% and 86% of reporting participants disclose that they are ambivalent toward their spouse.[86] Ambivalent relationships may be the product of conflicting societal or generational

---

[84] Goossens, Luc, Eeske van Roekel, Maaike Verhagen, John T. Cacioppo, Stephanie Cacioppo, Marlies Maes, and Dorret I. Boomsma. 2015. "The Genetics of Loneliness: Linking Evolutionary Theory to Genome-Wide Genetics, Epigenetics, and Social Science." *Perspectives on Psychological Science* 10, no. 2: 213-226.

[85] Holt-Lunstad, Julianne and Bert N. Uchino. 2019. "Social Ambivalence and Disease (SAD): A Theoretical Model Aimed at Understanding the Health Implications of Ambivalent Relationships." *Perspectives on Psychological Science* 14, no. 6: 941-966.

[86] Birmingham, Wendy C., Bert N. Uchino, Timothy W. Smith, Kathleen C. Light, and Jonathan Butner. 2015. "It's Complicated: Marital Ambivalence on Ambulatory Blood Pressure and Daily Interpersonal Functioning." *Annals of Behavioral Medicine* 49, no. 5: 743-753.; Uchino, Bert N., Jos A. Bosch, Timothy W. Smith, McKenzie Carlisle, et al. 2013. "Relationships and Cardiovascular Risk: Perceived Spousal

norms, one's early family environment, general attachment style, poor interpersonal transactions, etc.[87] People tend to enact erroneous coping strategies which no doubt further complicates the ambivalence occurring in the relationship. Transformations between ambivalent persons can be improved, but what is more intriguing here is that many persons continue to voluntarily engage with their family system even when some interaction or ingrained behavior afflicts their commitment.

6 Conclusion

Family's' willingness to engage in relational autonomy will be linked to how people are committed to the family. The family is a sensitive unit of society, especially when it comes to conflicting interests and voluntary investment. Despite the complex of reasons outlining why families or its constituent member relations are too broken or asymmetrical in power to be called on for addressing the common good, there is a omnipresent assumption about distrusting families. This default assumption has kept families out of shared decision-making processes for fear of enabling members to abuse vulnerable or ill patients.

It has been made clear that the opposite case holds for the individual. A tenet of individualistic philosophy asserts that psychological separateness and cognitive function endow a person with the capability to think for themselves. *Respecting patient autonomy* in medicine rests on this assumption, unless a patient proves otherwise. In a similar vein, the condition of inclusivity presupposes cognitive function directly translates to self-government and associated decision-making, so long as individualistic autonomy conditions are met by the patient.

With the assistance of empirical studies and familiar examples, I have shown why these assumptions cannot adequately meet the expectations of the individualist's version of autonomy.

Ambivalence in Specific Relationship Contexts and its Links to Inflammation." *Health Psychology* 32, no. 10: 1067-1075.

[87] Ibid.

In medical circumstances, it is common for people to not meet the minimalist thresholds of being autonomous decision-makers. This is because responding to and understanding illness is a demanding task. It is worthwhile to give as many people the opportunity to contribute to decisions about their health care, because such decisions can have profound effects on the rest of their lives as well as their intimate others, so keeping to the inclusivity condition has been a goal of this project.

Increasing capacity according to my argument involves the family because its ethical framework constrains members to being trustworthy and fulfilling moral responsibilities. The family is by no means a perfect source of collaboration. But the manner in which the medical field has avoided taking the family's interests into consideration, on a systematic scale, has denied the moral significance and practical efficacy of acknowledging patient's social embeddedness. Cooperating with a family's relational autonomy will be less of an exercise of 'letting' the family into medical decision-making. Instead, making visible the way medical interventions affect families and their functions, the medical complex will need to share in their authority about knowing a patient's interests.

Bibliography

Appelbaum, Paul S. and Thomas Grisso. 1988. "Assessing Patients' Capacities to Consent to Treatment." *The New England Journal of Medicine* 319, no. 25: 1635-1638.

Arnold, Robert M. and Lachlan Farrow. 1990. *Deciding for Others: The Ethics of Surrogate Decision-Making.* Vol. 11. Taylor & Francis Group.

Baier, Annette. 1994. *Moral Prejudices: Essays on Ethics.* Cambridge, Mass: Harvard University Press.

Baylis, F., N. P. Kenny, and S. Sherwin. 2008. "A Relational Account of Public Health Ethics." *Public Health Ethics* 1 (3): 196-209.

Beauchamp, Tom L. and James F. Childress. 2019. *Principles of Biomedical Ethics.* New York: Oxford University Press.

Bertrand, Pierre-Marie, Bruno Pereira, Mireille Adda, Jean-François Timsit, Michel Wolff, Gilles Hilbert, Didier Gruson, et al. 2019. "Disagreement Between Clinicians and Score in Decision-Making Capacity of Critically Ill Patients." *Critical Care Medicine* 47, no. 3: 337-344.

Birmingham, Wendy C., Bert N. Uchino, Timothy W. Smith, Kathleen C. Light, and Jonathan Butner. 2015. "It's Complicated: Marital Ambivalence on Ambulatory Blood Pressure and Daily Interpersonal Functioning." *Annals of Behavioral Medicine* 49, no. 5: 743-753.

Bogenschneider, Karen. 2014. *Family Policy Matters: How Policymaking Affects Families and what Professionals can do.* Third ed. New York: Routledge, Taylor & Francis Group.

Buchanan, Allen E. and Dan W. Brock. 1990. *Deciding for Others: The Ethics of Surrogate Decision Making.* Cambridge [England];New York: Cambridge University Press.

Christman, John. 2004. "Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves." *Philosophyical Studies* 117 (1): 143-164.

Doan, Michael D. and Ami Harbin. 2020. "Public Health and Precarity." *International Journal of Feminist Approaches to Bioethics* 13 (2): 108-130.

Dworkin, Ronald. 1994. *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom.* First Vintage Books ed. New York: Vintage Books.

Foot, Philippa. 2001. *Natural Goodness.* New York: Clarendon.

Gaylin, Willard and Bruce Jennings. 2003. *The Perversion of Autonomy: Coercion and Constraints in a Liberal Society.* Washington, D.C.: Georgetown University Press.

Goldberg, Emma. 2020. "She Didn't Want a Pelvic Exam. She Received One Anyway." *New York Times (Online).* Accessed 03 2021.

Goossens, Luc, Eeske van Roekel, Maaike Verhagen, John T. Cacioppo, Stephanie Cacioppo, Marlies Maes, and Dorret I. Boomsma. 2015. "The Genetics of Loneliness: Linking Evolutionary Theory to Genome-Wide Genetics, Epigenetics, and Social Science." *Perspectives on Psychological Science* 10, no. 2: 213-226.

Gready, R. M., P. H. Ditto, J. H. Danks, K. M. Coppola, L. K. Lockhart, and W. D. Smucker. 2000. "Actual and Perceived Sability of Preferences for Life-Sustaining Treatment." *The Journal of Clinical Ethics* 11, no. 4: 334-346.

Grisso, Thomas and Paul S. Appelbaum. 1998. *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals.* New York: Oxford University Press.

Hardwig, John. 1990. "What about the Family?" *The Hastings Center Report* 20, no. 2: 5-10.

Holt-Lunstand, Julianne and Bert N. Uchino. 2019. "Social Ambivalence and Disease (SAD): A Theoretical Model Aimed at Understanding the Health Implications of Ambivalent Relationships." *Perspectives on Psychological Science* 14, no. 6: 941-966.

Jones, Karen. 1999. "Second-Hand Moral Knowledge." *The Journal of Philosophy* 96, no. 2: 55-78.

Kant, Immanuel. 1724-1804. *Foundations of the Metaphysics of Morals: And what is Enlightenment?* Vol. 113. New York: Liberal Arts Press.

Kashaff, Michael Saheb and Elizabeth McGill. 2015. "Does Shared Decision Making in Cancer Treatment Improve Quality of Life?" *A Systematic Literature Review* (SAGE Publications) 35.

Kenny, Nuala P., Susan B. Sherwin, and Françoise E. Baylis. 2010. "Re-Visioning Public Health Ethics: A Relational Perspective." *Canadian Journal of Public Health* 101 (1): 9-11.

Kim, Scott Y. H. 2014. "Improving Medical Decisions for Incapacitated Persons: Does Focusing on "Accurate Predictions" Lead to an Inaccurate Picture?" *The Journal of Medicine and Philosophy* 39, no. 2: 187-195.

Lindemann, Hilde and James Lindemann Nelson. 1995. *The Patient in the Family: An Ethics of Medicine and Families.* New York: Routledge.

MacIntyre, Alasdair C. 1999. *Dependent Rational Animals: Why Human Beings Need the Virtues.* Vol. 20. Chicago, Ill: Open Court.

Mappes, Thomas A. and DeGrazia. 2006. *Biomedical Ethics.* New York: McGraw-Hill.

Meyers, Diana T. 1989. *Self, Society, and Personal Choice.* New York: Columbia University Press.

Nedelsky, Jennifer. 1990. "Law, Boundaries, and the Bounded Self." *Representations* (Berkeley, Calif.) no. 30.

Nedelsky, Jennifer. 1989. "Reconceiving Autonomy: Sources, Thoughts and Possibilites." *Yale Journal of Law and Feminism* 1: 7-36.

Okin, Susan Moller. 1989. *Justice, Gender, and the Family.* New York: Basic Books.

Osamor, Pauline E. and Christine Grady. 2018. "Autonomy and Couples' Joint Decision-Making in Healthcare." *BMC Medical Ethics* 19 (1): 3-3.

Perissinotto, Carla M., Irena Stijacic Cenzer, and Kenneth E. Covinsky. 2012. "Lonliness in Older Persons: A Predictor of Functional Decline and Death." *Archives of Internal Medicine (1960)* 172, no. 14: 1078.

Putnam, Hilary. 1981. *Reason, Truth, and History.* New York: Cambridge University Press.

Roberts, Laura Weiss. 2002. "Informed Consent adn the Capacity of Voluntarism." *The American Journal of Psychiatry* 159, no. 5: 705-712.

Sessums, Laura L., Hanna Zembrzuska, and Jeffrey L. Jackson. 2011. "Does this Patient have Medical Decision-Making Capacity?" *JAMA: The Journal of the American Medical Association* 306, no. 4: 420-427.

Sherwin, Susan and Katie Stockdale. 2017. "Whither Bioethics Now?: The Promise of Relational Theory." *International Journal of Feminist Approaches to Bioethics* 10 (1): 7-29.

Smith, Dylan, George Loewenstein, Christopher Jepson, Aleksandra Jankovich, Harold Feldman, and Peter Ubel. 2008. "Mispredicting and Misremembering: Patients with Renal Failure

Overestimate Improvements in Quality of Life After a Kidney Transplant." *Health Psychology* 27, no. 5: 653-658.

Smucker, William D., Renate M. Houts, Joseph H. Danks, Peter H. Ditto, Angela Fagerlin, and Kristen M. Coppola. 2000. "Modal Preferences Predict Elderly Patients' Life-Sustaining Treatment Choices as well as Patients' Chosen Surrogates do." *Medical Decision Making* 20, no. 3: 271-280.

Taylor, Charles. 1979. "Atomism." In *Powers, Possessions, and Freedom,* by Alkis Kontos, 39-62. Toronto: University of Toronto Press.

Turoldo, Fabrizio. 2010. "Relational Autonomy and Multiculturalism." *Cambridge Quarterly of Healthcare Ethics* 542-549.

Uchino, Bert N., Jos A. Bosch, Timothy W. Smith, McKenzie Carlisle, et al. 2013. "Relationships and Cardiovascular Risk: Perceived Spousal Ambivalence in Specific Relationship Contexts and and its Links to Inflammation." *Health Psychology* 32, no. 10: 1067-1075.

Walton, Douglas N. 2003. *Ethical Argumentation.* Lanham: Lexington Books.

Williams, Bernard. 2012. *Morality: An Introduction to Ethics.* New York: Cambridge Press.

Wilson, Timothy D. and Daniel T. Gilbert. 2005. "Affective Forecasting: Knowing what to Want." *Current Directions in Psychological Science: A Journal of the American Psychological Society* 14, no. 3: 131-134.