

**RESPECT FOR PERSONS: THE FOUNDATIONAL MORAL DISPOSITION IN MEDICINE
(A RENEWED PHYSICIAN ETHOS: RESPECT FOR PATIENTS AS PERSONS)**

By

Pascal Michael Caruso

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Approved:

John Lachs, Ph.D

Jeffrey S. Tlumak, Ph.D

Michael P. Hodges, Ph.D

Keith G. Meador, M.D., Th.M., MPH

DEDICATION

For my mother, Johanna Caruso, who exuded love toward all, encouraged us to think for ourselves
and, by example, showed us that it is never too late to follow your bliss.

A woman of extraordinary gifts and talents, who endured these being taken from her,
one by one, with grace and without complaint, teaching us, in the end, how to suffer.

She left us too soon.

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DISSERTATION INTRODUCTION

This dissertation seeks to establish Respect for Persons as the foundational moral concept of medicine and in particular for the doctor-patient relationship. It also seeks to establish that the fundamental moral commitments of medicine are entailed by the conceptual recognition of patients as persons. I argue that these combined conceptions ground the therapeutic relationship as a fundamentally moral one. I propose and provide evidence that these key concepts can serve as guideposts in actual medical practice, when understood as both moral dispositions (or moral feelings) and as moral principles at the core of moral medical practice.

Respect is the primary ground of physician-patient ethics and serves as the basis for our attitudinal, cognitive and behavioral orientation toward patients. Respect for persons grounds a host of mid-level, contingent principles including, but by no means limited to, autonomy, beneficence, non-maleficence and justice. Respect grounds not only obligations but also virtues that physicians must develop and exemplify if they are to appropriately show the respect for their patients to which they are committed. Examples of virtues that are particularly applicable to medical practice include fidelity, trustworthiness, honesty, humility, respect and caring.

This dissertation seeks to describe the moral commitments that underlie patient-centered care by analyzing the key ideas that are commonly described in the literature on respect for persons and relate them to caring. As the moral basis for patient-centered care, respect begins to take effect through the entailed physician obligation to establish an atmosphere of trust with the patient that ensures mutual participation and shared decision-making.

In the literature of moral and political philosophy, the notion of respect for persons commonly means a kind of respect that all people are morally owed, just because they are persons, regardless of social position, individual characteristics, achievements, or moral merit. An explanation for our belief that humans (and perhaps other beings) are owed respect may first lie in our actual felt experiences of

reverential respect and plays a significant role in our intuition and development of this disposition toward others. It has been argued by Susan Buss and others that what justifies accepting our experience of respect for humans (or other beings) as grounds for an obligation is its coherence with our other moral beliefs (Buss 1999, Margalit 1996, Gibbard 1990).

Kant argues that rational beings are the only entities that are ends in themselves and that all rational beings are ends in themselves. The term “person” means a being whose rational nature “already marks them out as ends in themselves...and an object of respect” (Groundwork 4: 428). Kant calls this distinctive worth “dignity.” In Kant's theory of value, dignity is the supreme value; thus ends in themselves are to be valued morally above all other beings.

Kant argues that although individuals, as members of some social community or other, may have or lack meritorious accomplishment or status or may deserve honor (or evaluative respect) to differing degrees (or not at all), all persons are members of “the moral community.” Kant refers to the community of persons, under the moral law, as the kingdom of ends (in themselves). As such, all persons are owed the same moral recognition respect, by virtue of the dignity that they possess unconditionally and independently of all other characteristics. While all normally functioning human beings possess the rational capacities that Kant argued (at least in some of his writing) grounded respect, there are humans in whom these capacities are altogether absent and who therefore, according to some theories of human rationality or autonomy, are thus not persons and are not owed respect. It is unlikely that this is even close to what Kant had in mind.

Simultaneously, we now understand that these capacities may be possessed by beings who are not biologically human (such as higher primates). Such beings would also potentially be persons and whom we are morally obligated to respect. It is most unlikely that Kant would have agreed to such designations, for, fundamentally, Kant grounded respect for persons in humanity, not in autonomy (at least not in the actualized or functional sense of autonomy).

Kant also held that because dignity is an absolute worth grounded in the rational capacities for morality, it is in no way conditional on how well or badly those capacities are exercised, or on whether a person acts morally or has a morally good character. Thus, dignity cannot be diminished or lost through vice or morally bad action, nor can it be increased through virtue or morally correct action.

Recognition respect is not something individuals have to earn or might fail to earn, but something they are owed simply because they are rational beings. Finally, Kant argued that because dignity is absolute and incomparable, the worth of all rational beings is equal. What grounds dignity is something that all persons have in common, not something that distinguishes one individual from another. The equality of all rational beings, however, does not entail that each person must be treated the same as every other person, nor does it entail that persons cannot also be differentially evaluated and valued in other ways for their particular qualities, accomplishments, merit, or usefulness. Such valuing and treatment must always be constrained by the moral requirement to accord recognition respect to persons as ends in themselves. In this there is agreement between Kant's view and my own.

The point of this dissertation is not to argue for Kant's conception of persons as grounded in autonomy. This project focuses rather on Kant's arguments that respect is grounded in humanity or human nature. This general perspective of respect for persons is the only defensible understanding of the value of human beings, as persons, and of human life as possessing the dignity that is commensurate with the goals of medicine. The claim I will argue for is that within the practice and domain of medicine, all patients are persons and are deserving of respect.

Central to this idea is that patients as persons have a distinctive moral status and physicians have special categorical obligations to regard and treat them in ways that are constrained by certain inviolable limits. These limits require that both the ends chosen and the means by which they are to be achieved should not violate the duties of respect to oneself (qua physician) or to one's patients (qua persons). From this rudimentary understanding it is my intention to focus these concepts and their entailments upon medicine and, in particular, upon the relationship of patients with their physicians.

Thus the concept of person plays an essential justificatory role in bioethics. Nevertheless, some writers in bioethics have argued that we ought not to use the term ‘person’ to resolve difficult issues, since it is so inescapably normative and its use hides underlying values. I counter this argument with the claim that the term is not only useful, but also unavoidable in medical ethical discourse and furthermore its normative (evaluative) characteristics reveal that it is a thick concept that defies simple descriptive definition.

It must be admitted, however, that in the general vernacular, person is loosely understood and has fuzzy boundaries. This arises partially because it applies to beings that come gradually into existence, grow, develop and mature and then cease to exist. Furthermore this growth and developmental process does not occur in an orderly or predictable manner. It occurs in fits and starts, rises and falls, and maturation occurs at different points in different people’s lives and for some persons not at all. Users of the term “person” can clearly identify cases outside the scope of the term, but the rules which determine whether particular cases are in or out are vague at best. The skepticism concerning the employment of this concept in bioethics, therefore, does contain an important truth.

Critics (myself included) correctly point out that it is not fruitful to concentrate debates in bioethics on the analysis of the concept of personhood *per se*. I think this is right for two reasons. First, since person is a thick concept, which Logi Gunnarsson pointed out in 2008, and has elements that are both descriptive and evaluative, this concept simply cannot be analyzed into purely descriptive conditions for its application. Second, a premature emphasis on the concept of personhood may distract from the crucial point for medicine that all patients, as persons, **deserve respect** (“The Great Apes and the Severely Disabled: Moral Status and Thick Evaluative Concepts,” *Ethical Theory and Moral Practice* 11 (3): 305 – 326).

In medicine, however, it is not and cannot be the case that persons *qua* persons of necessity must also meet the criteria of being moral agents and responsible for their actions. Patients are moral persons, regardless of the current status of their functional qualification as moral agents. Injuring or

failing to help a person is morally wrong in a way that similar actions toward other kinds of entities are not, regardless of whether this person is a young child, a schizophrenic, a criminal or a patient suffering from Alzheimer's dementia. In other words, because of the unique vulnerability of patients by virtue of the nature of illness and disease, the concept of the patient as person (as introduced by Paul Ramsey) cannot be understood as synonymous with the patient as responsible moral agent.

Bioethical discussions of rights generally pertain to the rights of persons (e.g., The Universal Declaration of Human Rights 1948). The vague but frequently invoked bioethical concept of "dignity" also seems closely related to personhood and has been defined as "the presumption that one is a person whose actions, thoughts and concerns are worthy of intrinsic respect" (Nuffield Council on Bioethics 2002). It is the moral patient aspect of personhood, rather than the moral agent aspect, that has been the focus of my research and of this dissertation. From a normative (rather than descriptive) standpoint, the concept of person in medicine must be attributable to all who present themselves as patients and this differentiation needs further elaboration and defense. The reason that this is so (and the fact that this distinction pertains to medicine more powerfully than in any other 'ethical tradition') is that the 'practice' of medicine often involves persons who are unable to be categorized as moral agents (at least at the moment of their medical need).

Physicians do not and need not deliberate over the status of moral agency of a person who presents to an emergency room unconscious, delirious, writhing in pain or behaving irrationally. All such persons and all patients who present seeking medical care, regardless of their functional constraints inhibiting, diminishing or impairing their full moral agency are still deserving of 'respect as persons' and possessors of human dignity.

The functional ability to exhibit rational, moral autonomy and competence in self-determining decision-making cannot, from the standpoint of medicine, be a determinant or requirement for 'personhood.' For this reason (among others) I will argue that there is a set of moral obligations and duties toward all persons that is intrinsic to medical practice and medical ethics and is essential to the

aims and purposes it espouses. This is not to say that these moral duties are relevant only to medicine, but it is to say that in each aspect of our lives, we may not, of necessity, be subject to the same responsibilities, duties and obligations toward others that physicians owe to the patients they treat and provide healthcare for. Physicians, *qua* physicians, have (and have accepted and embraced) a higher level of responsibility and accountability to all persons and must conceive of all human beings, by virtue of their humanity, as persons.

Many of the most contentious issues in bioethics arise in cases involving entities regarded as persons by some and non-persons by others. In such cases it is unclear whether or how to apply the four principles of Beauchamp and Childress. Examples come from both ends of the human lifespan and from ethical issues involving nonhuman animals as well. In point of fact, people do not see personhood, especially their own and that of close friends or family members, in terms of necessary and sufficient conditions that if absent negate existence. A person has a history and a social place in the moral community not permitting it to suffer and die (or suffer and be born) instantly, even if biological birth or death occurs instantly.

Claims about personhood are likely intrinsically undecidable in key borderline cases. Consequently, the pragmatic maxim of C.S Peirce that all difference in meaning makes a difference in practice is especially true in clinical contexts, where unsubstantiated (and perhaps unable to be substantiated) distinctions are unwelcome. The medical practice of caring for people will be potentially different in practical, observable ways, based upon different uses or relative weighting of the criteria and features of personhood.

We are people because of who and how we are, as in Kant's kingdom of ends, not because of what we do or because we meet standards that would exclude others. Furthermore, person might mean something different to doctors than it does to patients. Patients who are the sickest or most disabled suffer the greatest impairment to their self-determination or autonomy. For this reason, any view of personhood as rational needs to be supplemented with a pragmatic and social or communal view in

which physicians sometimes take responsibility for their patients without negating personhood. In such clinical situations, it is too easy for physicians to depersonalize patients.

In sum, personhood is a foundational concept in ethics, including both pure philosophical ethics and the applied field of bioethics. Nevertheless, the defining criteria for personhood have been elusive. The existence of persons in the world seems intuitively obvious, but our intuitions are much less clear on what makes an entity a person. It is not at all obvious what the right subset or hierarchy of traits (such as intelligence, language or the ability to represent the mental states of others) is, nor how well or fully an individual must possess any of these potentially graded abilities. We are left setting criteria that feel, in Daniel Dennett's words, "arbitrary." In effect, personhood is a concept that everyone feels they understand, but no one can satisfactorily define.

In clinical practice, the patient, referred to by the attending physician (especially if on rounds with student doctors and nurses) as the decubitus ulcer in room 212, may herself come to wonder if she is a person in fact or only in fiction. The damage insensitive physicians can do to the patient's self-esteem is exacerbated when the "care-givers" fail to even speak with the patient and converse among themselves about the prognosis, diagnosis and pathogenesis of the patient's condition. Attention to the process of 'living personhood' and to the process of 'recognizing patients as persons' is more important in medicine than philosophers' abstract faculties such as rationality and the capacity for verbal communication. When asked what they valued most about being a person, both patients and doctors most commonly respond, "being seen as the particular individual that I am and being treated respectfully."

Francis Peabody back in the 1940's, complained that new doctors relied too much on science and had lost "an interest in humanity... The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine – or, to put it more bluntly, they are too 'scientific' and do not know how to take care of patients." The changes in the character of medicine that Peabody

lamented have continued such that medicine has become “far more interested in diseases than the people who suffer from them.”

From Peabody in the 40’s, my research lead me to the brilliant work of Richard H. Blum, a research psychologist who spent more than five years doing a thorough analysis of the patient-physician relation on a full-time retainer for the California Medical Association. In his 1960 book, *The Management of the Doctor-Patient Relationship*, he addressed a series of questions and proceeded to answer them with documented research. His conclusion is illuminating:

Here then are the bitter fruits of breakdowns in the doctor-patient relationship: treatment failures, patients quitting their doctor, the majority of citizens critical of doctors and medical care, patients not paying doctors' fees, patients turning to nonmedical healers, and fast-rising rates of malpractice suits. These symptoms arise when the doctor is unable to manage the relationship successfully.

A good doctor-patient relationship is central to satisfactory medical practice, both from the standpoint of the doctor and of the patient. Most of the bedeviling problems which arise to plague the relationship can be controlled through proper treatment. That the way the doctor manages the relationship with patients is a crucial factor in practice has been demonstrated through research.

Doctors Menzel, Coleman, and Katz studied how doctors practiced medicine and how satisfied the doctors were with their practice (“Dimensions Of Being 'Modern' In Medical Practice,” *J. Chronic Diseases* 9:20-40, 1959). They found that “the question of the doctor-patient relationship at the broad level. . . is the most pervasive of all the issues examined; the one that is most likely to color the entire atmosphere in which the doctor's work is carried on” (Blum, R.: 1960, *The Management of the Doctor-Patient Relationship*, McGraw-Hill, New York).

Why should the doctor be concerned about the doctor-patient relationship? This relationship plays a crucial role in determining the successful practice of medicine. Why should the doctor worry about preventing patient dissatisfaction? Patient dissatisfaction leads to therapeutic failures and to a host of unpleasant personal consequences for both doctor and patient. Of particular concern today is the fact that patient dissatisfaction with doctors is growing dangerously greater. The basic requirement for a good doctor-patient relationship is mutual respect on the part of two mature people, each of whom acts with understanding and sympathy for the human efforts, tribulations, and limitations of the other. There are a number of signs and symptoms which show that the doctor-patient relationship is in dire need of strengthening: I argue, along with Peabody and Blum, that this relationship requires a moral grounding in Respect for Patients as Persons. In his 1970 book, *The Patient As Person*, Paul Ramsey

(who will receive an in depth treatment in this dissertation, especially in chapter 5) first developed the conception of patients as persons, though he never specifically developed, nor made explicit reference to, the concept of respect.

A large percentage of all patients criticize the way doctors conduct the doctor-patient relationship. They say modern doctors lack human warmth. Patients may be satisfied with the quality of medical care, but they dislike the way it is given. Most patients criticize the personal care and attention which they get in hospitals and, in fact, have a "virulent dislike for the care they had received" in hospitals. Half of all patients have at one time or another quit their doctor because they were dissatisfied with the doctor. Their anger arises from a breakdown in the doctor-patient relationship.

Medical malpractice suits are ever more frequent. Studies have shown that the malpractice suit itself is a dramatic symptom of the breakdown in the doctor-patient relationship. A malpractice suit often occurs without any actual medical malpractice. It undoubtedly reflects patient dissatisfaction with the doctor and this is far more likely to be at a personal level than one of questioning medical expertise.

This dissertation is an exposition of respect for persons as the moral grounding of the principles of human relations with suggestions for the application of these principles to medical care. Focus upon 'respect for persons' in medical ethics and bioethics, as the foundational basis of morality in medicine, will require 'respect for persons' to be robustly understood with the emphasis being upon respect. Respect is not only a duty, but it is also an ethical orientation and moral disposition toward patients as persons in the morally suffused universe of medical practice and research. I use the term universe because this orientation must be capable of being universally understood and accepted if it is to function as the ground of the moral principles upon which medicine establishes its claim to being, in Pellegrino's words, "a moral community."

Summary of Chapter One

I am proposing that medicine re-adopt the principle of respect for persons and that it replace the currently operative principle in medical ethics of ‘respect for autonomy,’ as first proposed by Tom Beauchamp and James Childress in *Principles of Biomedical Ethics* (1979). Grounding medicine in respect for persons will result in a practical, yet theoretically sound way of conceptualizing autonomy as a mid-level moral and relational principle, located among a wider range of moral values as commensurable secondary (*pro tanto*) principles under the umbrella of respect for persons. This re-adoption of respect for persons as primary and foundational (along the lines of its characterization in *The Belmont Report*) should be acceptable to many philosophers and bioethicists who may have previously rejected Kant and Kantianism altogether.

The concept of ‘respect’ itself is equally in need of re-examination and re-definition in medical ethics if we are to accept it as specifying the obligations (and moral commitments) of physicians to their patients in both medical practice and in research upon human participants. Moral respect for patients as persons ought to be embraced by all rationally reflective persons within the domain of medicine. Autonomy-based theories, some opponents argue, assume a formal equality of moral agents in relevant respects that fails to consider what many view as the most pervasive feature of illness: vulnerability. Once the imbalance is recognized, they assert, attempts to subsume questions of power under the rubric of autonomy can be seen as obscuring the role different forms of power (held by patients and physicians) actually play in the clinical setting.

It is for this reason that the foundational principle I am espousing is not autonomy, but respect for persons, which locates the moral equality of human beings, regardless of functional autonomy or power, in their humanity. This claim requires (and will receive) development, but preliminarily, it is the claim that human beings have a higher moral status and, therefore, are deserving of greater respect than other highly developed primates.

To be clear, this differential is not, as I conceive it, grounded in rationality (which is shared by many other animal species) nor established simply by virtue of being a member of the species homo sapiens (which amounts to speciesism). Humans require the care of other humans and, so long as they relate to other humans in even minimally human terms, they possess moral status higher than the most developed non-human animals. The line of argumentation to support this will be forthcoming and is based upon work done by Logi Gunnarsson.

Showing respect for persons, as I will use it in the context of medicine and medical practice, is initially the foundation for a moral system that recognizes that all human persons are deserving of respect, regardless of their functional level of autonomy or moral agency. This viewpoint does not depend upon the person having a functionally good will or functional moral autonomy. It is a system for interpersonal interaction in which respect boils down to the moral obligations that one human person has toward another and, in the universalized sense, toward all human persons. In the course of this dissertation, I will offer proposed answers to questions surrounding the nature of the obligations that satisfy the duty of respect and how they comport with the notion that all human persons have a dignity within the tradition and the practice of medicine.

This abstract notion of respect will be developed practically as caring, which I will argue centers a patient-centered model of the therapeutic relationship squarely on the patient. Caring particularizes the respect owed to this individual patient that the broader concept of respect for persons universalizes to all patients.

Respect for persons is argued to be compatible with a wide variety of moral theories that are often themselves mutually incompatible (at least superficially). My thesis is that ‘respect for persons’ is a universally acceptable and minimally controversial commitment of all moral theories and can be understood as the common unifying thread that runs through all non-relativistic moral theories that are practically applicable to the practice of medicine. If I can convincingly show this to be so, then my claim for this concept to ground the ethics of medicine gains plausibility. It would thus deserve a more

critical evaluation as a ‘foundational’ concept that has the potential to transcend moral and cultural pluralism.

Many bioethicists and moral philosophers insist upon the irreconcilable lack of moral agreement that must inevitably result in our acceptance of a deep seated and incommensurable pluralism of moral values. This leads many of them to accept one form or another of moral relativism or skepticism. The practical approach I am advocating for medicine claims that regardless of personal philosophy, politics, religion or life stance, we should (as morally sensitive and reflective rational beings) find little if any difficulty in committing ourselves to the principle of caring respect and to the principles grounded in it. Moreover, this orientation or disposition toward patients as persons encompasses most (if not all) of the moral issues that arise in both health care practice, delivery and policy.

I analyze this key concept of respect and provide evidence that it is both a moral disposition (as a value) and a moral principle (providing rational justification) at the core of moral medical practice and entails physician duties that are (in Kant’s words) also virtues. I develop the entailments of this moral perspective of respect for persons along Kantian lines and rely heavily (but not unequivocally) upon Kant’s categorical imperative from the *Groundwork for the Metaphysics of Morals* as well as the “Doctrine of Virtue” from Kant’s *Metaphysics of Morals* and his *Critique of Practical Reason*. The obligations that emerge from understanding patients as ends-in-themselves (and never merely as means), as Kant’s formula of humanity enjoins, provides us with sound reasons and accurate guidance in treating patients with caring respect.

This dissertation strives to develop a plausible definition of respect for persons as not merely an abstract moral principle, but as an empirically verifiable phenomenon in the practical domain of physician action in the practice of medicine. Respect for persons grounds a moral system that, at least as I am proposing it for medicine, places respect for persons as the moral ground of the obligations and

caring attitude that each physician must have toward self, patients, other members of the health-care delivery team and toward all humanity.

It is also about the ground level practice of medicine, where doctors and patients interact. The therapeutic encounter occurs for no other reason than for skilled and knowledgeable physicians to meet patients in their hour of need with the commitment to both treat their illness and respect their humanity. To accomplish this, physicians must be both capable of providing quality medical care and also be caringly disposed toward their patients. Respect serves not only as a motive for caring but also as a brake that constrains physicians from over-stepping their mandate and trampling the very humanity and personhood they are committed to promote.

Respect for persons is argued to be capable of justifying the substantive and universalizable moral norms of health care ethics. I propose that the duties and obligations of physicians to patients that are entailed by having reverential (moral) respect for each patient establish this relationship to be one of covenant and I develop this form of doctor-patient interrelation in depth.

Summary of Chapter Two

Chapter Two is an exploration of Kant's ethics with the goal of revealing how Kant's ethical thought is particularly helpful in the ethics of medicine and in understanding the moral entailments of the social interrelation of doctor and patient. As I read him, Kant's ethics is far from the rigid, formalistic, atomistic and individualistic theory that has been glibly accepted as the "received view." In order to make liberal use of my reading of Kant, I must dispel some of the more egregious misperceptions of Kant's moral commitments and theory. Chapter Two is devoted to reading Kant's ideas on the moral law, self-legislation and the social, relational and moral aspects of autonomy with a refreshed and renewed appreciation. My focus goes beyond Kant's *Groundwork* and places more emphasis upon the Doctrine of Virtue, his *Lectures on Ethics* and his second *Critique*. The recent pioneering work by Allen Wood in *Kant's Ethical Thought* (1999) and *Kantian Ethics* (2008) has

developed and elucidated an alternative reading of Kant from the “received view.” His work synchronizes well with what I had been seeking to establish about the socially situated Kantian patient as person. Patients do not present to their doctor as atomistic individuals, but as persons contextually bound to many other persons by relationships of love, trust, and/or mutual respect and with whom he must interact. The very fabric of society and social interaction is premised upon a reciprocal respect for one another as persons and the duties this entails. This understanding can be translated into the language and practice of medicine and this is the aim of my dissertation. Throughout this chapter I maintain my emphasis upon medical practice. This drives me to restrict the discussion of Kant’s ethical theory within the practical realm of applied medical ethics, though it is often difficult to not speak in more general terms regarding Kant’s ethical theory as it applies to all segments of human interaction.

My intention, however, is not Kant exegesis and some of the conclusions for the physician-patient relationship that I draw from my reading of Kant may be better described as Kant inspired or neo-Kantian rather than as direct interpretations of Kant’s own thinking and writing. My reading of Kant is in keeping with my own ideas of where his depth of thought helps us in medicine to find universal and objective grounds for the principles that, by virtue of the nature of medical practice, are essential.

In its simplest form, respect for persons maintains that human beings have intrinsic and unconditional moral worth and should always be treated as if there is nothing of greater value than they are. The Doctrine of Virtue (from the *Metaphysics of Morals*) affirms the broad scope of the Formula of Humanity (from the *Groundwork*) in this passage:

Every human being has a legitimate claim to respect from his fellow human beings and is in turn bound to respect every other. Humanity itself is a dignity; for a human being cannot be used merely as a means by any human being (either by others or even by himself) but must always be used at the same time as an end . . . [Every human being] is under obligation to acknowledge, in a practical way, the dignity of humanity in every other human being. Hence there rests on him a duty regarding the respect that must be shown to every other human being (*MoM*, 462).

Kant’s viewpoint arose from his acknowledgement that neither notion (humanity or person) was likely

to attain autonomy in the fullness of that concept, due to the fallibility of the species. Nonetheless, all such beings possess the capacity for rationality and autonomy and it is this capacity that Kant believes distinguishes human beings as persons, regardless of whether they are capable of meeting more exacting criteria or not.

This chapter develops my understanding of Kant's commitment to the particularity of persons and the recognition of the many barriers to autonomy with which all human beings must contend, especially during illness, pain or distress. These constraints upon the functional autonomy of patients reinforce the stringent duties exacted by respect in principles such as truth telling, loyalty, privacy, and confidentiality. These are values that medical practice aims to acknowledge and protect by interacting respectfully with people. This patient-centered ethics of medicine serves as a check upon the physician's temptation, in her zeal, to act in the 'best interest' of her patient with a paternalistic form of beneficence. Respect for this patient as a person re-orientes her approach toward respect for the patient as an end-in-himself. This guides her to inform and educate her patient and foster and promote his capacity for functional autonomous involvement in his own medical care and decision-making. This mutually respectful relationship as partners identifies the importance of the physician to the optimal care of the patient, while recognizing the centrality of the patient and his autonomous choosing, in so far as is possible.

Summary of Chapter Three

Chapter Three is devoted to developing the principle of respect for persons in medicine as it was first pressed into the service of medical ethics in the Belmont Report. Respect for persons as introduced by Kant and adapted to medicine by Ramsey in *The Patient as Person* (1970) was adopted as the first principle of medicine in "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research," first published in the Federal Register on April 18, 1979.

This notion differs from contemporary ‘respect for autonomy’ in several important aspects. Respect for persons subsumes both the negative contemporary notion of respect for patient autonomy (as non-interference with the patient’s ability and authority to make decisions for herself) and also delineates a positive physician duty to respect, support, care for and protect those persons with diminished capacity or status as “competent” or “autonomous” choosers. Thus respect for persons is not the kind of respect that requires (or is only applicable to) functionally autonomous patients.

The Belmont authors concluded that respect for persons was the first and foremost of three principles for medical ethics (the other two being beneficence and justice). Additionally, for the commissioners, all human beings qualified as persons without any specific cognitive or perceptual requirements (thus including children, the comatose and those with mental impairments). This chapter builds upon the brief discussion in Chapter One regarding excluding no patient or research subject from the respect and dignity of being a person. It is interesting to examine physician obligations, with regard to the modes of education, therapy and protection that patients deserve, based upon the distinction between those who possess functional autonomy and those who do not.

The philosophy of medicine, while grounded by the over-arching moral disposition of respect, must ultimately be based in the clinical practice of medicine. To be practically relevant, the attitudes, principles and virtues that are grounded in respect are instrumental in bringing about the goals of medicine which are squarely centered upon the patient. Medicine’s end is to seek the good of the persons in need of professional medical care and expertise while understanding them always as ends in themselves. Physician recognition of patients as ends is to see them as persons with their own notions of what constitutes the good (or at least the best of the available options) for themselves. This caveat seeks to prevent physician beneficence from venturing into paternalism, thus treating patients as means to the doctor’s own ends (even if well-intentioned).

Because medicine deals with humans in vulnerable states and physicians confront the most personal and intimate aspects of the lives of these other persons, a relationship of trust is needed in

order to gain access to important but often sensitive information. A doctor is permitted, by the trusting patient, to explore this “inner life” while guarding its confidentiality. The good physician welcomes and needs the patient’s trust in order to accomplish the optimal outcome for the patient. The physician is judged by the degree to which the good of the person served is attained by her practical activities and by the caring attitude and respectful treatment she provides her patient.

Summary of Chapter Four

Chapter Four will then provide a critique of the adverse effect Beauchamp and Childress, in their text the following year, introduced into the lexicon of medical ethics in replacing ‘respect for persons’ with ‘respect for autonomy’ as the object of our respect. I object to this maneuver and argue that it fundamentally changes the object of our respect from persons to the principle of autonomy. This shift of emphasis from persons to autonomy as the object of respect is partially explanatory of the progressive shift in emphasis towards patients’ rights and the demand for the patient’s autonomous right to make medical decisions regarding his own health without interference, manipulation or coercion. The principle of ‘respect for autonomy’ has put physicians on the defensive and has heightened patient suspicion of physician’s motivations. These problems, which began in conceptual misunderstanding, have resulted in increasing tensions in medical practice and mistrust of doctors, while inadvertently empowering (or emboldening) patients.

The impact of this attitude of control coupled with the loss of trust in doctors has lead physicians, in many instances, to relinquish decision-making to their patients, often without recognizing the need for and obligation to provide the necessary guidance for patients to make these decisions well. In fact, it is not uncommon for such guidance to be reduced to the celebrated doctrine of informed consent, validated by a ‘legal’ document signed by the patient and one that Onora O’Neill has famously described as being, at best, the right of ‘informed refusal.’

Both the physician and the patient are losers due to the strains placed upon their relationship, but the patient is the biggest loser. The distance that has developed between doctor and patient now interferes with the patient receiving the caring benefit of a mutually respectful relationship. Beauchamp and Childress additionally set the bar for functional patient autonomy too high for the majority of patients to consistently achieve under the constraints placed upon their autonomy as a result of illness. This impairs the inter-personal process of deliberation in which the patient's autonomy ought to be promoted by the doctor's knowledge, expertise and caring support. This estrangement of patients from doctors might be described, as Veatch has done, as "Patient-Heal Thyself."

This erosion of trust, while only partially of medicine's creation through prior paternalistic practices, has nonetheless resulted in an environment of distrust that is evident from the dramatic increase in malpractice claims and the litigious climate in which physicians currently practice. The near epidemic proportion litigation has reached in the United States is symptomatic of the strains to which the doctor-patient relationship is currently subjected. In attempting to rectify the erosion of trust that has befallen the doctor-patient relationship, we need to take a different approach than taken by our medical ethicist predecessors.

Rather than starting with the question of how patient autonomy and physician paternalism should be balanced in the physician-patient relationship, the starting point seeks to answer the simple question, "How should physicians relate to, regard and respect their patients?" Approaching the issue in this way allows the relationship to start from a non-adversarial and more productive position and opens the door to dealing with many other issues from a relational point of view rather than viewing patients from an individualistic, "rights-based" contractual agreement fostered by a misdirected "respect" for "the principle of patient autonomy." It is the person who is respected, while his autonomy should be fostered and promoted. Autonomy, as a principle, should not be an object of our respect. The physician who develops a caring relationship with her patients will know what it means to

have respect for them as persons such that questions of how to deal with issues like truth-telling, confidentiality, and paternalism become intuitive, natural and second-nature.

The need for grounding the ethics of medicine in respect for persons arises partly in response to my wariness of the stance of Beauchamp and Childress in describing their principled approach to bioethics as, in a strict sense, a ‘theory’ (2009, p. 333). Their understanding of the four operative principles (respect for autonomy, beneficence, nonmaleficence and justice) for bioethics are offered as independent, mutually exclusive, irreducible principles that have *prima facie* standing such that each may supersede any other. I will develop their reasoning and the problems with their approach and offer the potential corrective of the foundational notion of respect for persons from which these principles can be understood as emerging.

I do think it is appropriate to describe their work as broadly theoretical in its commitment to the analysis, defense and application of general moral principles. In fact, no work of moral theorizing has had a greater influence on health care ethics over the past 35 years than the successive editions of their *Principles of Biomedical Ethics*, first appearing in 1979 and, at the time of this writing, in its ninth revision. It is consequently of significant interest that Beauchamp wrote in 2004 of the gradually reduced place for philosophical ethical theory in bioethics. After describing its initial role in the middle of the nineteen-seventies he writes:

The literature of an interdisciplinary bioethics has shifted in the last 15 years or so toward greater levels of comfort with law, policy studies, empirical studies, standards of practice, government guidelines, and international guidelines—progressively marginalizing the role of ethical theory. Moral philosophers have not convinced the interdisciplinary audience in bioethics, or even themselves, that ethical theory is foundational to the field and determinative in practice (Beauchamp 2004, p.216).

So marked was this shift, in his assessment, that a real question arose for him of whether ethical theory in the future would have any significant place in bioethics at all. These pioneering bioethicists, in their attempt to please and meet the needs of all ethically minded medical thinkers, ended up espousing an anti-theory that is satisfactory to very few. My goal, is to restore the ethical theory that is foundational to the field, namely that grounded in respect for persons.

Summary of Chapter Five

In the way I articulate the covenantal model as one of trust in Chapter Five, it will become apparent that the care based duties and virtues of this method of interrelating with patients can manifest themselves and be exhibited differently in different contextual settings of patient independence and functionality: from the comatose and other highly dependent patients to the highly educated, intellectual and self-directed. In this model, any practicing physician with direct patient contact could develop caring relationships with all of those patients.

The conception of covenant as well as the previously proposed models for the patient-physician relation in the literature of medical ethics will also be developed in detail in Chapter Five and the reasons that favor covenant will be presented. The personhood of patients provides us with reasons why we should adopt respect as a guide toward acting morally with, for and on behalf of patients. The literature in health care ethics (specifically, clinical ethics) focuses individually on issues like truth-telling, disclosure of medical error, dealing with demands for inappropriate treatment, effective physician-patient communication, and so on. Patient-centered care places emphasis upon the whole person, including the social context of his life, relationships, beliefs, values and commitments. The doctor-patient relation, understood as a covenant of trust, is able to provide physicians with guidance on all of these issues.

This moral disposition toward persons stresses the distinction between curing and caring and the appropriateness of continuing to care when cure becomes impossible. Within the physician-patient relation, respect entails, among other things, the pledge of loyalty (whether explicitly stated or not). This pledge is a commitment to stay with the patient in time of need and has been described by W.D. Ross as fidelity. It is one of the many mid-level moral principles that I contend are grounded in caring respect.

I am also making the argument that an understanding of respect for persons as a moral concept is able to rescue the therapeutic relationship from being a purely legal or contractual one. Through a covenant with their patients, doctors should be able to restore patient trust and improve the quality of healthcare. Caring respect lays the proper groundwork for equipping students with the necessary skill-set and the philosophical underpinnings for developing trusting doctor-patient relationships. Covenants that are patient-centered and based in caring respect are capable of providing non-paternalistic guidance to patients in medical decision-making. Respect for persons is understood as entailing obligations which include the duty to educate, empower, develop and promote the ability of patients to make informed decisions, thereby promoting the exercise of their autonomy.

The covenant model in the work of Paul Ramsey and William F. May, as well as the recognition of respect as a ‘super-principle as characterized by Robert Veatch, will be employed to address the short-comings of contemporary health care practice. Ramsey voiced a concern for the vulnerable in the face of bureaucratic and utilitarian tendencies. May was deeply concerned with the evasion and denial of death that puts physicians at a moral distance from their patients. Veatch expressed concern for preservation of basic moral norms among strangers and in the face of the power of medicine.

The covenantal model of the physician-patient relationship, as I develop it, marks a significant improvement over the previously offered doctor-patient models in achieving this goal. One significant advantage it has over many of the previous models is that it begins with a more basic and fundamental characterization of the physician commitment to the patient as the starting point. Rather than beginning as a contractual arrangement, a fiduciary duty or a priestly or parental relationship, the covenantal model begins in the underlying respect the physician holds for the patient as a person, antecedent to her concern for the patient’s illness. This respect manifests itself in the physician’s attitude and behavior before a diagnosis has even been made. Even the deliberative model (of

Emmanuel and Emmanuel), which is relationship-centered, places its focus upon the relationship itself, rather than squarely upon the patient.

It would be unfortunate, in my judgment, if the relationship between physician and patient were reduced to a commercial contract. Something intangible, but significantly valuable, would be omitted. First, the notion of contract suppresses and significantly shifts the mindset away from caring and care giving. It reduces, if not eliminates, the impetus to see or understand the patient as a whole person and in the end is destructive to the physician's perceived need for respecting her patients as persons. It allows physicians to treat patients as diseases so long as they are successful at treating or curing the illness.

Consider also the predominance of chronic diseases that are treated, but never cured. These diseases require on-going care and great investments of personal and interpersonal human capital that require understanding, empathy, commitment and trust. Contracts do not assure that any of these needs are met, nor is there an obligation to even acknowledge any responsibility, unless it was spelled out in the terms of the agreement.

Contract and covenant both include an exchange and an agreement between parties. But, in spirit, contract and covenant are quite different. Contracts are external; covenants are internal to the parties involved. Contracts are agreed upon and signed to be expediently discharged, while covenants have an implicit promissory nature that engenders trust and grows relationships between persons. This nourishes rather than limits human dignity, respect, responsibility and ultimately autonomy.

Confining the ethical issues at stake in this project to those that directly affect the doctor-patient relationship is done in full recognition that this is but one segment of a plethora of ethical issues in medicine. It is defensible in so far as this dissertation is centered upon the conception of respect for persons in medicine and the patient-doctor relation, i.e. how it might be understood in ways beneficial to both patients and doctors. Showing respect for persons in caring for contemporary patients requires a significant knowledge of the moral aspects of providing medical care and an

understanding of the inherent moral dimension of relationships. From a patient-centered (covenantal) perspective, the therapeutic relationship (as an alliance forged between patient and physician) can be seen clearly as entailing moral duties, not simply professional ones.

Summary of Chapter Six

The concept of moral respect has not been adequately represented in practically meaningful terms from a healthcare practitioner's perspective in the literature of medical ethics. My discussion of caring respect in Chapter Six takes an important step in that direction. Caring and caringness will be developed as the practical exemplification of respect for persons. I have synthesized care and respect as 'caring respect' in order to capture the sentiment of respect that characterizes this relationship as one of covenant. Caring as a disposition and caringness as a virtue are useful concepts to emphasize that respect is a matter of valuing the relationship and the patient in a special way.

While respect and care may appear to be very different notions and to occupy different places in the moral scheme, I want to propose the view that recognizes (and builds upon) the similarity between the philosophical discussion of respect by Kant in "The Doctrine of Virtue" and various accounts of care as succinctly put forth by Milton Mayeroff in *On Caring* and John Kultgen in *Autonomy and Intervention*. I argue that there is a conception of respect for persons that incorporates the most characteristic elements of the care perspective and a strong conception of caring that interpersonally embraces respect for others. Without the constraints of respect, caring risks devolving into paternalism, with net negative consequences. Conversely, without the relational and inter-subjective communion of the caring provider and the cared-for recipient, respect for persons risks an arms length distancing, out of a mistaken respect for autonomy as non-interference.

Patient-centeredness is generally regarded as an important feature of high quality patient care, but little effort has been devoted to grounding patient-centeredness in an explicitly moral concept. Some have contrasted patient-centered care with care that is directed primarily at combating disease.

Illness-oriented medicine, as such, is impersonal rather than relational. Still others have identified medical paternalism as the opposite of patient-centeredness. Paternalism fails to acknowledge the preferences, needs, and values of individual patients, thus failing to show proper respect for the patient as a person or recognition of the patient's autonomy. On other accounts, patient-centeredness is seen in contrast to a purely technical or biomedical model of care, where the physician is seen merely as the technician who delivers interventions and performs procedures. Some refer to this as the engineering model in which the physician's abilities and skills are commodities and the person of the physician is disregarded. Patient-centeredness, grounded in respect for persons functionally understood as 'caring' in a broad and robust sense, can be envisioned as a strategy to correct for all of these negative tendencies in medical practice simultaneously.

Unfortunately, the development of a physician's humanistic and caring attitude (so often needed in contemporary patient interactions) is not as valued in the current process of medical education as is the development of a physician's scientific knowledge. What is often not made clear to medical students is that scientific knowledge is also not irrefutable, but contingent, and the nature of scientific progress lies in identifying and correcting the errors of our forbears. Sadly, this emphasis in medical education all too often produces a doctor who sees himself as a scientist. The caring function is further eroded in institutional settings such as teaching hospitals, where the acuity of the medical conditions coupled with the short term relationships with patients in tertiary care settings breeds the impersonalization, if not depersonalization, of the patient and a detached and distanced attitude in residents and students, which carries over into their medical practices.

The conception of caring respect, as I interpret and develop it, views caring for a person as a way of respecting her. Care, in my conception, is one kind of respect rather than a disparate rival for our moral allegiance and demands the recognition of the person as a whole, not merely as an illness or a diseased body part. Physicians owe caring respect to all persons who are their patients, not just to their loved ones and friends as many proponents of the care perspective espouse. I believe that in the

union of respect and care, we can find the ethical resources for justifying the more integrative approach of covenant to moral medicine and a moral relationship between the patient and her doctor that will help in overcoming this trend toward “scientific medicine.”

Covenant personalizes physician focus upon the patient, developing in physicians the internal motivation of caring respect as a moral feeling oriented towards patients and calling for the doctor to recognize the inherent constraints upon patient’s functional autonomy. The psychological effects of illness and the knowledge gap between patient and doctor result in a natural dependency of the patient, at least to some extent, upon the physician. Covenant recognizes this and prompts the doctor to make a concerted effort to close this gap

A moral philosophy of medicine, toward which this project strives, should consist in grounding the normative basis of medical practice itself, not just the normative evaluation of specific ethical activities. These norms are binding on physicians, even if physicians choose or wish not to be bound by them. ‘Care,’ ‘Caring’ and ‘Caring Respect’ will be developed in contradistinction to the ethic of care model espoused by Carol Gilligan, Martha Nussbaum and Robin Dillon and to the ethic of caring justice model espoused by Lawrence Blum.

Within the context of the three major schools of ethical thought, person-centeredness can be understood in three similar, yet distinctly different, ways based upon the concepts of being grounded in deontological, consequentialist or virtue-based theory. Deontological theory emphasizes how patient-centered care reflects the ethical norms inherent in medicine, such as respect for persons and shared decision-making. Consequentialist moral theory focuses on the positive outcomes of providing patient-centered care. Virtue-based theory highlights the importance of developing patient-centered attitudes and traits (virtues), which in turn influence physicians’ behaviors toward their patients.

Perhaps what is most remarkable is that these quite different ethical approaches lead to essentially the same answer, namely that the old notion that the patient comes first is a morally desirable feature of all physician–patient interaction. Using consequentialist reasoning, patient-

centered care is morally required based upon the empirical evidence that it leads to improved outcomes for patients. Using deontological reasoning, patient-centeredness may be justified because many of the features of patient-centered care align with the ethical norms and principles emergent from the duty to treat all persons as ends-in-themselves. Finally, patient-centeredness also encompasses an element of virtue-based ethics in its insistence that physicians develop their ‘character.’ Character, in this context, is understood as the moral capacity for self-reflection and the desire to better understand and adopt those attitudes and dispositions that positively influence their own behaviors and inure to the benefit of their patients.

Patient-centered care, grounded in caring respect, is equally applicable to patients that the physician knows and to patients who are strangers. The universality of respect can be particularized through the moral feelings of empathy and through the virtuous nature of caring. A further advantage of basing the relation in caring respect is that it is applicable to the wide range of physician-patient relationships that must be encompassed under the umbrella of ‘care,’ (due to the wide range of clinical situations encountered in medical practice). The covenantal model, in its patient centeredness, meets the patient where he is (cognitively, emotionally and psychologically). Covenant is thus able to encompass patient encounters with all patients, whether “autonomous” or “non-autonomous,” treating them with respect and according them the dignity of personhood.

Conclusion of Introduction

It is my intention to re-establish an ethical foundation upon which socio-political, multi-cultural and inter-disciplinary thinkers about medicine can find a common starting point. Medical practice requires a different ethical starting point than one that is grounded in abstract principles without a significant linkage to the actual moral needs of persons as patients. It must begin within the setting of providing care to persons who now find themselves in the unfamiliar role of patients with needs that compromise their independence. The recognition of this encourages a turn toward patient-

centered ethics that places the relationship, forged between care-giver and patient, at the center of ethical thinking. Caring respect for persons is not the end-point, but rather the starting point.

In medical decision-making, whether at the micro doctor-patient level or the macro societal one, particularities and specificities of given situations and issues require the latitude to respond appropriately from a broad range of perspectives. Caring respect provides medicine with not only a moral starting point, but also the ethical commitment to patients as persons specifically and to humanity generally. The contemporary move away from doctor-patient relationships of caring respect toward a depersonalization of the interaction between physician and patient is being fueled by the “system” we are developing in America (and in the western world). Doctors must learn to be internally motivated by respect to buck this trend and to essentially “take on corporate medicine” as advocates of their patients and all persons in need of healthcare. Furthermore, they must develop a caring spirit toward all patients that is not self-serving. If medical educators and physician mentors fail to inculcate these commitments in students and physicians in training, there will be little incentive for them to become involved in the lives of their patients at all.

This sad state of American medicine (once the envy of the civilized/developed world) needs to be addressed and the moment is now. Doctors, through a heightened awareness of the social breakdown in which they practice, must redouble their efforts to emphasize the moral commitments they have placed upon themselves in accepting the ‘call’ to medicine. Trust in medicine (which has been so deeply eroded) can only be re-established with the American people through physicians demonstrating that they are motivated to action by caring respect for patients and not by self-interest. The relational aspect of the covenantal model can be the medium for building relationships of trust with the public, one person at a time.

Respect is richer and more interesting than most prior accounts have given it credit for and it has significant and varied implications for clinical practice and research. In particular, there are important ways to respect autonomous participants beyond respecting autonomy, and duties of respect

exist toward non-autonomous participants that are defensible and are not limited to protection. I limit this discussion to patients that all medical practitioners would generally agree are persons or at least have the moral status ascribed to persons.

I want to isolate questions of respect for persons from questions about persons' moral status or moral worth. It is different to ask what it means to respect entities with a given moral worth than to ask what makes them respect-worthy. We cannot directly translate how to respect persons from descriptive definitions of personhood and its consequent moral status.

I wish to avoid getting mired in debates about personhood (though I am intrigued by the propositions of Gunnarsson and will devote more time and thought to that approach subsequently). Accounts of personhood may determine who deserves respect as persons (McMahan 2002), but most debate over respecting patients and research participants has little to do with assessing personhood or moral worth. We (as physicians and medical ethicists) rarely argue, for example, whether children or cognitively impaired adults have the moral worth of autonomous adults, but how to respect them is a topic of considerable debate, irrespective of their relative moral status.

Discussions of respect for persons marked by an attempt to distinguish persons from other entities create situations of potential contestation when such disagreement is not even germane to how such contested persons are to be respected, treated or cared for in medicine. Some respect-worthy features of persons are not unique to persons. Emotional attachment, for example, does not distinguish me from my cat, but respecting me may require regard for my emotional state and concerns. Respecting particular persons may require appreciation for properties not shared by all persons. In my estimation, autonomous agency is not necessary for personhood, but it must be respected in a very particular way in all those who are functionally autonomous.

Respect is frequently invoked as an integral aspect of ethics and professionalism in medicine—how good physicians ought to conduct themselves. Health care professionals are frequently reminded to have respect for cultural differences. Disclosure of sensitive medical information is restricted out of

respect for patient privacy and confidentiality. References to respect, often with different connotations, are ubiquitous in the literature of medical ethics.

This project is an effort to re-educate and persuade physicians to willingly re-commit to the primacy of the patient. This requires that doctors subordinate self-interest in order to resuscitate medical practice and the therapeutic relationship as grounded in trust. This is necessary to save medicine from shareholder driven corporations who hold the purse strings. Such organizations (along with the government) have steadily been consolidating the power to ‘control’ doctors by placing incentives and disincentives that direct physician practice. Physicians and those in training need to be educated regarding what is at stake and how to resist these external pressures upon their decision-making for the sake of their patients and ultimately for the sake of the preservation of medical practice as we know it.

CHAPTER 1

THE ELEMENTS AND ENTAILMENTS OF RESPECT FOR PERSONS IN MEDICINE: IDENTIFYING CONSTRAINTS AND DEMANDS

Respect for persons is a fundamental moral disposition or attitude that entails the duty to recognize humanity, both in the universal and in the particular individual patient, as having unconditional value. This dissertation seeks to establish Respect for Persons as the foundational moral concept of medicine and especially for the doctor-patient relationship. It also seeks to establish that the fundamental moral commitments of medicine are entailed by the conceptual recognition of patients as persons. These combined concepts, it is argued, ground the physician-patient relationship as a fundamentally moral one and also provide the moral basis for patient-centered care. Respect for persons is not contingent, hedged, or *prima facie*, but rather is an objective principle in so far as it is universally applicable to all persons and insofar as it is rooted in Kant's categorical condition that no one has a right to use another as a mere means to his or her own ends.

This chapter develops a conceptual definition of respect as a phenomenon in the realm of physician action within the practice of medicine. Respect emerges as a fundamental and essential aspect of medical practice. It is the primary ground of physician ethics and serves as the basis for doctor's attitudinal, cognitive and behavioral orientation toward patients. Within this chapter on respect, I put forth, in clear and practical terms, the moral attitudes and commitments that underlie respect for persons in the medical setting of patient-centered care. The conception of the patient-doctor interaction that best captures this understanding of respect will be referred to as *covenantal* to highlight important aspects of respect within the therapeutic interrelation: caring and trust.

I propose and will provide evidence in this and subsequent chapters that these key concepts can serve as physician guideposts in actual medical practice, when understood as both moral dispositions (or moral feelings) and as moral principles at the core of moral medical practice. These principles ground a

host of mid-level principles and virtues including, but by no means limited to, autonomy, beneficence, non-maleficence and justice. Respect grounds not only obligations but also virtues that physicians must develop, practice and exemplify if they are to appropriately show respect for their patients. Examples of virtues that are particularly applicable to medical practice include fidelity, trustworthiness, honesty, humility, respect and caring.

I regard the disposition of the physician toward her patient as central to respect. Actions and modes of treatment count as respectful insofar as they either manifest the attitude of respect or are of a sort through which the disposition of respect is characteristically expressed. A principle of respect is one that must be adopted by someone with the attitude of respect or that prescribes the attitude or actions that express it (Frankena, W.K., 1986, “The Ethics of Respect for Persons,” *Phil Topics*, 14: 149–167; Downie and Telfer, 1969, *Respect for Persons*).

Medical practice, despite the large body of “scientifically tested evidence-based medicine,” still requires the physician’s evaluative and deliberative reflection, aided by experience, to apply that knowledge to a particular clinical patient’s contextual situation grounded in respect. This fundamental principle places emphasis upon the duties entailed by the imperative of respect and introduces an understanding of moral respect as grounding the relationship of mutual respect between doctor and patient. I intend to show how this notion is at least compatible with all non-relativistic ethical theories and theological commitments under this commonly shared conviction.

I demonstrate and give supportive reasons that reformulating ‘respect for autonomy’ as ‘respect for persons’ will result in a practical, yet theoretically sound way of conceptualizing autonomy as moral, relational and located among a wider range of moral values as commensurable principles under the umbrella of respect for persons. This re-adoption of respect should be acceptable to many philosophers and bioethicists who may have previously rejected Kant and Kantianism altogether. Furthermore, I believe that respect ought to be embraced by all rationally reflective persons.

Autonomy-based theories, I argue, assume a formal equality of moral agents in relevant respects that abstracts from what many consider the most pervasive feature of illness: vulnerability. Once this imbalance is recognized, attempts to subsume questions of power under the rubric of autonomy can be seen as obscuring the role differing forms of power (held by patients and physicians) actually play in the clinical setting. It is for this reason that I am not espousing autonomy, but respect for persons, which locates the moral equality of human beings, regardless of functional autonomy or power, in their humanity.

Focus upon ‘respect for persons’ in medical-ethics and bio-ethics as the foundational basis of morality in medicine will require ‘respect for persons’ to be robustly understood, not only as a duty but as a moral orientation toward persons as patients in the morally suffused universe of medical practice and research. This orientation must be capable of being universally understood and accepted if it is to function as the ground of the moral principles upon which medicine establishes its claim to being a moral community.

Comparing respect to related medical concepts reveals that respect is to caring, presence, recognition and humanized care. It incorporates empathy, sympathy and *agape*, or love of humanity, but is not fully captured by the summation of these moral feelings. These principles, virtues and feelings are all, I contend, grounded in the broader moral conception of respect. In clinical practice, respect emerges as a concept that is fundamental to medicine’s purposes, perspectives and practices.

Medicine, as a cultural tradition, has a need for the re-articulation of the moral commitments and obligations it espouses and embodies. These commitments are, in several instances, unique to medicine and have been ridden roughshod over in the recent era. At its core, medicine is crucially dependent upon the trust of patients to accomplish its goals (the caring for and the healing of patients). This trust must be grounded in respect for persons. Respect for patients as persons is the foundation for the profound and deeply held commitments of medicine in the universal (all patients) and the commitments of the physician in the particular (this patient before me). Respect for persons, then,

brings as its first entailment trustworthiness (or honesty) that covers duties of truth-telling, promise-keeping and refraining from deception and coercion.

The concept of respect, while frequently used in the literature of medical ethics, has not been satisfactorily defined conceptually or empirically from a medical practitioners perspective. In addition, patient-centeredness is generally regarded as an important feature of high quality patient care, but little effort has been devoted to grounding the patient-centered model in an explicitly moral concept such as respect for persons.

In the current era of managed care and HMO's, trust cannot survive without such grounding. The failure of corporate medicine and of health-care policy makers to recognize this fact has led to the exacerbating influences of external market forces, which are driven by principles of utility (and unless otherwise specified, can allow for the sacrifice of the few for the greater good/happiness of the many). These forces have co-opted medicine as an institution of trust. The belief that physicians' actions represent the exemplification of the personal duties of individual physicians toward individual patients has lost considerable currency.

If we, as physicians, are determined to restore patient and societal trust, the ethics of medicine must embrace the concept of respect as both the source and the justification for its moral principles, duties, actions and virtues. The principles subsumed under respect for patients and operative in medicine are in accord with the universal morality of respect for persons. A helpful way to conceive of the moral principle of respect is as an objective moral standard by which other moral theories, moral principles and moral actions can be weighed and measured. Emergent from this disposition of respect are a set of duties and obligations that may either be stated in terms of principles, virtues or maxims of action, and more specifically codify the physician actions entailed by respect.

Respect grounds the appropriate attitude or disposition for physicians toward patients as one of caring for and caring about. Care involves a shift in the balance of power from physicians towards sharing power and responsibility with their patients. This occurs when a physician encourages the

patient to become an active participant in his own care. Rather than envisioning the patient as a passive recipient of care, a physician should empower patients to ask questions, receive and understand information, and participate in their own healthcare decisions.

This demonstrates respect clinically, for it acknowledges the beliefs, values, preferences and choices of individual patients as important and valuable. The patient-centered vision of sharing power and responsibility goes far beyond the limited contemporary conception of ‘respect for autonomy’ which is understood as non-interference with a patient’s expressed preferences secured by the current understanding of informed consent. Genuine physician sharing of power and caring respect encourages patients to deliberate and form preferences through mutual collaboration in the process of diagnosis, education and decision-making. This mutual participation extends to even those patients who might otherwise be passive in clinical situations.

Respect for persons is inclusive of all patients unlike the currently operative principle of respect for autonomy. At the same time, a truly patient-centered approach takes patients’ goals and needs seriously, but does not force patients to assume power and responsibility that they would prefer to leave with their physicians. For willing patients, shared decision-making can help to restore a sense of control and self-efficacy. For at least some patients this is an essential part of respecting and preserving their dignity and autonomy (Katz J. *The Silent World of Doctor and Patient*, 1984).

I am proposing that caring respect points us toward a conceptual definition of respect for persons as a patient-centered phenomenon in the realm of physician action within the practice of medicine. This attitude of respect has cognitive dimensions (beliefs, acknowledgments, judgments, deliberations, commitments), affective dimensions (emotions, feelings, ways of experiencing things), and conative dimensions (motivations, dispositions to act and forbear from acting). Kantian respect has also (and I think most importantly) a valuational dimension.

Physicians have specific duties to all patients that begin in Kant’s formula of humanity and require that they be treated as ends and never merely as a means to one’s own end (whether as a source

of revenue, as an object to promote one's own learning, as a subject of research, or as a means of maximizing the delivery of healthcare to society). The practice of medicine takes place one patient at a time and the formula of humanity entails that respect be demonstrated by treating this particular patient as the sole focus of the doctor's attention. This undivided attention affirms the physician's responsiveness to this person's value and importance.

Moral respect in terms of the formula of humanity is deserved universally and in the context of medical practice, the specific quality of humanity that renders persons respect-worthy does not need to be either specifically identified (beyond being intrinsic to human nature) or established with epistemic certainty. Respect for persons is not dependent upon, nor constrained by, the debate that swirls around the meaning and scope of the principle of respect for autonomy. In medicine, however, there must be universal agreement among all health care providers that patients, by their very nature, deserve respect as persons with normative certainty.

Respect for "Autonomy"

Introduced by Beauchamp and Childress in 1979, the "principle" of "respect for autonomy" provides only for the respect of those patients who are functionally autonomous. Respect, in their view, is no longer the primary principle of medical ethics, but one of four and the subject of respect is no longer the person of the patient, but their presumed autonomy as independent choosers. These principles (respect for autonomy, beneficence, nonmaleficence and justice) are free standing (ungrounded), co-equal, and *prima facie* (that is, only conditionally binding). From treating patients to making treatment decisions, medical ethicists no longer understand the Belmont principles (grounded in respect for persons) as originally intended. The term "respect" currently functions increasingly as a rhetorical device in public bioethics discourse rather than as the ground of ethical principles in respect for persons.

In this four-principle methodology of understanding and practicing ethical medicine, patients who, for whatever reason, are significantly constrained by their illness and suffer the compromise of their functional autonomy are understood to have their well-being provided for under an independent principle of beneficence, as adjudicated by the physician (an open-door to physician paternalism). Unconstrained beneficence not only promotes physician control, but is also a maximizing principle that encourages utilitarian thinking rather than respect for the patient as person. Contrarily, when beneficence is understood as a duty of the formula of humanity it is constrained to ascertain and respect the patient's own ideas regarding his well-being, even if he is not sufficiently autonomous to warrant unassisted decision making.

The contemporary critique of Belmont's principles does not emerge from the failure of these principles to capture the correct emphasis in focusing upon respect for patients as persons. The criticism is that, against the backdrop of the rising societal demands for interpreting the conception of autonomy as non-interference, medicine's mandate has shifted from acting for the good of the person as a whole to acting for the good of a patient's body part or physiological system. Sadly, the views of many contemporary commentators on the state of the relationship between doctor and patient in today's medical milieu describe it as a relationship between strangers. The goal of this project is to 'resurrect' Belmont's first principle of respect for persons and to restore this core relationship in medicine to its rightful central prominence.

As I detail in Chapter Four, in 1979, before the ink was dry on the Belmont document, Beauchamp and Childress were already publishing their first edition of *Principles Of Biomedical Ethics*. In this text, the Belmont principle of respect for persons was immediately de-valued to respect for autonomy. The understanding of respect in medicine was tragically altered to instantiate non-interference and the doctrine of informed consent as the gold standard of respecting autonomy in medicine. Simultaneously, patients who could not, for whatever reason, meet the requirements for

autonomy fall out from under the protection of respect for persons. These alterations, made by Beauchamp and Childress, threw Belmont's principle of respect for persons under the bus.

Respect for the person has been redefined from an overriding concern for the sick, to the 'right' of the patient to choose independently from among all options. Justice was originally not seen as particularly applicable to clinical medicine at the level of the doctor and patient. Now, as a society, we no longer understand the medical covenant as that of an individual clinician caring for an individual patient within a relationship of trust, but as a commodity or resource within a marketplace. Their relationship discounted, the participants in the medical drama have been thrust into the role of atomistic individuals, regardless of their wishes, and treatment is increasingly evaluated by the successful therapy of body parts or systems. Scientific, legal, and marketplace worldviews have increasingly defined the participants and their actions, with medicine reflecting changes that have occurred in the surrounding society.

This ethical paradigm shift away from respect for persons causes conflicts between the currently operative principles of autonomy and beneficence that are often irresolvable. The conditional, free-standing nature of each *prima facie* principle further compromises the resolution of conflicts between these potentially competing principles. The absence of a single unifying principle or order of priority offers no method for adjudicating disputes and differences of opinion with regard to the most appropriate principle to even invoke. More significantly, this change in the object of respect from the patient as a person to an impersonal principle of autonomy produced a radical revision in the roles of doctors and patients causing a serious erosion of trust between them and has done damage to the central caring relationship of mutual respect.

Emphasis upon respect for the autonomy of patients (non-interference of physicians in patient decision-making) with informed consent as the end-goal has fundamentally altered the structure of the doctor-patient model. Rather than being grounded in trust, it has evolved into one that is rights based,

contractual and ultimately juridical. This arms-length model has created severe moral tension between the patient and his doctor, at a crucial point of vulnerability of patients.

Benevolence and the avoidance of harm are the contemporary expressions of respect for the humanity of patients. Patients are to be treated as fully human, even if non-autonomous, but are not accorded the respect that is due to them as persons. Persons in the context of respect for persons I am espousing, in contrast, are not merely human; they are social, moral, legal, and political entities with rights, to whom obligations are due. Because of this, persons can not only be harmed, they can be wronged.

My contention is that this false dichotomy (created by Beauchamp and Childress), separating patients based upon their qualification as persons and dependent upon their functional “autonomy” as moral agents, denigrates the value of infants, children, the mentally infirm and those suffering from Alzheimer’s to a status less than that of persons. Furthermore, the autonomy of even patients who prior to their illness were functionally autonomous, quite often find their autonomy disrupted and constrained in suddenly finding themselves suffering from disease or injury. This jeopardizes their potential for moral agency and places them, at least temporarily, among the non-autonomous.

Issues such as the nature of the person, the impact of illness on decision-making capacity, the problems of autonomy specific to medical care of the sick, and the meaning of autonomy in the special relationship between patient and physician have been buried under the legal interpretations of these concepts and the rise of the language of rights. Contemporary bioethics and ethicists, in my opinion, bear as much responsibility for the current adversarial milieu as medicine does for the abuses and paternalistic practices that precipitated the ‘rights’ movement of patient autonomy in the first place.

The conception of respect for patients as persons restores and re-invigorates the primary principle and ground of the ethics of medicine. Respect for persons subsumes the four *prima facie* principles of Beauchamp and Childress under this principle of respect. Doing so gives these “mid-level”

principles a moral foundation and justification and can help resolve conflicts between previously co-equal and free standing “principles.”

Principles that can be derived from “respect for persons” and from honoring the “dignity” of each human being are applicable to and embraceable by all parties involved and emerge from asking the question, “By what principles are we, as actually or potentially rational persons, bound in our relationships?” Beginning from within the relationships in which we find ourselves in medicine (the institutionalized relationships of established medical practice, such as the relation between patient and doctor), we discover that it is through such relationships alone that we can achieve the benefits and goals internal to the practice of medicine. These mutual benefits are indeed what give meaning and purpose to these relationships. Holding an understanding of relational autonomy as inter-subjective, when applied to the interactions of doctors and patients, both empowers and strongly obligates physicians to not only respect their patients as autonomous persons, but to caringly promote and develop their patients’ autonomy and thereby promote their patients’ own needs, desires and goals.

The caring physician perceives the need for the development of her patient’s autonomy, while also recognizing the patient’s medical needs and need for medical treatment. By caring, the doctor recognizes that the patient has worth in her own right. In light of this, the doctor does not impose her own will regarding the direction the patient’s medical care takes, but rather is guided by the patient’s own wishes and a shared decision-making process emerges. Whatever the direction the doctor may give to the patient’s care, it is governed by her respect for the patient’s dignity. Caring emphasizes respect for the patient’s autonomy by fostering and promoting his ability to determine and articulate his own desires and goals. This notion of autonomy is understood as a capacity possessed by all (even minimally) rational beings and which must be nurtured and developed through caring.

Patients, by virtue of the effects of illness and their ignorance of medical science, face many barriers to the actualization of their autonomy and some overtly choose not to try. Most can only achieve this with the caring guidance and education of their physician. Patients with significantly

impaired autonomy (or competence) have varying degrees of dependence and inter-dependence upon family and physician; each situation must be individually evaluated. All such patients, however, have dignity and must be treated with respect and approached with care.

We are all dependent upon others to foster our initial development of autonomy as well as to sustain it later on in life. Autonomy, therefore, cannot be conceived of as total independence from the caring sentiments, judgments and actions of others. Autonomy consists in the ability to distinguish those areas of our lives in which we ought to be independent and can assert our independence from those situations in which we ought or must recognize and accept our dependence. To be autonomous in this way, within our relationships, acknowledges the fact of the human condition and adds richness, meaning and purpose to our lives that would be unavailable were we atomistically and individually autonomous. The human person, then, can be understood in several interrelated ways. As a subject and not merely an object, a human person must be treated with respect in such a way that recognizes his or her human dignity and unconditional value.

Doctors should not be viewed (or view themselves) as morally empowered to “give weight” to patient choices and it must be understood that patients do not receive their authority for self-determination from physicians. Patients possess this authority because they are persons which must entail respect for the autonomy of every person, to whatever extent she is capable of enacting it. The appropriate action for doctors is, therefore, not to give authority to patients’ values, but to acknowledge patients’ independent decisional authority based on their own values and commitments. This allows physicians to influence patient decision-making through education and to guide patient decisions based upon their knowledge and experience. Even persuasion is acceptable and is often required, so long as it does not entail deception, manipulation or coercion.

Moreover, physicians are obligated not only to acknowledge patient independent choice, but also to promote, to the extent possible, the exercise of that power in patients for whom deliberation about choices may be compromised by illness, uncertainty, anxiety, fear, or lack of information. This

moral disposition toward patients in general is embodied in the fundamental concept of respect for persons that encompasses all humanity. In the particular, however, the attitude of respect must be translated into specific acts of attention and focus upon this patient “as if he were the only patient.” This degree of involvement is necessary if the doctor is to garner the patient’s trust and, for the therapeutic relationship to succeed, the doctor must establish this connection of trust with the patient. This plays as important a role in the delivery of care as does medical expertise.

The practitioner’s clinical expertise and her caring respect for the patient as a person protect the moral integrity and foster the autonomy of both patient and doctor. The exercise of the physician’s caring respect, under this enriched conception, includes mindfulness of the subtleties of ‘staying present’ with patients in times of crisis or at the time of their death. The physician’s duty to the entailments of respect and caring can and should also be utilized as tools for ongoing self-regulation and serve as the reminder to always put the “good of the patient” first.

The physician must subordinate personal goals or incentives to those of the patient and must resist those inclinations which might result in treating the patient as less than her highest priority. Inclinations for power, money, prestige, research results and so forth must be constantly screened from her thoughts and their influence guarded against. These moral duties arise internally from the caregiver’s own recognized and embraced responsibility to treat patients (and all others) with empathy and care. This fulfills her duty to treat them as ends-in-themselves.

Morality demands more of physicians than mere good conduct. It also demands, for instance, that they have the right priorities and that they value things appropriately. And so the physician should be as worried about her own values as she would be about what she might do, just in case she becomes aware that she does not value the dignity of her patients enough. So, the recognition that one tends to favor or indulge desires raises legitimate practical questions concerning one’s character and values. One important aspect of our duty to treat others with respect and as ends-in-themselves is to be self-reflective and, if we find ourselves coming up short, self-critical.

The failure of the physician to live up to her responsibilities often stems from an indifference to these relationships of trust and the refusal to acknowledge her moral obligations to her patients. Respect for the inherent worth, dignity, and human rights of each individual patient is a common central phenomenon in medical practice that reflects and unites medical ethical theory and practice. In each clinical encounter, the doctor will communicate “you are a person of worth and I care” or “you are an object and you mean nothing to me.”

The capacity of physicians to reduce humans to objects (or worse) can profoundly influence patients’ sense of well-being and healing. It is unfortunate that there is a rather common practice in the clinical setting: focusing on the pathology or task to be performed to the exclusion of the person. References are often heard to “the broken leg in room 563” or “the PICC line on floor 2 West” without realizing that these speech patterns seemingly ignore that there is a patient connected to that leg or receiving the central line. This is perhaps the simplest of challenges to respect, but it is significant in that such behaviors place caregivers in danger of violating their moral obligation to respect the inherent worth of patients.

Many feminist scholars in medical ethics have shed light on this moral dimension of relationships as an important corrective force because it suggests that the relationship should be valued and enhanced. Some patients, by virtue of being young, old, sick, weak, under-served, or otherwise vulnerable, require more attention or a different sort of attention. From a covenantal perspective, it is because of the value ascribed to the therapeutic relationship, as an alliance forged between patient and physician, that such requirements come to be seen clearly as moral duties, not merely professional ones. Doctors often realize that their profession calls them to a higher ethic. Whether acknowledged or not, central to medicine’s core identity is the duty of advocacy for patients. At times like those referenced above, being an advocate for patients will mean finding constructive ways to challenge other caregivers who are disrespectful of patients.

This approach encourages physicians to see the ‘best’ in patients, even when they are non-compliant, self-abusing, disrespectful or ignorant. The actualization by doctors of respect for patients as persons is not merely the fulfillment of their medical duties to patients. Respect further entails developing the ability and willingness to look past the differences in power and status between themselves and their patient in order to meet the patient on the level playing field of morality. When a physician approaches her patient with a bedside manner of humility, rather than arrogance, she is able to suspend the power and status she possesses. Her caring respect for another at his moment of need empowers her to devote her full attention to her patient’s suffering and needs. There is no more evident display of respect than recognizing him as a person in this way.

Respect For A Person Or A Principle: Is This A Real Distinction?

Is the distinction that I am drawing between the object of respect as the ‘person’ or the ‘principle’ significant clinically or is this more semantic than real? I would answer that decisions made in the name of respect for persons, as opposed to the principle of autonomy, can result in different conclusions about the right thing to do. At present, under the conception of respect for autonomy, choice is exercised as if it were independent of circumstances. It is the immediate, individual choice that counts. The rights based principle of respect for autonomy does not require of the physician anything more than honoring the patient’s choice at that very moment. It offers no middle ground.

The perspective of respect for the whole person calls upon the doctor to consider the contextual dynamics of the case at hand. She must realize the needs of this person, with an understanding of his life values and commitments, in order to provide the guidance he requires to make the best decision for himself that he can. Under respect for persons the physician is expected to give the situation far more of her own deliberative reflection. She must put herself in the patient’s situation and consider what she would and what she ought to do if she were the patient.

Respect for persons does not serve as final arbiter in medical decision-making, far from it. It is the moral disposition and principle that serves as the starting point of doctor-patient interaction and sets the ground rules for how that interaction ought to be structured, with respect for both parties. Each of the possible therapeutic options being considered for treatment must also satisfy the demands of respect. This ensures that no option poses an inappropriate risk of harm or uses the patient as a means only (such as a research subject). Respect for persons aids in evaluating the patient and his wishes in the context of his life and defines duties that go much further than honoring autonomous choice.

Whether viewed from the microcosm of the doctor-patient relation or the macrocosm of the wider society, particularities and the specificities of given situations and issues require the latitude to respond appropriately (for that given doctor) from a broad range of perspectives. Respect provides us with an ethical commitment not only to persons in specific, but also to humanity in general. Respect for persons provides medicine with the moral justification for its existence. Medicine's existence must be for the good of mankind, one patient at a time, and it has no other defensible end.

The conception of respect relies heavily upon the Kantian wide "imperfect" duties to self and others. The argument for respect for persons is not to be understood in an absolutist sense. An absolutist interpretation would state that an adequate normative theory must not allow for any dilemmas by rationally justifying competing interpretations or decisions. Within the boundaries of respect for persons, however, there is sufficient latitude of interpretation and application of the duties of this principle that allow for more than one right answer in a given dilemma. More importantly, it can readily disqualify unacceptable options or choices with a rationale that ought to be understandable by the others participating in the deliberative process. Respect for persons is more facile than other ethical theories or guiding principles in moving back and forth from the particularity of the patient present in the doctor's office and the universal patient, represented for this doctor by the host of other patients to whom she bears direct responsibility and for whom she also cares and holds respect.

My approach develops the principle or moral disposition of respect as logically prior to, and necessary for, the patient as a person, as well as the doctor, to properly comprehend and apply mid-level, contingent principles. Deliberative, considered and reflective judgments provide the patient and the physician with both general and particular maxims (or rules) as particular specifications of moral respect that are still required to achieve moral decisiveness. Committed to the duties to self and others that Kant has inscribed, these duties gain determinacy through our rational reflection and application of appropriate operative principles or maxims of action dictated by the context of a given particular situation and with the collaboration of care-giver and patient.

Unlike the mutually exclusive and irreducible principles of the ethical pluralism espoused by Beauchamp and Childress, such principles, properly understood and applied, should not need balancing in the manner described in *Principles Of Biomedical Ethics*. This is because, in actual particular cases, we often find that more than one (if not several) such mid-level principles are mutually compatible, inter-dependent and reinforcing the breadth of factors affecting our moral deliberation and decision. Their applicability and actual application to specific cases is determined by how well they address the moral aspects of the medical dilemma at hand and conform to moral, relational and rational respect for both self and all other persons.

I view this latitude and indeterminacy as a strength. It allows for the reality of individual variations in development of our human faculties, abilities, sensibilities and methodologies for apprehension, appreciation, deliberation, reflection, evaluation and decision-making. This approach provides ethical space for intuitive and emotional approaches, provided that the core value is based in respect for self and others and in the recognition of the value of persons as well as their fallibility, vulnerability and perishability. It is this latitude that encourages respect to be characterized by not only caring, but by a number of feelings, including empathy, sympathy, presence and attention within the covenantal relationship of trust.

Respect, Covenant and Trust

I look to Kant's second formulation of the categorical imperative for guidance in directing our ethical thought and the application of our moral duty to the intricacies and variables encountered in assessing the needs, goals and vulnerabilities of the person who is ill. This reflective assessment must also recognize and give an accounting of the abilities and competencies of the physician who assumes the role of caregiver. The responsibilities and limitations placed upon the physician often weigh heavily and require an inner strength to discharge them faithfully. This process is more than a reflective and evaluative appraisal. It calls for physician action on behalf of her patient, within her capabilities and expertise. It also calls for physician self-knowledge and self-constraint when she is unsure or feels ill-equipped to deliver the appropriate skilled level of care required. She feels no shame in recognizing her limitations and caring respect for her patient informs her decision to refer the patient or call in a consultant.

There is something sacred about the inter-personal and inter-subjective nature of this relationship that I argue is one of covenant. Patients encounter health care professionals at the most vulnerable and needy moments of their lives. At these times they are most dependent upon someone else to do what is best for them. The first obligation of medicine must be to serve the good of those persons who seek physicians' help and who trust them to provide it. The practice of medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patients' best interests. Let us consider some of the virtuous attributes physicians must possess in order to fulfill their role as caring healer.

Physicians are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times. By its traditions and very nature, medicine is a special kind of human activity. It cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. Incorporation of

virtues, when understood as commitments to act or duties, can help physicians integrate and appreciate the particular non-moral circumstances of the case with a regard for the patient as both a person and moral agent. Reflection upon virtues, as well as upon principles of action, help the doctor recognize the caring disposition she should cultivate in order to enhance her ability to make sound medical decisions.

The covenantal relationship characteristically must involve openness, fidelity and concern for the patient. These traits not only mark physicians as members of a moral community dedicated to something other than their own self-interest, but also provide appropriate moral constraints upon the uses and potential abuses of physician power. At the same time, it gives outside observers a basis for evaluating physician moral responsibility, accountability and blame-worthiness. Covenant implies that there is reciprocity of giving and receiving at work in the relationship, which needs to be acknowledged. There is a significant distinction between covenantal and contractual models of the physician-patient relationship and this will be discussed in detail in Chapter Five.

The Core Elements Of Respect For Persons

There are many ways to respect patients as persons, but there are three core elements of respect: appreciating what is valuable or important about a person, recognizing the constraints or demands that such a valuation places on one's own conduct, and acting in a way that expresses that recognition. The form of respect involved in medicine is a mode of valuing and appreciating the patient as having an objective worth and importance that is independent of the physician's appraisal of him. Persons have unconditional worth, whether others acknowledge that value or not.

Considering the patient's situation within the context of the doctor's own life and life situation can promote points of identification that contribute significantly, not only to respect, but to caring and empathy. Doing so often reveals unexplored ways to reflect upon the thorny dilemmas that patients (and thus doctors) may be facing. Respect is a constant reminder to keep the human connection real.

Unlike many other disciplines, medicine is inherently dependent upon trust in order to function and that trust (which patients place in doctors) must often be placed before it has been demonstrably earned. Trust, in medicine is more akin to faith, in that the knowledge, experience and power to evaluate, diagnose and treat resides within the physician and is virtually un-evaluable by most non-medical persons. The vulnerability this imbalance creates is further exacerbated by the impairment of the patient's exercise of practical reason by illness, which extends beyond the physical, empirically observable disordered function of the body. This places a moral duty upon doctors that expects more than providing medical treatment or even providing the information and education required to obtain what has come to be encapsulated in the 'doctrine of informed consent.' It can only be properly appreciated, valued and respected within a covenantal relationship of trust.

Respect for persons directs our attention to the intrinsic moral worth of people. It is not intended to give the impression of moral absolutism or that all moral disagreement can be eradicated or resolved. It does, however, provide each of us (healthcare providers and patients alike) with a starting point from which to begin our interpersonal communication in an atmosphere of mutual respect and trust.

Respect for patients as persons must rely heavily on actual particular medical judgments to assess a patient's current capacity to absorb and act on information presented in a number of ways. Medical judgment determines what constitutes respect only when guided by concern to communicate effectively what patients can understand and to respect the decisions that they can make in an atmosphere of caring. Principles are important talking points and help theoretical medicine do its best to reflect the ethical realities of the real world of medicine, but are only starting points. The end-point is the translation of ethical principles into actions that exemplify the personal nature of caring.

Francis Weld Peabody, in "The Care of the Patient" published in JAMA in 1927, captures the essence of the two primary elements of the physician's ethical obligation:

She must know her professional business and she must trouble to know the patient well enough to draw conclusions, jointly with the patient, as to what actions are indeed in the patient's best interest.

The treatment of a disease may be entirely impersonal: the care of the patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it.

On this account, in addition to autonomous agency, respect demands attention to important subjective experiences, persons' existence as participants in relationships and as members of communities, and considerations of behavior. Peabody's account has important implications for the conduct and practice of delivering clinical care with persons who are autonomous as well as with those who are not.

Physician Humility: Developing Respect for Patients and Becoming a Caring Physician

One of the important qualities a physician should have toward her patients and role-model to students and residents is that of personal humility. Humility, in the practice of medicine, is the ability of a caregiver to give up some of her self-importance and assertiveness to show her patient that she is willing to listen to his concerns caringly with attentiveness to his psychological and emotional needs in addition to his medical ones. It is hard for some doctors, especially medical school attending faculty, to shy away from expressing their self-importance. This is unfortunate because physicians are not always right in what they know, what they say and what they do. They need the feedback of others. Without behaving with humility, all of the other virtues a physician might possess may be masked by hubris, leading to misjudgments, medical error and absence or loss of the trust of their patients and colleagues. Were I an attending on the wards, I would tell students: "Physician, Be Humble".

Humility means not only listening to and considering (even accepting) the advice and concerns of colleagues in one's own discipline, but also the concerns, advice and point of view of those from other disciplines, of patients and finally of those students and residents who look up to you as their mentor. Humility is conducive to approachability. Without being approachable, the true candidness and trust that the patient could develop with the physician will be compromised. "Approachability" is

a direct consequence of a doctor's behavior regarding humility. There is a certain irony that doctors expect approachability from their patients (allowing their bodies to be touched and probed as part of the physical examination, telling the doctor intimate details of their history and willingness to be compliant with the doctor's advice). Yet, at the same time, these doctors deny approachability to their patients by their distance-keeping behavior. Such physicians seem oblivious to the fact that they may be unwittingly inhibiting their patients from developing intellectual or emotional commitments of trust and preventing the formation of open lines of communication.

As previously mentioned, the inequality of the playing field within the doctor-patient relationship cannot be considered satisfactory for the provision of the best medical care. The doctor-patient covenant is a very personal one and needs the trust of the patient. Without that trust, the best in treatment and care is a hollow exercise. Because medicine deals with humans in vulnerable states and physicians confront the most personal and intimate aspects of the lives of these persons, a relationship of trust is needed to gain access to important, and often sensitive, information. The trusting patient permits a doctor to explore this "inner life" with the promise only to use this information for its relevance to the provision of optimal health care, while guarding its confidentiality.

A good physician welcomes and needs the patient's trust in order to accomplish the optimal outcome for the patient. Physicians are judged by the degree to which the good of the person served is attained by their practical activities and by their caring attitude and respectful treatment of the person who is their patient. Larry Churchill, in his insightful analysis of the work of Edmund Pellegrino on patient vulnerability, was prompted to draw this conclusion:

Every formulation of medicine's moral norms will be suspect if it does not put the patients vulnerable situation squarely in the center of attention. Any portrayal of the doctor's obligations that displaces the patients "wounded humanity," or places it at the periphery, will inevitably distort medicine's central obligations. This is the gravamen of Pellegrino's insight (*Damaged Humanity*, *Theoretical Medicine* 18:113–126, 1997).

Medical ethics can only be helpful to medicine if it is practical and aids solutions to the complexity that patient vulnerability injects into the care of the patient. The clinical context is essential. Medicine

is practiced by physician-patient interaction and deliberation and is governed by mutual clinical decision-making. This functional relationship is utterly dependent upon mutual trust and respect. Medicine, as a moral practice, seeks to clarify what is good for the patient and then to seek the patient's good using available medical technology. An openly moral medicine offers the possibility of practicing medicine in ways that do justice to the deepest commitments of patients and physicians alike and more importantly to the mystery and meaning of the human condition.

Respect as Moral Feeling

Respect is sometimes identified as a feeling. In the case of persons, Kant helps us clarify this kind of feeling by describing it as "moral feeling." This introduces the conception of ethical and objective feelings (in distinction to the subjective nature of our "empirical" feelings). While respect for persons may begin as an attitude, it ought quickly to be experienced simultaneously from a rational perspective as a 'moral feeling' entailing duties and constraints upon all persons and as an 'emotional feeling' as a 'kinship' with all of humanity. Applied to medical practice this moral feeling produces within each physician the intentions of generosity, helpfulness and, in a sense, selflessness. Pure altruism is perhaps a bridge too far, but respecting persons ought to generate a willingness to assist those in need (whatever that need is) with the desire and commitment to go above and beyond the minimum duties of respect for persons. 'Respect,' if truly embraced as a 'moral feeling,' generates the kind of "good-samaritanism" to properly motivate physicians to go the extra mile on behalf of their patients.

The affective moral inner life (moral feelings) of persons prompts our deliberation and reflection upon how we ought to act. To then act morally we must turn our moral perception towards what we perceive to be the ends of moral action, the moral welfare of self and caring for and about the welfare of others. Our moral feelings (or moral intuitions) shape our particular moral acts, in accordance with the general principles of moral duty that emerge from respect for persons. The

diversity and complexity of moral feelings are influenced by prior experiences in addition to rational principles. Feelings are essential to the moral life and it seems hard to argue that we could even be aware of many of our moral duties if we did not have the right feelings. I am proposing to bundle these feelings and duties under the conception of respect as caring. Caring is a term particularly meaningful in medicine and medical practice and the emphasis I am placing on respect for persons and for patients as persons is in the context of both caregiving and caring attitudes towards others and their well-being.

Centered upon the needs of the patient (who first presents to the doctor seeking help), the natural human response of a physician is to experience this as calling for and activating her attention and caring concern. This moral feeling is grounded in the respect she holds for all patients as persons and so her initial responsiveness will be universalizable to all patients who present in this way. This caring respect motivates her to seek not only an appropriate remedy for the patient's illness, but also to develop a therapeutic relationship based upon trust. Motivation to act with kindness and interpersonal interest rests in the caring physician's knowledge that delivery of appropriate 'care' requires an inter-subjective interchange of medical and personal information about the patient. When initiated with care and kindness, the trust building begins with the first encounter and by the conclusion of the 'visit' the groundwork for a relationship of caring and trust has been laid. Through this 'process,' the universal becomes particular and she becomes more and more subjectively engaged in the uniqueness of the persona of 'this particular patient.'

This process is dynamic and dialectical and requires the moral compass of this caring respect. Physicians are constantly making value judgments ranging from interpretations of data, to choosing a clinical strategy and to forming relationships with patients and hospital personnel.

The Special Care for Persons as Perishable: The Imperative of Responsibility of Hans Jonas

Hans Jonas is a 20th century philosopher whose book, *The Imperative of Responsibility* (1984), situates his deontological ethics as building upon and extending Kant's formula of humanity. His work

sheds light upon the responsibility of respect as an obligation and responsibility for the preservation of humanity as the only repository of value in the world. Jonas also expresses a deep concern for human perishability.

In a broad sense, Jonas argues that all patient related medical judgments are directed by the ethics of caring respect, personal integrity and personal beliefs that he has articulated as an “ethics of responsibility.” The point of Jonas’s ethical reflection is that the persona of the physician (*qua physician*) is formed in response to the physician’s personally adopted obligation to the patient. This constellation of values that Jonas espouses can be understood as a deontological ethics of care that closely resembles my notion of caring respect for persons and addresses the moral intimacy of the doctor-patient relationship. Jonas calls the physician to the primordial recognition of the patient as other and, from this perspective, respect emerges from the physician’s phenomenological response of duty and responsibility to the person of the patient.

The way Jonas frames this point of view reveals his continental, phenomenological orientation. There is nothing in this viewpoint that contradicts, nor pushes against, the perspectives I have offered except in his expansiveness to the future of humankind and the preservation of the possibility of a kingdom of ends that requires “survival of the species.”

In writing about the ethics of responsibility, Jonas draws an important distinction between formal and substantive responsibility entailed by respect. The “formal” responsibility of respect for patients as persons entails that the physician must “care about” her patients and, in assuming this responsibility, can be the subject of praise or blame. The “substantive” responsibility of respect for patients as persons entails that the doctor “care for” her patients. This is to say that she is, both in an empirical and a moral sense, responsible for being committed to particular actions concerning, and on behalf of, her patients. Thus respect for persons as a positive duty is empowering and substantive responsibility “is a function of power and knowledge” (Jonas, p.125).

Respect for persons involves cherishing human beings, regarding them as having great value and as fragile, perishable and calling for special care. When we respect persons this way, we act or forbear to act out of benevolent concern for them. This distinctive perception of and attitude toward persons serves to distinguish the proposed understanding of caring respect for patients, within the practice of medicine, which has been neglected by other discussions and understandings of respect.

Jonas argues that an ethics of responsibility must not only show that there is an objective good (in this case the patient) that can categorically obligate us, but must also provide us with the motivation to act. His worry is whether there is a sentiment or emotion that motivates and enables us to fulfill our objective responsibility for that which is perishable. While Jonas' concern is for the perishability of humanity and the future life of the species, the physician particularizes this concern to the vulnerability of the individual human person that is her patient. The sentiment or emotion that provides the motivation for moral action based upon respect for persons lies in the notion of care and caring itself and caring respect is held both for this patient in particular and for all perishable persons universally.

Caring respect for the patient as person, then, can readily be seen to operate on at least two different levels, subjective and objective. It is a subjective, internally generated disposition of the physician to both care for and take responsibility for persons as patients and this generates personal accountability. This subjective disposition of respect toward the patient finds its ground or basis in the patient, himself, based upon a fact or feature of that person and all persons which calls for respect. Therefore, respect begins as a subjective disposition or attitude toward patients as one of caring for and caring about them, based upon the physician's subjective awareness of and responsiveness to their vulnerability and need. The Kantian conception of respect has obvious affinities to the notion of care that informs discussions of the care perspective in ethics, particularly in the work of Marcia Baron, John Paley and Robin Dillon. I develop this care perspective as caring respect for patients in chapter 6.

Ultimately, however, this respect is grounded and governed by the reasons-responsiveness of

the physician, who recognizes that the patient, based upon his humanity, has a respect-warranting characteristic, shared by all patients generally and in equal measure. Furthermore, these reasons are categorical, especially in medicine, in the sense that their weight or stringency does not depend upon the physician's interests, goals or desires and therefore gives objectivity to the doctor's attribution to and the patient's deservingness of respect. As an obligatory duty of a physician within her medical practice, it entails that the doctor bring all of her faculties and abilities to bear upon the needs of the patient. In an objective sense, her accountability to perform this duty can be both internally (self-reflectively) and externally subject to criticism.

The explanation of the simultaneous subjectivity and objectivity of the responsibility of respect seems to lie in the step-wise manner in which human beings come to the realization and justification of respect and of the responsibilities it entails. It is through a combination of intuitive, emotional and rational capacities that we come to grasp the moral centrality of respect for persons and the rational justification of its objectivity as the ground of morality. This paradox will be discussed in much greater detail in the next chapter on Kant's ethics.

Basing morality on respect for persons is predicated on the principle of the intrinsic value of "being," according to Jonas. As such, it is a defensible normative claim that may well be insufficiently defensible epistemologically. The more complex the being (the more capable of rationality and autonomy), the more valuable it is. The capacity for practical reason and evaluative judgment of human beings is (at least arguably) something unable to be said of lower species and establishes the complexity of human beings as deserving of unconditional value. Ultimately, this grounding serves as the basis of all other moral principles, which arise derivatively from respect.

To be clear, this is not an argument for species-ism. It does not deny that there are certain activities in the societies of primates that qualify as at least rudimentary value-systems and in which praise (and more often blame) can be charged by other members of the community. An individual may even be driven out of that community altogether. It is clear that other species also are rightly

characterized as beings (rather than things) and share in some measure of deservingness of respect. It is likely that some higher ‘animals’ also participate to some extent in what we refer to as ‘personhood.’

Moral Respect in Medicine has both Subjective and Objective Components

The actions of physicians should derive from and communicate their understanding of the demands or constraints entailed by important and valuable features of persons. Several general implications illustrate ways this understanding of respect improves upon traditional accounts. First, despite the objectivity of respect, what is important about particular persons in particular situations may differ, as may actions expressive of respect for these particular features. Respect is thus highly particularized (Robin Dillon, 1992).

Ascertaining the implications of respect for clinical practice requires understanding how these kinds of treatment happen and can be avoided. A preliminary assessment of individual patients that is of utmost priority regarding its implications for showing proper respect in the clinical setting entails the determination of each patient’s status with regard to his capacity for functional autonomy. I use this term because actualized autonomy is always incomplete in persons, especially in patients afflicted with one form or another of infirmity.

If indeed there is a moral duty of physicians to respect every patient (as I am arguing), it cannot be founded on Dillon’s conception of particularized or differential respect unless we qualify it substantially. The qualification is that the particularized manner of properly respecting this particular patient must be based upon the uniquely particular situation and needs of this patient. Were another patient in a circumstance sufficiently similar to this one, it would rightfully be handled identically. Furthermore, and more importantly, this particularized “manner” is merely that. It does not displace or supersede the undifferentiated respect for persons that lies at the core of the ethics of medicine.

This is not to disparage particularity or aspects or qualities that are unique to individuals that could give rise to the special feelings. Such distinctiveness is the essence of caring for and about other

people: admiration, empathy, and joy on one hand and anger, discouragement, and frustration on the other. Feelings specific to this patient or that relationship give credence to our assertion that each situation is unique and add richness and meaningfulness to the activity of caring that otherwise might become repetitive and stale. The problem only arises when our appraisals of patients serve as the basis for believing that some are “worth more” than others or for providing some patients with decidedly less adequate care than we otherwise would provide them. To do so is to set a troubling precedent, namely, to imply that patients “deserve” a certain level of attention, according to who they are, to what they have or have not accomplished in their lives, or their ability to pay.

By contrast, the type of respect that I am concerned with for medicine (and which I suggest is morally required) is one that is unconditionally owed to all patients, simply because they are persons. There is a certain irony here. Our conception of respect, which involves valuing patients as persons, is on one level not really concerned with the differences between individuals that make them unique. Clearly I am not opposed to the idea that physicians ought also to value the individuality of particular patients. In promoting the duty to respect, however, I seek to acknowledge something else about persons, something that everyone has in equal measure.

Second, this account illuminates the notion that there are many ways to respect persons and that respect involves multiple types of moral assessment, particularly in medicine, where human illness and distress ground its existence. Since illness is almost routinely associated with the reduced cognitive and volitional capacity of patients, it is fair to say that these impairments (constraints) undercut some, but not all, possibilities for action.

In other words, there must be an acceptable notion of partial autonomy with attendant reduction, but not absence, of agency for decision-making (moral and non-moral). To grant this, it is necessary that we understand patients as persons in the context of illness. Thus, our concept of ‘person’ within the practice and tradition of medicine of necessity must begin in the reality of impaired autonomy at least to some extent. We cannot expect the abstract and ideal moral theories that are

agent-centered to be of much help to us when they portray an inaccurate view of ‘patient autonomy.’ Suggesting that physicians’ approach to patients should be guided by the understanding of personal autonomy as non-interference demonstrates a lack of understanding of the clinical realities of medical practice. As Onora O’Neill put it, “The notion that we could be ‘ideal rational patients’ cannot stand up to a moment’s scrutiny” (“Paternalism and partial autonomy,” *J of Med ethics*, 1984,10,173-8).

There are many philosophical and psychological conceptions of “conditional” or “conditioned” respect for autonomous persons, but I share Robin Dillon’s point of view: “I maintain that while the exercise of one’s practical reason or [functional] autonomy is an achievement and may be a matter of degree, the essence of autonomy is the unconditional capacity [for rationality] that allows its exercise” (Dillon, R., *Introduction to Dignity, Character and Self-Respect*, 1995, p.15). Autonomy is not a conditional description of the special circumstances of one’s life. It is not empirically present or absent in varying degrees. Autonomy is universal and unconditional (Treiger-Bar-Am, K., *In Defense of Autonomy: An Ethics of Care*; *NYU J of Law & Liberty*, 2008). That said, in the imperfect, empirical lives of persons there is a second understanding of autonomy that I have described as functional and which is more akin to competence. It is this ability that requires the evaluation and judgment of the physician in order to ascertain a particular patient’s ability to make decisions regarding their healthcare for themselves.

Finally, this account expands on what it means to treat-or not to treat-persons as means. For example, this account is very much in line with Martha Nussbaum's (1995) work on objectification. Behavior that instrumentalizes, denies autonomy or subjectivity, or treats persons as inert, fungible, proprietary, or violable is disrespectful behavior. The ways that she suggests one might wrongly objectify people count as failures of respect as they represent failures to appreciate what makes people valuable and what that value requires in one's interactions.

Medical practice respects patients as persons when it allows patients, as they actually are, to refuse or accept what is proposed to them. Obviously, severe impairments such as coma, persistent

vegetative states and so forth have to be treated from beneficence in the absence of a surrogate decision maker, but even in the absence of sentience, these patients have not lost their status as persons. My point is, however, that many more patients can understand and refuse or accept what is proposed over a much wider range of functional autonomy than might be assumed by medicine if we accept a less than ideal notion of functional autonomy. We can and should make room for the notion of ‘partial autonomy.’

A patient should never have her autonomy disregarded. To the contrary, the patient needs all the help she can get from the physician and other healthcare workers to foster and promote whatever level of autonomy she is capable of (and all patients are different in this regard). This understanding of autonomy, within the doctor-patient relationship, sees it as relational and dependent upon numerous variables from patient to patient. It recognizes the important role good physicians play in optimizing patient autonomy, but it does not equate autonomy with personhood.

Under this conception of respect for persons, physician duty also requires the understanding that information is a tool that can be used for healing or hurting. Deciding what should be said, when, where, and how requires knowledge of not just the medical facts, but the nature of the sick person and his or her needs beyond the simply "medical." There can be no freedom of choice in the absence of an adequate sharing of knowledge on which to base choices and an adequate understanding of the uncertainty that surrounds such knowledge when dealing with human diseases. Bringing patients up to this level of understanding is no small task and often is very demanding. Furthermore, it is not only an increase in the patient’s understanding that is essential, but also an increase in the doctor’s understanding and recognition of the values of the patient.

Respect as a Responsive Relation

Respect is a responsive relation and ordinary discourse about respect identifies several key elements of the response, including attention, deference, judgment, acknowledgment, valuing, and

behavior. Respect is a particular mode of apprehending the patient: the doctor who respects her patient pays attention to him and perceives him differently from someone who does not. Furthermore, she responds to him in light of that perception. The idea of paying heed or giving proper attention to the patient, which is central to respect, often means trying to see him clearly, as he really is in his own right, and not seeing him solely through the filter of the physician's own desires and fears or likes and dislikes. It is in virtue of this aspect of careful attention that respect is sometimes thought of as an epistemic virtue.

A certain degree of knowledge about the particularity of each patient leads the physician to tailor her approach to that patient in an individualistic way. This demonstrates that respect for persons is not fully satisfied by according a patient only the universal, impersonal respect that is owed to all persons. Rather, from the entailments required to satisfy the universal duty to respect all persons, emerges the duty to particularize that respect to the individual patient. In actual practice this is never fully actualized, differs from patient to patient, and is not required by the absolute duty to respect all persons. Rather it emerges from the universal duty of respect as an imperfect duty and, when it can be achieved, a more personal level of respect is the positive result. Physicians should strive for this more personalized demonstration of respect, but are not failing to discharge their moral duty if this does not occur. There are numerous factors that are either conducive to, or constraints upon its attainment. Patient responsiveness, like autonomy, comes by degree; it is not all or nothing.

Let us consider the many modes of responsiveness that physicians ought to show their patients and the benefits to patients and strengthening of the relationship that such seemingly insignificant actions and attitudes generate. It is my view that the moral feeling of caring for others and the emotional sensibility of empathy toward others play important roles in informing ethicists and physicians that they do indeed need to embrace a commitment to respect patients as persons. Moral feelings of respect often emerge within the physician from the empathic recognition of the suffering patient that also elicits an emotional connection to this person in distress. The empathy engendered

serves to motivate her caring actions. The suffering other provides the ground of sympathy and greatly promotes the physician's incentive to show 'respect' in unequivocally human terms. Such identification is not based upon similarities of culture, societal background or language, but upon the deeper recognition that his humanity is identical to her own.

Robin Dillon writes of care respect, which she sees as exemplified in an environmentalist's deep respect for nature: "Care respect involves regarding the object as having profound and perhaps unique value and so cherishing it, perceiving it as fragile and calling for special care. It is acting or forbearing to act out of the benevolent concern for nature" (Respect and Care: Toward Moral Integration, *Can J of P*, 22: 105–132). This analysis of respect draws explicitly from a feminist ethics of care and has been influential in feminist and non-feminist discussions of respecting persons as unique, particular individuals. It certainly aptly characterizes the moral feeling of caring respect for one's patient within the covenantal relationship. Chapter 6, as mentioned earlier, is devoted to fully developing my conception of caring respect and how it differs with and is clearly distinct from Dillon's care respect.

Empathy, when appropriate, is a form of attention to the person and attunes the physician to her patient's life and the patient's own conception of his life. When a patient, for whatever reason, cannot accept the scale of his infirmity, it may be because to do so would threaten his sense of self. Responding with empathy respects and values his autonomy and is expressed by not talking-down to him or giving him facts that are overwhelming. The point here is that truth-telling, if understood as the whole truth and nothing but the truth, is not always the best or even an appropriate maxim of action. The sensitive and respectful physician will pick-up on the situations in which she must parse out the truth of the patient's disease and prognosis in smaller doses over a period of time in order to not overwhelm the patient's capacity to cope. This shows appropriate physician responsiveness with mercy to the patient's frailty, yet such behavior does not condone overt deception. Merciful respect is

a matter of working with the patient to re-establish his sense of self-control and autonomy. It is often appropriate to discuss with the patient whether he is ready to understand more about his disease.

Affirmation, as the opposite of depersonalization, involves having one's existence acknowledged and legitimated through the caregiver's therapeutic use of herself. Affirmation of the personhood of patients facilitates their capacity for self-expression, reinforces their individuality and fosters their personal healing. The notion of respect arises from the recognition of the unconditional value of patients as persons. This cannot be reduced to other concepts, like politeness, honesty, deference to patients' wishes, and so forth. The intention and understanding of respect is not as a duty that is regimented or that arises from a cold and sterile understanding of duty (as some uncharitable commentators characterize Kant's moral theory). Rather, the duty of respect is one that the doctor openly and gladly embraces. This is not the kind of duty that is merely owed like we might view the duty to obey the law.

Respect also encompasses the concept of presence. "Being-with" breaks down the oppositions between the powerful and the helpless, the active and the passive, and counteracts the tendency to objectify and deny recognition to those weaker (in this case patients) while instead becoming the basis of compassion. I define compassion as the ability to share feelings and intentions without demanding control and to experience sameness without undermining difference. Reciprocity cannot be achieved through submission, obedience or repression. Reciprocity rather relies upon the cooperation of individual physicians and patients. The awareness of difference is importantly needed because reciprocity is not possible if otherness is reduced to sameness.

If a physician is truly interested in developing a relationship such as those that ought to develop between a patient and her physician, then mutuality and a genuinely affirming interaction is central to this development. Engendering the patient's trust and confidence through being-with them and validating their experience of suffering is often more beneficial to their well-being than the effects of the physician's medical treatment.

Attention is another form that respect takes that is similar to presence in the way it conveys availability. In her attentiveness to her patient, the physician initially defers her will to the patient's wishes, such as a patient's rejection of the doctor's recommendation of a drug-based pain management plan. Attention, as a form of respect, is not simply acknowledging a patient's rights under the law and tailoring treatment to fit within these. Rather, respect is expressed by withholding judgment or prejudice and by the attempt to recognize another's perspective. In this case it would entail soliciting the patient's reasons for rejecting the prescribed plan. This level of attention and concern is validating to patients and shows the patient respect for the person who he is.

Often a patient's refusal of treatment or request for unusual or unreasonable treatment is an indicator of his need to be "seen" as not only a person, but as the person that he is (whether consciously or sub-consciously). Exploration, by the physician, of where his concerns lie with regard to the treatment plan and a request for his alternative treatment suggestion is often all that is necessary to achieve the patient's compliance and the continuation of a mutually affirming relationship. Of course, the patient may refuse pain management for fear of losing his sense of self-control from the sedating effects of the drugs and, if the patient is already feeling his self-control diminished by illness or disease, this fear must be recognized by the doctor. Attentiveness of physicians to patient needs is usually sufficient to "read" the patient's underlying worry and respond appropriately.

Treating others with respect may also include such things as respecting someone's privacy or personal space. Regarding privacy by, for example, taking care to pull the curtain or to close the door before exposing even non-sexual body parts in conducting one's exam demonstrates a mode of respecting and valuing the patient. Many patients are more sensitive and aware of even minor improprieties and are offended by the callous treatment they receive in the hospital setting. The respectful physician responds to this sensitivity, in light of the perception gleaned from attentiveness, when it comes to interactions with them.

As responsive, respect is other-generated rather than wholly self-generated. It is something that is owed to, called for, deserved, elicited, or claimed by patients when respected as persons. Doctors not only respect persons because they want to, but also because they recognize that they have a duty to respect them. Respect involves “a deontic experience—the experience that one must pay attention to and respond appropriately to other persons” (Birch, 1993). It thus is itself motivational: it is the recognition of the patient “as directly determining our will without reference to what is wanted by our inclinations” (Rawls 2000, p.153).

In this way respect differs from, for example, liking and fearing, which have their sources in the subject's interests or desires. When we respect something, we heed its call, accord it its due, and acknowledge its claim to our attention. Rawls is explicit: "Respect is a willingness to see the situation of others from their point of view, from the perspective of their conception of their good; and in our being prepared to give reasons for our actions whenever the interests of others are materially affected" (A Theory of Justice, Cambridge, 1971, p.337).

Thus, respect involves deference, in the most basic sense of yielding: self-absorption and egocentric concerns give way to consideration of the patient and one's motives or feelings submit to the patient's reality. As a physician, one is disposed to act in meeting the patient's needs. If this is the closest that the physician can come to a love of humanity, it is close enough for, as Kant made clear, such love cannot be commanded or required. What can be demanded is the recognition and satisfaction of one's physician duties of respect for patients. What is needed and called for is often over and above what can be required. It is up to the physician's commitment to respect for her patient that leads her to go the extra mile.

Treating the patient with respect means recognizing that the patient, like any other person, has interests, desires, and feelings, and is not an object; treating the patient with kindness and consideration and whatever else might be considered part of decent human interaction. Failing to treat

the patient with respect in this way violates the dignity of the patient by treating her as less than human.

In his essay, “A New Professional: The Aims of Education Revisited,” Parker Palmer writes:

The education of the new professional will reverse the academic notion that we must suppress our emotions in order to become technicians. We will not teach future professionals emotional distancing as a strategy for personal survival. We will teach them instead how to stay close to emotions that can generate energy for institutional change, which might help everyone survive (*Change*, 39, no.6, p. 5-12, 2007).

In this essay, he is arguing against definitions of medical professionalism that separate physicians from their own emotions and feelings. Berwick suggests that if we ask patients what they dislike about health care, they will mention distance, helplessness, discontinuity and a sense of anonymity. Each of these is all too often a sequela of the fragmented institutions in which modern physicians work and train (2009).

I would argue that consequentialism of the flat-footed act-utilitarian variety is an ethical theory that is blind to the value of respect for persons. It is blind in its structure in that it fails to recognize that individual persons have intrinsic value. It is materially blind because its conception of persons forecloses ethical responses like empathy, respect or mercy. If I am right, then there is reason to be suspicious of purely utilitarian reasoning in those areas of medical ethics in which concerns for respect for patients as persons are central.

To be clear, those who are committed to the way utilitarianism is characterized by John Stewart Mill do acknowledge the dignity of humans. Mill, however, grounds dignity in sensitivity, which he conceives as the ability to enjoy pleasure and suffer pain. Mill’s theory also holds self-determination, understood as the liberty to formulate and carry out one’s own life plan, free from interference and coercion, as an essential element of attaining the human good, which for him is happiness. Mill additionally has an important place for human virtue and the development of character and he seems to hold a number of other principles of morality besides human happiness. Many commentators refer to the uniquely nuanced understanding of utility in Mill’s theory as a form of “rule-utilitarianism.”

Unfortunately, most who attempt to apply utility to medical ethical issues (and especially to health care policy) have an unsophisticated and pedestrian understanding of utilitarianism that is much closer to the viewpoint of Jeremy Bentham. This form of utility can be quite simply stated as the “greatest good for the greatest number,” understanding pleasure or absence of pain and suffering as good and as the single determinant of the moral good. There are no other principles and judging anything else as good is strictly the recognition that it is instrumentally conducive to pleasure or the relief or absence of pain and suffering. In this sense, act-utilitarianism is an absolutist ethical theory and bases its determination of actions as moral or immoral upon the application of a way of assessing the maximization of the good upon a kind of utilitarian calculus.

On the face of it, utilitarianism seems a natural fit for medical ethics. My concern, however, lies in its blindness to the intrinsic value of respect for particular patients as persons. Act-utilitarianism regards respect for persons as only instrumentally valuable in so far as it is conducive of better patient compliance (and thus better outcomes). If my perception is correct, we ought to reject it in favor of the deontological approach that I am espousing (one that places emphasis upon one’s duties grounded in respect). Deontology is not indifferent to consequences (as many commentators misrepresent) because the consideration of the likely outcomes of actions is important for considering which actions are in accord with one’s duties. I will develop Kant’s consequentialism in the next chapter.

The most challenging aspect of a patient’s request for help is to respond with the proper form of attention to the patient. It is through forms of attention that doctors express the value that they perceive of patients as persons. This realization leads me to the conclusion that, especially for the practice of medicine and the ethics of medical practice, respect for persons (as opposed to utilitarian consequentialism) is the only adequate grounding upon which a moral philosophy for medicine can be based. If the logic of respect is ‘patient as person-generated,’ it is the logic of objectivity and universality in four key ways (Dillon,R, 1992, Coultrap-McQuin and Cole, eds., *Explorations in Feminist Ethics: Theory and Practice*, Bloomington).

First, in respecting a person we do not respond to her as an extension of feelings, desires, and interests that we already have, but as someone whose significance is independent of us. Second, we experience the person as constraining our attitudes and actions. Third, our reasons for respecting someone are, we logically have to assume, reasons for other people to respect him also (or at least to endorse our having respect for him from a common point of view, i.e. objectively). Fourth, respect is universalizing, in the sense that if humanity is a respect-warranting feature of Jane, then respecting Jane on account of her humanity commits us, other things being equal, to respect the other beings that also have the feature of being human like Jane. When it comes to respect, then, subjectivity defers to objectivity.

Respect is thus unlike eros or filial love and more akin to a general love of humankind (agape). At first glance, this seems a somewhat paradoxical and impersonal response to the patient as person in light of the attention and empathy I have just been extolling. If we recall that respect is first a pre-reflective disposition toward humanity that precedes a physician even having met the person who is to become her patient, we can regain the proper perspective that makes agape appropriate.

Threats to the physician-patient relationship come from denying our basic instincts and intuitions to help others rather than from embracing these intuitions. Asking the patient “How can I help you?,” if sincerely intended, demonstrates caring and initiates respect and trust-building. I need to be clear that, as I see it, patient-centeredness is a stand-point: a way of regarding the therapeutic relationship that welcomes the patient to assert his humanity and his individuality. At its core, however, as care-givers and healers, respect for patients as persons is not a route to patient-centeredness, it is the starting-point and the end-point – the *alpha* and the *omega*.

The principle of respect for persons has been firmly ensconced in medical ethics discourse as a result of the writing and reflection of pioneers in this arena such as Paul Ramsey in his 1970 book, *The Patient as Person*, and Downie and Telfer in their 1969 book *Respect for Persons*. The inclusion of respect for persons as the first of the three core principles in the *Belmont Report* (National

Commission 1979) indicates the consensus view that respect for persons encompasses both the autonomous and the non-autonomous. Even so, the meaning of this principle and its demands on physicians in practice and upon researcher conduct has continued to remain ambiguous.

At some level, we all know what it means to be respected; we generally agree that respecting others is morally important; and it seems obvious that physicians and researchers should respect patients and research participants. Despite familiarity with the concept of respect, characterizing moral duties of respect for persons has been a challenging and elusive task. Why such a challenge? To start, there is a disconnect between many philosophical constructions of respect for persons and the use of respect in ordinary language (Dillon 2003; Lysaught 2004; McGuire 2004; Beach et al. 2007).

Whereas analytic discussions of respect for persons have focused on autonomous agency, ordinary language use of respect with phenomenological reference to persons embodies a broad range of concerns, as expressed by patients' responses to questions about what respect means to them. These responses tend to emphasize the caring attitude of the physician toward them, such that they did not feel as if they were a "non-entity" or a "slab of meat." The following quotations have been extracted from in-depth interviews conducted with 19 survivors of Sudden Cardiac Death. The identification numbers listed with the quotations are random identifiers. Patients were asked their views on respect generally, respect in the conduct of medical practice and research, and the conduct of care and research in emergency settings (Dickert, Neal. *Kennedy Institute of Ethics Journal* 19.4 (Dec 2009): 311-38).

"You don't know how important it is to a patient to feel that the doctor cares...Telling them what's going on and showing that you care a little, you know. I know you have to separate yourself but...you have to show some compassion too (#019). "I think doctors and nurses should be conscious of the speed in which they move and the speed with which they talk and how they pick up things and look at their beeper and all of those machinations, because it makes you feel like a cow" (#546). "I asked her if I could have a little bit of water and she just totally ignored me, just turned her back and said "you can't have anything right now..." and the other nurse said to me "don't you realize what a strain we're under." (# 837). "[Respect is] Acknowledging what people would want to do or be." (#916)

Some of these statements reflect conceptions of respect rooted in autonomy, but others reflect elements of care, empathy, behavior, attitude and attention to needs. These elements are absent from

many philosophical accounts of respect or respect for persons, but they reflect the way we speak of respect on a regular basis. These statements treat respect as a more multi-faceted concept than most philosophical discourse on respect would indicate. Philosophical concepts cannot be defined by popular opinion, but intuitions about respect reflected in ordinary language warrant careful consideration and may reveal elements of respect for which theory has failed to account.

Some may argue that attitude only matters insofar as it affects the interests of the object of respect. Although an emphasis on respectful action or behavior is less important at the level of institutional policy, denying the importance of an agent's attitudinal state and reasons for action runs counter to the moral intuitions that many of us share (grounded in respect for persons) and reflects a narrow view of moral assessment.

Consider an oncologist conducting randomized controlled trials of chemotherapeutic agents for metastatic disease. His studies enroll sick patients with few treatment options. Imagine now that he conducts these studies solely to promote his career. He has not considered the fact that the lives of his participants are profoundly affected by study participation. The studies are entirely ethical in the way they are expected to affect the interests of the participants, and the investigator generally acts “respectfully” because he knows he cannot conduct the study without patients. This researcher, however, is being disrespectful in a morally important way. Respect requires, as one patient recently said, understanding that “these are people’s lives you are dealing with here,” and that is precisely what this researcher does not do. He may simply be preoccupied with his own ambitions and goals and has “forgotten” about the real people with whom he is dealing; it may be that he just does not care. These distinctions matter. Although irrelevant for an assessment of the permissibility of his actions, attitudes and reasons are crucial to determining the respectfulness of people.

Another critical aspect of respect highlights its paradoxical objectivity. Respect is, on one hand, highly particular and involves appreciating or understanding different things about different persons.

But respect is also objective, in that its content is determined by facts about the persons being respected that emanate from their being human persons and facts which are true of all human persons. Respect thus exists in sharp contrast to love (also an evaluative attitude) that can carry important moral responsibilities (Dillon 1992; Anderson 1993). We can love persons for qualities they possess, but whether and how we love them and what responsibilities love entails is determined as much by the lover as it is by the beloved.

Respect, however, is generated by properties or features that the person to be respected possesses. Because of this objectivity, the moral demands of respect toward any given person will be the same for the respect that multiple persons owe, provided the circumstances are similar. Our respectful actions, however, may differ among holders of similarly respectful attitudes.

Different doctors may have radically different styles of conveying the same respectful stance toward their patients or research subjects. Some may be stern, serious, and authoritative, referring to patients as “Mister” or “Miss.” Others may be warm, jovial, and self-effacing. Both methods can convey similar messages of appreciation and respect for the patient as a person and dedication to her health and care.

The basic moral stance that doctors should take toward patients is the same and is rooted in the properties or characteristics that patients possess at the core of their humanity (whatever those might be determined to be). Yet the particularities and idiosyncrasies of doctors and patients leave open the opportunity for self-expression and personality to play important roles in the development and stability of this relationship.

Transcending Cultural Relativism

I argue that it is the ability of respect for persons to transcend identification with the cultural meanings of respect (the many and often incommensurable ordinary everyday uses of the term) that allows it to avoid the critique of its culturally pluralist implications. Certainly, people in different

cultures will define the terms differently, will recognize different limits on the norms, and will construct different theories to account for their experience. The primitive idea that there is something generally wrong with killing other humans will be articulated very differently in different cultures – some referring to the “sacredness of life,” others to a duty not to kill, some to a right to life, or others to a prohibition on killing the innocent. Some may extend the insight to a duty to prolong living, others limit it merely to a prohibition of direct, active killing. Some may endorse more exceptions (i.e. killing of unjust aggressors, killing in just war, killing in self-defense); others, such as pacifists, will be much more reticent to dole out exceptions.

Certainly, people at different times and places articulate norms in different language and embed them in different ethical or theological beliefs and commitments. The basic claim I am making is that there is a primitive, pre-theoretical insight that is shared by all normal, morally serious persons that human beings, as persons, deserve to be respected and given a very special status in the world.

Many bioethicists and moral philosophers insist upon the irreconcilable lack of moral agreement that must inevitably result in our acceptance of a deep seated and incommensurable pluralism of moral values. This leads many of them to accept one form or another of moral relativism or skepticism.

I do not deny that some moral norms are unique to particular cultures, groups, or individuals, but one need not be a cultural or ethical relativist to accept multiculturalism. Cultural relativism not only prevents us from criticizing the brutal and intolerant practices of others, it also does not permit our criticism of our own past. We could not say, for instance, that slavery or child labor or the oppression of women were wrong or ethical mistakes, since this implies an objective moral standard according to which we can evaluate past practices.

To deny cultural relativism is not to deny multiculturalism. Multiculturalism requires an open mind towards the customs and the beliefs of other cultures, but such open-mindedness need not, and should not, be uncritical. These differences in perspectives are beneficial when they offer different

potential solutions to the moral problems faced by human beings. Multiculturalism is the awareness that there are a variety of different ways that people live, including differences in their practices, institutions, values, and moral rules. Multiculturalism can be a welcome corrective to those moral blind spots within our own culture including the tendency to assume superiority and dismiss other ways of life as inferior and backward. Multiculturalism is entirely consistent with a conception of morality as amenable to rational considerations and the conviction that there can be better or worse moral justifications. Respect for persons and the duties it entails ought to be held in common by all persons and cultures who are committed to the objectives of morality.

I intend this to mean that, as a principle, respect for persons is a rational concept that is reasons-responsive and requires a justificatory defense based upon logical reasoning. I am not going to offer an epistemological defense, but rather a normative one. I perceive a clear distinction and draw it, in the process of justification. Emerging from this disposition of respect are a set of duties and obligations that may be conceived either as principles, virtues or maxims and that more specifically apply the abstract notion of respect to the practical actions entailed by respect for persons.

None of these, however, displace the need for reflection upon the moral issue at hand and collaborative deliberation regarding the contextual particularities of a given clinical situation in conjunction with the values, goals and desires of the patient. Respect for persons does not ground a series of algorithms that, if merely followed, lead to “right answers.” Our ethically informed and educated moral sensibilities, under the guidance of respect for persons and the entailed mid-level principles, still come down to the use of practical reason and phronesis to arrive at our particular ethical judgments.

Treating Patients As Persons: Consequences Do Matter

Some philosophers that reject respect for persons contend that this ethical stance is overly formalistic and does not take the consequences of our actions adequately into consideration. To claim

that an ethical theory based upon respect is devoid of content (a hollow form), however, fails to give recognition to the universal and objective nature of such respect. Others refer to this view as deontological, meaning that certain behaviors are simply our duty even if they do not produce benefit.

This label was initially introduced pejoratively against Kant's ethics and, while it has come to no longer represent a criticism, it nonetheless is misleading. Respecting autonomy, telling the truth, keeping promises, or avoiding killing people are all examples of duties many hold that we owe to all people regardless of the consequences. Each, however, is a duty precisely because of its consequences, both in terms of the effect the duty has upon the person who is the object of the duty, as well as the internal effect it has upon the moral standing, character and merit of the subject carrying out (or failing to carry out) her duty.

Each of these can be expressed as a principle of ethics: autonomy, veracity, fidelity, and avoidance of killing or the sacredness of life. Often this collection of principles gets grouped together under the heading of respect for persons. Respect for persons can be taken, as Robert Veatch describes it in chapter 6 of *Case Studies in Nursing Ethics*, as a kind of super-principle that focuses our attention upon the intrinsic moral value of people. It requires that we treat them as ends in themselves, not merely means to good consequences (or to our own ends). In fact, as Veatch takes note of, "some important ethical theories simply list respect for persons as **the** principle that directs our attention to the intrinsic moral worth of people" (ibid).

What this description of respect has not yet taken note of is that being treated with respect has already likely had both a positive and a negative influence in this person's life at various times in the past. During our 'formative years,' unless we come to see ourselves as 'valuable' through the eyes of those significant others with whom we are in relation, it is less likely that we will have become self-valuers. Our potential for 'normal' maturation may well have been thwarted. Unless those involved throughout our lives have, for the most part, treated us with respect, we will not develop the appropriate sense of self-worth, self-respect and self-control to guide our own continuing development

of autonomy into self-determining responsible moral agents. It is necessary in childhood development that we are treated with respect and given a sense of self-worth. This continues throughout our lives, especially in vulnerable situations, such as when we find ourselves medically unwell and suddenly thrown into the role of patient.

Respectful treatment, at the moment of first encounter is undoubtedly an important determinant of the dignity and self-worth patients experience as the recipient of this respect. This must be done with attentiveness to subtle mannerisms and facial expressions that may be clues to how people's life experiences have them prepared or unprepared to deal with the illness they now face. Yet, the pre-existing influences upon a person's self-regard are beyond the doctor's ability to assess in the initial visit. That being the case, physicians must, at least initially, assess the patient as she presents and acts now, and sort out the social and psychological past history at the same time as inquiring about the patient's past medical history. These are important factors, within the context of their lives, which the doctor must be responsive to.

The duties to self and others (for physicians) that have been stressed to this point and which are the primary concern of this project are those that gain moral force in the particular cases where patients face significant disrupting and potentially life changing conditions. In order to understand their duty in these situations, doctors must recognize and almost instantaneously (and often subconsciously) assess and appraise the patient, not as a medical problem or set of complaints, but rather as a person in distress and in need. The physician must first identify the person's willingness and ability for communicating (whether verbally or through body language) the degree and kind of effect their disordered state of mind and body has upon their demeanor and (un) cooperativeness.

There are a wide range of contingent physician duties and obligations that emerge from the notion that patients are 'ends-in-themselves.' These duties are 'implicit' in the conception of respect in the categorical imperative. Physicians make them explicit in the manner that they apprehend, regard, and appreciate the value of the particular person through their caring concern. It is often true, in these

situations that respect plays out as the duty to assist their patients to overcome the immediate constraints upon their autonomy. These have arisen from pre-existing factors or as a consequence of illness, suffering and pain.

Alleviation of their discomfort can also be a way of conveying the reassurance that they are being tended to by a sensitive person, who sees and regards them as persons as well as patients. Thus, even when acting from respect, it is, as said earlier, the minimum requirement. With a constant eye on self-improvement, both as a doctor and as a person, physicians always have opportunities for growth in more completely, appropriately and effectively responding with caring respect. This entails focus upon both the consequences of illness and injury and the consequences of treatment and of preventive care.

Consider that, when human beings suffer significant set-backs to their well-being, it is often difficult for them to exercise their capacity to accurately assess their emotional and psychological state of mind. A human being can behave “with dignity” in coping with miserable circumstances and the attendant suffering and, despite these challenges, can demonstrate the ability to overcome the obstacles to exercising his functional autonomy. He grows in moral spirit, or merit, and moves a step closer toward that elusive ideal of autonomy, but he is no more worthy of the doctor’s best efforts and respect than the patient who is completely broken down and overwhelmed by her infirmity. Such is the spectrum of human particularity in accepting and dealing with illness and it is the physician’s constant challenge not to favor one over the other in distribution of time and talent. This would be the height of disrespect (and perhaps of self-conceit).

For those lacking sufficient strength of will or virtue development, intense pain not only has the power to make one forget almost everything else, but even far less intense, physical and psychological suffering can turn that person into a creature who simply “goes through the motions,” responding to the circumstances in which she finds herself as being defeated. The person, as human

being, who has been thus diminished, nonetheless retains her potential for autonomy, though it has been virtually obliterated by the constraints of suffering and pain.

Her autonomous power is only temporarily rendered over-ridden or overwhelmed, but to the extent that someone is prevented from exercising this capacity, she is externally indistinguishable from persons who lack it irreversibly. To this extent, her personhood, while not extinguished, is no longer functionally allowing her to participate in or experience the dignity which is still in her possession and which may well be reversibly restored.

The efforts of a caring doctor to ameliorate or reverse the suffering of another person and help restore her sense of self-control are the greatest ways in which respect for her as a person can be shown. An effort to protect the well-being of persons and help them preserve or restore some functional level of autonomy is the respectful response to their value. Physicians are “privileged” to be a part of the human drama that plays itself out day after day. At least for the foreseeable future, there will be no end to human suffering. Yet, precisely because human beings are capable of giving things of value their due, doctors have reason to acknowledge their own value, to contribute to their well-being and to assist in engineering successful outcomes that restore their proper sense of self. This, then, is the end result of Kantian (or Respect for Persons) consequentialism.

Kantian Virtue and Beneficent Duty

Patient-centeredness encompasses an element of virtue-based ethics in its insistence that physicians possess a moral capacity for self-reflection and a desire to better understand and adopt those attitudes and dispositions that positively influence their own behaviors. The moral virtues in medical practice, then, are primarily duty-based rather than beneficence-based and are rooted in Kant’s Doctrine of Virtue, rather than in Aristotle’s Nichomachean Ethics. This does not change the fact, however, that duties of virtue often are aimed at the benefits (and beneficence) such acts will produce. It is just that it is not the production of benefits that determines the morality of the action. Actions are

moral just in case they show respect for beings who are themselves unconditionally valuable and deserving of respect and its entailments.

I recognize the necessity and appropriateness of paying great attention to the consequences of physician actions and treatment outcomes when grounded in respect for the patient. This ensures that the patient is a participant in the process and is aware of possible treatment outcomes as well as any attendant risks. Respectful patient care is dependent upon the physician's personal virtues and character traits for practically, effectively and efficiently attending to the medical and personal needs of the patient in the actual practice of caring, respectful medicine. It is through virtuous caring that doctors are motivated to go beyond the minimal requirements of respect. Treating patients in this way is not merely good clinical practice: it is good moral practice as well.

Respect, as I am describing it, guides the doctor to inform and educate her patient and to foster and promote his capacity for functional autonomous involvement in his own medical care and decision-making. This mutually respectful relationship as partners identifies the importance of the physician to the optimal care of the patient, while recognizing the centrality of the patient and his autonomous choosing, in so far as is possible.

The reasons justifying the principle of respect as "fundamental" begin in the recognition that respect for persons is a necessary element of any other ethical principle and is a necessary concept to incorporate within any ethical theory. Respect for persons is multivalent: a disposition, an intuition, a moral feeling and the foundational moral principle of medicine. It is strong enough and flexible enough to provide the groundwork for moral decisiveness, even in the face of both ethical and multicultural pluralism. If successfully employed, this underlying moral commitment can and does provide us with a way of prioritizing conflicting moral claims.

For medicine, I see no other option but to judge all living members of the human moral community as persons. Medicine can come to no other conclusion. Where we have need for cooler heads and sharper insights is in the recognition that personhood is not the determinant of who should

be kept alive and who should be allowed to die. Persons, in order to fully respect them in the technological era of life-sustaining support, do not and must not be viewed as requiring or deserving life as some irrefutable or undeniable value. In fact, allowing persons to die with dignity best honors respect in many of these conditions. Fortunately, these moral dilemmas are the exceptions, not the rule.

Respect provides us with a moral orientation towards the ethical dilemmas faced daily in medicine that center upon the patient. Understood and utilized properly, it can give us guidance in recognizing and correctly choosing the most appropriate mid-level, contingent, *prima facie* principle of action and guidance in empowering virtuous attitudes as the foundational basis and commitment for human character development and moral growth.

Respect for Persons vs. Medicine's Social Responsibility

I understand this to mean that physician duty, in addition to overriding any personal conflicts of interests, also subordinates her concern for her responsibilities to social and distributive justice, health care policy, fiscal responsibility (whether to employers, insurers or governmental agencies), and rationing or placing limitations upon the degree of care she provides to her patient. Seen in this light, there is a distinctly practical and particularistic cast in the ethics of medicine as it pertains to patient care and physician responsibility. Commitment to the principle of respect for persons and acting upon the caring disposition of such respect provides the appropriate guidance and prioritization for doctors to maintain focus centered on the care of the patient.

Physicians are not and should not be conflicted by pedestrian utilitarian concerns, which might lead to sacrifice of the one for the many in the interest of the greater good. Resolution of any conceptual difficulties that a physician may have, in reference to her attitudes and behaviors in particular situations are also clarified for her by her commitment to the entailment of respect within her medical practice. Respect for persons in the universal is respect for all human beings as members of the moral community. Furthermore, within the process of diagnosing, healing and curing, the

physician duties to her patients must be more inclusive and more strictly morally binding upon physicians and other healthcare providers than in other disciplines and other forms of human activity that recognize human value.

Contemporary medical ethicists have increasingly grounded medical ethics in cultural practices and norms. They then contend that because these practices and norms shift, practices and norms are relative. This error can be corrected by demonstrating that respect for persons is a universal moral norm that is foundational for medical ethics. It is harmful and dangerous to hold the understanding of medicine as a “social construct” (as many contemporary medical ethicists do). Whether understood as a practice or as a profession, this view orients medical practice in an outward direction, toward providing, for society, the maximal health care benefits for the largest possible number of those persons who comprise the social order. This commitment to the maximizing principle of utility does violence to the sanctity of human dignity and the duties entailed by respect for persons to treat no person as a means to the ends of others.

Medicine, such theorists argue, is undoubtedly socially situated and has been granted by society considerable authority, autonomy and self-directedness. This comes in exchange for medicine’s duty to discharge its social obligations. I would respond that while it may be true that these social responsibilities and commitments of medicine seem to be better articulated from a utilitarian perspective of a just distribution of health care benefits for the greatest number of persons in a society, in fact, there is more to justice than “distributive justice.” Justice, I would submit, is better conceived as a deontological norm, as the duty to treat all persons fairly. Understood in this light, justice would never validate sacrificing the one or the few for the many and flat-footed utilitarian notions of justice fail to account for the unconditional value of persons. This social duty, then, can also be validated and grounded in respect for persons. Our understanding of the social duties of medicine are improved by seeking their ground and justification in respect for persons. We, as a people and a society, should

never satisfy ourselves with the sacrifice of even one, regardless of the fact that, in the real world, such sacrifices may be unavoidable.

The Limitations Of Respect For Persons

I wish to acknowledge and accept that major moral issues will remain even if my thesis is accepted. The approach to practical ethical deliberation and decision-making that emerges from grounding moral principles in respect for persons does not purport to provide a method for dealing with every dilemma that arises from the conflict of secondary or mid-level moral principles or of the many more specific moral obligations encompassed by them (though much of the conflict between these principles may be reduced or eliminated).

Nor does it purport to resolve disputes about the scope of the principles that received their justification by this general and overarching moral commitment of respect. Questions of scope apply to each of the secondary principles individually and are particularly important in relation to the principles of autonomy and beneficence, which are subject to conflict with each other. Respect for persons does, however, establish the priority of autonomy over beneficence when functionally present and establishes the duty to foster and promote the autonomy of persons, resorting to beneficent action on the behalf of others only when autonomy is clearly lacking. In addition, the primacy of respect for persons does not deny that good and virtuous characters are needed to instantiate it and the principles it encompasses in real life situations.

CHAPTER 2

KANT'S ETHICS OF RESPECT FOR PERSONS IN THE PRACTICE OF MEDICINE

Immanuel Kant was the most influential philosophical proponent of respect for persons. I examine his theses and arguments, as well as offer what I judge to be a normatively plausible justification in support of his contention that persons, by virtue of their humanity, are of unconditional value. The idea of respect for persons is most commonly associated with Kant's conception of treating persons as ends in themselves. Indeed, the end-in-itself formulation of the categorical imperative is regarded as the pre-eminent statement of the principle of respect for persons and it is upon this conception that I base my understanding of respect for persons in medicine, for it achieves a universalizable duty that physicians owe to all patients, regardless of their particular characteristics, attributes or virtues. It essentially holds that all human beings are respect-worthy, have dignity and are due this respect purely on the basis of their human nature alone.

Respect for persons depends upon our mutual understanding and agreement regarding these two contested concepts: "respect" and "persons." The widespread usage of both of these terms, in philosophical and ethical discussions as well in everyday conversations, make it decidedly less likely that I can convincingly argue for the understanding of respect and personhood necessary for medicine to be embraced by all other disciplines which also make use of these concepts. The term "respect" has functioned in ethical discourse since the strong argument Kant made for "respect" as the ground of his system of morality characterized by duties and obligations toward self and others. Respect, in Kant's usage, means something far more deeply embedded at the core of the justification of morality than its common contemporary usage in interpersonal discourse.

This version of the categorical imperative seems to say that we must respond appropriately to a value that does not depend on what we think or decide is the case:

Beings the existence of which rests not on our will but on nature, if they are beings without reason, have only a relative worth, as means, and are therefore called things, whereas rational beings are called persons because their nature already marks them out as an end in itself, that is, as something that may not be used merely as a means...(GW 4:428)

Consider the way Kant introduces The Formula of Humanity:

If, then, there is to be a supreme practical principle and, with respect to the human will, a categorical imperative, it must be one such that, from the representation of what is necessarily an end for everyone because it is an end in itself, it constitutes an objective principle of the will and thus can serve as a universal practical law. The ground of this principle is: rational nature exists as an end in itself. (GW 4: 428)

The FH is introduced almost immediately after this line of thought. Explicitly, the second formula of the categorical imperative, The Formula of Humanity as an End in Itself (FH) as iterated in Kant's *Groundwork for the Metaphysics of Morals*, states: "Act so that you use humanity, as much in your own person as in the person of every other, always at the same time as an end and never merely as a means" (GW 4:429). Kant's conception of respect for humanity regards persons as having an intrinsic, absolute and objective worth that must always be respected and never sacrificed or violated. It calls for according all persons with this level of respect (including ourselves) and, when properly understood in the setting of our social interactions, respect can only flourish in an environment of mutual reciprocity.

Through the formula of humanity, respect for human dignity generates, in an obligatory and compelling way (based in Kant's conception), specific moral requirements regarding coercion, deception, murder, slavery, discrimination, rape, ridicule and humiliation. The impermissibility of heinous acts of these sorts, regardless of whether such actions are toward a few persons or even one, cannot be justified according to Kant, regardless of how much benefit to a vastly larger number of persons such behavior might bring about. These unyielding commitments forge an alliance with the fundamental commitment of medicine to treat patients with the utmost respect and to do so, one at a time. The physician is committed to each patient individually in his particularity and thus, it goes without saying, that none of the above breaches could ever be tolerated or rationalized in medical practice.

Kant stated it forcefully: “Every man has a rightful claim to respect from his fellow men and is bound to show respect to every other man in return.” This seems to be, in its essence, Kant’s respect for persons principle. It, together with a description of the humanity of persons (the basis of respect) and the more particular moral duties that follow from it, constitutes what I will refer to as Kant’s respect for persons theory of morality.

A full statement of the principle might be “respect and treat respectfully the humanity of every person.” Yet far more commonly, when philosophers and ethicists make reference to respect for persons, they choose to attribute it to Kant through citing his second formulation (FH) of the Categorical Imperative as its source. These two slightly differing views of respect for persons, as Kant puts it, assert that the only thing that qualifies as an object of respect and the only objective end is “the human being and in general every rational being”(ibid). After ruling out other candidates for this status, Kant further specifies what he has in mind:

Beings the existence of which rests not on our will but on nature, if they are beings without reason, still have only a relative worth, as means, and are therefore called things, whereas rational beings are called persons because their nature already marks them out as an end in itself, that is, as something that may not be used merely as means, and hence so far limits all choice (and is an object of respect). These [persons], therefore, are not merely subjective ends, the existence of which as an effect of our action has a worth for us, but rather objective ends, that is, beings the existence of which is in itself an end (*GW* 4: 228).

Synthesizing the two closely related notions, it is clear that Kant attributes unconditional value to humanity, which he also refers to as rational nature (that is, the rational human nature possessed by every human being). This human rational nature which has unconditional worth, qualifies human beings as persons deserving of respect and obligates others to treat them as ends and never merely as means. By virtue of this fact persons have dignity, as well as an unconditional and incomparable worth, and the only appropriate response to this dignity is what Kant calls respect (*GW* 4: 436). We show respect by conducting ourselves virtuously and the categorical imperative’s job is to help us determine what this entails.

Kant and The Dignity of Humanity for Medicine

Humanity is an important notion within Kant's moral theory and grounds or justifies the notion of the deservingness of respect. Kant's analysis of ethical obligation and his expositions of rights and duties in the *Metaphysics of Morals* refer frequently to humanity. How we understand this concept, then, has significant implications for how we understand Kant's ethics and what we ultimately mean by the attitude, disposition or principle of respect for persons. In Section II of the Groundwork, Kant ascribes absolute worth to the end in itself, humanity (*GW* 4: 428–31). He also attributes dignity, which he describes as an unconditional, incomparable, inner worth, both to humanity and to “a morally good disposition” (*GW* 4: 435–6).

What gives us our dignity and moral importance, according to Kant, is that only people are capable of functioning as rational and free agents capable of making decisions, setting our own goals and guiding our conduct by reason. The moral law is the law of reason and rational beings are the embodiment of that law itself. Moral goodness can exist only insofar as rational agents apprehend the moral law and, acting from a sense of duty, enact it. So we rational beings have value beyond price since we are, according to Kant, the sources of value recognition in the world.

If we were to understand Kant's notion of respect for persons solely in these terms, respect would seem to be dependent upon functional autonomy. The term autonomy is more firmly associated with the name of Immanuel Kant, than that of any other philosopher. Kant gave great and repeated emphasis to the importance of treating people as ends in themselves and not as mere means, as persons rather than mere things, as rational beings and creatures with dignity, and as proper objects of “respect.”

Particularly for medicine, it is important that we grasp the full import of the moral commitment that we, as physicians, make to respect all patients as persons and accordingly to recognize the dignity and unconditional value of each human being.

The contemporary notion of autonomy as self-determination and as personal autonomy is beyond what Kant had in mind and as Joel Feinberg commented, “Kant surely would have rejected it” (*Harm To Self*, p. 94). Feinberg’s reading of Kant is quite unlike my own, but on this point we are in agreement. My emphasis is upon claims such as these, in which: “We are enjoined by Kant to respect, not the deliberate choices of persons whatever they may be, but the “humanity” in each person; not the voluntariness of decisions as such, but their “rationality”; not a uniquely concrete being, but some abstraction within him; not a personal dignity, but the alien dignity of some extra-personal source” (Feinberg, p. 95).

I contend that Feinberg overstates his case with his reference to an ‘alien dignity’ when, for Kant, it is ultimately the faculty of practical reason that is possessed by each person. This human power of evaluative reason is not alien but is central to what it means to be human. Because Kant is quick to acknowledge the fallibility of “concrete human beings,” Kant maintains that the rationality of human nature need not be actualized in each individual person for all persons to be deserving of respect.

Feinberg argues that Kant’s language implies that we must cherish and protect a person’s choice, not because it is simply his, “but because of something within him, quite independent of his will, a kind of internal Vatican City not subject to his sovereign control” (ibid). Feinberg clearly is not in sympathy with Kant’s conception of autonomy nor does he seem to properly understand it. Yet Feinberg is correct that a person’s dignity or deservingness of respect is, indeed, not subject to his (or any person’s) sovereign control.

Feinberg continues, “Kant then makes his strongest appeal: to the ‘humanity’ in one’s person, that internal something which is the true object of the respect owed a person. The way he uses this notion, the reader must think of it as something other than himself. He does not respect me; he respects some alien presence in me that in some circumstances can be a burden, even an enemy” (p.95). In this interpretation of Kant, Feinberg is also off the mark. He cites Kant’s *Lectures on Ethics*:

Man can only dispose over things; beasts are things in this sense, but man is not a thing, not a beast. If he disposes over himself, he treats his value as that of a beast. He who so behaves, who has no respect for human nature and makes a thing of himself, becomes for everyone an Object of free will. We are free to treat him as a beast, as a thing, and to use him for our sport as we do a horse or a dog, for he is no longer a human being; he has made a thing of himself, and, having himself discarded his 'humanity' he cannot expect that others should respect humanity in him. Yet humanity is worthy of respect. Even when a man is a bad man, humanity in his person is entitled to respect. (Trans. Louis Infield; Hackett, 1979, p. 151).

Feinberg interprets this passage as demonstrating how impersonal Kant's respect for persons is and again misunderstands Kant's intentions and suggests that when Kant respects a person, he respects him not as someone in rightful control of his own life, but rather as the "locus or repository of abstract qualities which are the true object of respect and which must be protected and preserved at all costs" (p. 96). The quotation is in fact, however, illustrative of the universal and unconditional value Kant places in humanity, even that of the respect owed to a "bad man."

It is important, in order to understand this quote in context, to recognize that in this lecture Kant is addressing suicide, which he held to be immoral. Suicide is, for Kant, a violation of the categorical imperative in the formula of humanity, by failing to treat oneself as an end. Kant's passage, quoted above by Feinberg continues immediately:

Suicide is not abominable and inadmissible because life should be highly prized; were it so, we could each have our own opinion of how highly we should prize it, and the rule of prudence, will often indicate suicide as the best means. But the rule of morality does not admit of it under any condition because it degrades human nature below the level of animal nature and so destroys it. Yet there is much in the world far more important than life. To observe morality is far more important. It is better to sacrifice one's life than one's morality (ibid p. 151-152).

We need not concern ourselves with this as a question regarding suicide, but the quotation is illustrative of the universal and unconditional value Kant places in humanity, regardless of whether it is recognized and acknowledged by oneself, or others, or not.

In the passage immediately preceding Feinberg's selected quotation Kant sustains this universality by extending it to not only all others but also toward oneself:

Humanity in one's own person is something inviolable; it is a holy trust; man is master of all else, but he must not lay hands upon himself... A being whose existence is not necessary must regard life as the condition of everything else, and in the consciousness that life is a trust reposed in him, such a being recoils at the thought of committing a breach of his holy trust by turning his life against himself (ibid p. 151).

The features of morality, when applied to humans, have also to take into account the sort of creatures that we are. Respect plays a crucial role in this. If the way I read the account is correct, the respect we give to persons is explained by understanding the interaction of pure moral philosophy with general features of human beings. Kant's conception locates a person's dignity in human characteristics not peculiar or particular to that person, but rather in the person's own humanity in order that every human being be valued as a person and considered worthy of respect (in and of himself). Thus this unconditional value and the duty to respect persons is objective, universal and independent of the specification of particular subjective aspects of this person or that life.

Kant's view is that human beings have dignity that is derived from those human traits and capacities that they share in common. Feinberg concludes his reflection by stating that: "if personal autonomy amounts to no more than that, it cannot be the same concept as that which we recognize and employ in every day life. It certainly is not the concept to which appeal has been made in this chapter" (p. 97). I couldn't agree with him more! The inviolable worth of both self and others is unconditional and beyond the interests of prudence. Interests are rationally stated versions of the original drives since, as Kant writes in the *Groundwork*, "Interests are that by which reason becomes practical, i.e., a cause determining the will. Therefore one says of rational beings only that they take an interest in something; non-rational creatures feel only sensuous impulses."

Maxims, or subjective principles of action, in turn, rest on these interests. Kant then writes, "A maxim is thus morally genuine only when it rests on exclusive interest in obedience to the moral law." I read this as asserting that only those interests which comport with the moral law of respect for persons are capable of grounding one's subjective principle of action. This notion of the moral law needs further explication, in order that it not be confused or conflated into the law of "common morality," later used by Beauchamp and Childress and in short, it is stated in his three formulations of the categorical imperative.

It is Kant's rather than Feinberg's conception of "moral autonomy," that is an attribute of "humanity" and contributes to the value of our beings and makes us worthy of respect as persons, in the context of medicine and medical practice. I will develop the reasons why this must be so, but these reasons ought to be intuitively obvious. Another important take away from this analysis by Joel Feinberg is that his perspective of personal autonomy reflected in contemporary personal autonomy theory is incompatible with a conception of autonomy that is defensible in medicine. Personal autonomy fails to account for the non-autonomous as persons, while medicine must have respect for non-autonomous persons as well (See Chapter 3). Further, contemporary personal autonomy theories set the bar for autonomy too high for many patients whose autonomy is constrained by the physical and psychological effects of illness. According to Sarah Bishop Merrill in *Defining Personhood*, (1998, Amsterdam-Atlanta, p. 54), "More than half of all patients who occupy hospital beds have complete lapse of, or relatively permanent impairment in rationality, verbal communication, self-consciousness, consciousness, ability to reciprocate and especially in their be taken to be a person by others."

We are said to owe respect to all persons equally, regardless of personal merit, role, or power. Moral respect in medicine is a matter of taking appropriate account of the fact that a patient is a person. Since respect in general is grounded in those features of a person that make him worthy of attention, so moral respect for persons is grounded in what we might call "the morally significant features of persons": those features which make something a person and make persons valuable and matter morally.

Some Kant commentators (such as Feinberg) argue that 'humanity' does not refer to a property or aspect of rational nature as such and, instead, is the name for the more fully rational nature that is committed to morality (which characterizes a good will) and is only possessed by rational, autonomous, responsible moral agents. By that definition many living humans (babies and individuals with advanced Alzheimer's disease, for example) are not persons. Such a position creates an insurmountable problem for medicine, which must regard all of humanity as deserving respect or have

no grounds for treating a large percentage of patients as persons and with respect. If Kant's position that only beings with 'humanity' are ends in themselves entails that they be 'beings with a commitment to morality' and, strictly speaking, 'the end in itself is a functional human good will,' then only beings with moral agency are deserving of respect and have dignity; all other human beings lack it.

Feinberg's interpretation may have value and meaningful implications in certain ethical arenas, such as social and political philosophy, but it fails to capture the broader conception of respect for persons as applying to all humanity operant in medical practice. I think the foregoing discussions have established my contention that personhood in medicine must have uniquely different criteria from that of contemporary personal autonomy theories (including the commitment to personal autonomy of Beauchamp and Childress). The Belmont Report's authors thought so also (as we shall see in the next chapter) for whom respect for persons applied both to autonomous persons and to non-autonomous persons alike.

Kant, in many of his lectures and published works, talks of humanity as a moral archetype, representation of moral perfection, or as a practical ideal. He also has recognized that human autonomy, literally speaking, is something beyond our ability fully to live up to or realize, at least in this life. Nonetheless, our reason sets forth the ideal of moral autonomy for us to aspire to, compare ourselves with, and approximate (*M 29*: 604–5). For example, in a lecture on the metaphysics of morals, Kant says that, when we conceive of humanity, we conceive of a human being 'as he ought to be and can be' (*MoM 6*: 480; *R 6*: 60–1; *CPR*: A568/B596). The point I derive from Kant's view here is that neither autonomy nor moral perfection is truly attainable and hence cannot be requisite for personhood, but this rational capacity, inherent in human nature, is the faculty that establishes humanity as deserving respect and confers upon it a dignity.

Kant, in support of my thesis, is explicit that we owe duties of respect to all other human beings. His claim is not just that we have duties to treat others as though they deserved respect, but that every human being is genuinely owed this respect because of the humanity in her person:

Every human being has a legitimate claim to respect from his fellow human beings and is in turn bound to respect every other. Humanity itself is a dignity; for a human being cannot be used merely as a means by any human being... but must always be used at the same time as an end . . . He is under obligation to acknowledge, in a practical way, the dignity of humanity in every other human being. Hence there rests on him a duty regarding respect that must be shown to every other human being. (MoM 6: 462, see also 435, 449–50, 464)

It is clear that Kantian duties of respect are grounded in the humanity of each person to whom the duty is owed, that every human being is owed this respect, and thus that humanity is present in each human person whether or not she is a responsible, functional moral agent. Moreover, it is clear that part of what duties of respect, as duties of virtue, demand of the physician is that she recognize the humanity within even the most non-autonomous other persons – that she recognize even the most impaired person as an end by virtue of his human self. It is not sufficient for compatibility with Kant’s conception of duties of respect and their grounding to say that we have duties to treat others ‘with respect’ or ‘as if’ they were ends in themselves.

Sarah Buss writes:

If, I have assumed, an “object of respect” has a value that gives us reason to treat it as an end in itself, then we are justified in taking the attitude of respect toward this object. Someone who relates to other human beings from the point of view of this attitude values them as beings worthy of being treated as ends in themselves—and, hence, as justified in expecting to be treated in this way, and justified in protesting if they are not so treated... I have stressed that our self-understanding requires nothing less. The point I am stressing now is that it requires nothing more. What could moral status possibly be if it is not a status we have good (non-second-personal) reason to attribute to one another? Once we see that our good reason to attribute certain rights to each other need not be that when we do so we are more likely to bring about certain desirable results, we can see that attributing these rights to each other is all there could possibly be to our having these rights. This is all there is to it, at any rate, if we grant one another such rights because we take this to be a fitting way of acknowledging the value of our humanity (“The Value of Humanity” J of Phil, May, 2012).

If respect for persons arises from our recognition that persons have a value that gives us reason to treat them as ends in themselves, then we are justified in taking the attitude of respect toward persons

as a motive for being disposed to act toward them in a certain ‘respectful’ way. We now need to look at precisely what Kant says about the composition of this motive. In particular, since he describes it, at least partially, as a feeling, how is this compatible with the contrast that he draws at the beginning of the Groundwork between the motive of duty and actions that result from immediate or mediate inclinations? What exactly is this subjective motive that Kant terms respect? Kant makes the following points.

Respect is a moral feeling because in thwarting inclinations that might be contrary to morality it is thwarting unreflective feelings of inclination. This feeling is (a) a feeling produced by an intellectual cause, (b) the only feeling that we can know completely and (c) a feeling of pain, which arises when our inclinations are thwarted. Kant describes this as humiliation (intellectual contempt).

A positive feeling is generated by the removal of the resistance of our inclinations. Kant writes, “respect for the law is thus by virtue of its intellectual cause a positive feeling that can be known *a priori*, for any diminution of obstacles to an activity furthers this activity itself” (*Critique of Practical Reason*, 5:79). Moral feeling is the cognitive state of consciousness of the moral law. He writes, “The immediate determination of the will by the law and the consciousness thereof, is called respect” (*GW*, 4:401, Footnote 14).

The nature of acting towards persons as ends in themselves becomes clearer if we view the action of assuming the medical care of a patient as maintaining a promise to do so to the best of our ability and with the utmost care. The engagement of a physician with a patient involves a promise in which the reciprocity of respect and trust is affirmed as the basis of action. Such reciprocal concern as is involved in maintaining a promise to a patient is acting with the personhood of the patient in view (and the recognition that his consent to the doctor's action or the possibility of such consent matters supremely to the caregiver). Kant’s intent of ‘acting with respect for persons,’ when applied to medical practice, is enacted by a caring physician by regarding her patient as a person and as being the person upon whose behalf she acts. Viewing the patient as an end-in-herself leads the physician to the

realization that our patient is the one that calls us, as caregivers, to morality and to the transcendence of our mere self-interest, elevating the relationship such that it transcends a mere instrumental relation. This is the sense in which the experience of patients as persons is a moral experience as such.

Treating patients as ends-in-themselves assists us greatly in over-coming the perceived contrast between the Kantian and Millian conceptions of freedom. On the generally accepted received view of Kant's moral theory, Adam and Eve were not free in choosing to disobey God's command. This interpretation is based upon the view that, in matters of morality, only actions justified by reason are autonomous and therefore free. Moral actions from unreflected inclinations or desires are heteronomous and, according to Kant's view in the *Groundwork*, are not free.

Conversely, on John Stuart Mill's generally received view, Adam and Eve were supremely free because freedom is determined by whether one's action is self-determined without interference or coercion regardless of the wisdom of such action. Mill argued in *On Liberty* that persons have the right to self-determination as long as they do not harm others. Mill's emphasis was on the "individuality" of autonomous agents and he defended the rights of individuals to pursue their own personal goals and emphasized the need for being one's own person:

A person whose desires and impulses are his own – are the expression of his own nature, as it has been developed and modified by his own culture – is said to have a character. One whose desires and impulses are not his own has no character, no more than a steam engine has a character (*On Liberty*, p. 62).

On Mill's view, this right of individuals prohibits not only government interference, but also paternalism or restrictions or interference with a person of mature age 'for his or her own benefit.'

Suppose then, that the counsels of reason from the physician and the desires of the patient for a prescribed course of action clash—which is to prevail? The Kantian (on the received view of Kant) would be inclined to say the counsels of reason, but it is difficult to view that as anything but the denial of self-determination. If, however, we incorporate Kant's *Metaphysics of Morals* and his *Anthropology* into the *Groundwork*, the central emphasis has to be repositioned from the purely

deontological to Humanity and Respect for Persons. Moral life can be re-described as a matter of expressing respect or reverence for a substantive value, ‘humanity’, and with it our ‘rational capacity to set ends.’

Violation of the autonomy of another occurs when one treats others as a mere means to one’s own ends (using others for our own purposes without regard for their goals or recognition of our own duty to treat them with respect as rational persons). This is the positive aspect of freedom and Kant understood autonomy as a faculty of the human will. All rational beings have it, whether they choose or are capable of expressing it or acting upon it or not. This conception has tremendous implications for the recognition of all people as equals and for establishing what others deserve from us, regardless of how we may otherwise regard them. Accordingly, all persons are deserving of our respect which, understood positively, entails deserving of our aid in the promotion of their ends and aid in raising their level of autonomy, so far as is possible.

A Kantian view of autonomy, with an emphasis on reason as the starting point for morality, must be understood in light of our existence as human beings, in a social world populated with other human beings who also have legitimate needs and concerns. The exercise of reason extends to all of the rational relations of humankind (such as the physician-patient relation).

For Kant, reason alone is insufficient to ensure right action (hence the need for principles such as the categorical imperative) and for medical relations, the formula of humanity provides the clearest guidance regarding the duty of physicians. Understood in this way, Kant’s moral autonomy supports the kind of relational social partnership between doctor and patient that commits the physician to recognize, promote and honor the wishes (or ends) of the patient above her own. In the *Anthropology*, Kant argues that our individuality and autonomy emerge from and are dependent upon the influences of others. Accordingly, it is appropriate for the physician to provide education, guidance and counsels of reason, regarding the patient’s diagnosis, prognosis and recommendation for treatment. When there is disagreement between patient and physician there is an added obligation upon the physician to lobby

persuasively for her recommendation and for her to provide further reasons that it is preferable and should be seriously considered by the patient.

This collaborative process of decision-making engages the reason of both physician and patient. Both are committed to the goals, values and commitments of the patient which are the ultimate determinants of what the final decision for action will be. Kant bases all of our specific ethical duties on our virtuous commitment to the ends of patients in accordance with a principle of inner-freedom (*MOM* 6:394). The fundamental principle on which Kant grounds ethics is not consequentialist, however, and this points to the importance of distinguishing the fundamental principle of an ethical theory from the style of reasoning it recommends in ordinary deliberation. Physicians may (as Kant does) advocate consequentialist reasoning in moral deliberation with her patient (in matters which do not involve a perfect duty) without accepting a consequentialist foundation for morality.

Kant's thinking about moral ends recognizes no utilitarian principles of summing, averaging, or maximizing, as essential to moral reasoning. When Kant says that the happiness of others is an end which is also a duty, he means that it is meritorious for a physician to promote any permissible part of a patient's happiness, but this does not entail or require the doctor to strive for maximizing that patient's happiness. Furthermore, Kant does not distinguish the moral worth of a physician who maximizes a patient's happiness from the moral worth of a physician whose effort to contribute to the patient's happiness through treating him as an end in himself is minimally successful. For Kant, the moral value of the physician's effort is not determined by whether she is able to bring about the best medical consequence of treatment or not.

Kantian ethics encourages each human being to set his own ends and devise his own plan of life. Both Kant and Mill believed it to be intrinsically good, other things being equal, when people live autonomously and a plan of life here serves as a way of integrating one's purposes over time, of fitting together the different things one values. This is a part of why a goal that flows from such a plan has more value than the mere satisfaction of a fleeting desire. It isn't just any desire, but one that matters

because it fits into a wider picture. A desire that flows from a value that itself derives from a life plan is more important than a desire (such as an appetite) that one just happens to have, for it flows from his reflective choices. This suggests that for Mill, as for Kant, action from reason, as opposed to inclinations, achieves a level of freedom that exceeds its negative conception. This is the degree of freedom and autonomy afforded to all patients as persons by the imperfect duties owed to others by the categorical imperative.

Kant did hold, however, that if, in a physician's estimation, the patient's wishes (or ends) are contrary to the development of or even damaging to his autonomy (or to his well-being, happiness, etc.) then the physician's duty is to intervene insofar as she is able through persuasion and rational discourse. This does not, however, empower deception, coercion, manipulation or any other form of paternalism. The significant distinction is that promotion of well-being or the happiness of others, according to a physician's assessment of his needs, is an act of beneficence, which can easily 'cross the line' into paternalism, depriving the patient of his autonomy. Conversely, promoting the ends of patients ensures that not only are doctors offering assistance toward patients achieving their own goals, but, more importantly, physicians are not imposing guidance or assistance that is not welcomed.

Therefore, if the exercise of one's autonomy is considered to be a significant part of one's ability to attain happiness, then, regardless of whether the patient's reasons are medically sound or sensible in the eyes of his physician, the exercise of his inner-freedom in making decisions for himself must, in order for the Kantian physician to treat him as an end-in-himself, be accepted as the final decision regarding the course of action to be taken. The answer to the question, regarding whose decision is to prevail then, from a Kantian perspective, is clearly that of the patient.

Duties of Respect

In the second section of the *Groundwork of the Metaphysics of Morals*, in which Kant attempts to specify the conditions a principle of action must meet in order to qualify as a practical law, he

argues that, in addition to being universalizable, such a principle must also include reference to an objective end (*GW* 4: 427). An end is objective if it “holds for every rational being” (*GW* 4: 427). Objective ends contrast with the subjective ends we set on the basis of personal inclinations, since these hold only for those who share those inclinations.

Why must practical rules refer to ends in the first place? Kant holds that all rational action aims at some end (*GW* 4: 437; *MoM* 6: 392). A practical rule, then, that did not include, either implicitly or explicitly, reference to an end, could not guide rational action. Kant's intent is to specify conditions under which a rule can be a practical law. We could not be obligated to set an end that depends on an inclination or desire for the simple reason that no one who lacked that inclination or desire would have a reason to adopt that end as her own. If one of the conditions under which a rule can be a practical law is that the rule specifies an end, then that end cannot be a subjective end-- something a person aims at because of a personal inclination or desire. What, then, could qualify as the right sort of end? Kant introduces his answer in the following famous passage:

But suppose there were something the existence of which in itself has an absolute worth, something which as an end in itself could be a ground of determinate laws; then in it, and in it alone, would lie the ground of a possible categorical imperative, that is, of a practical law. Now I say that the human being and in general every rational being exists as an end in itself, not merely as a means to be used by this or that will at its discretion; instead he must in all his actions, whether directed to himself or also to other rational beings, always be regarded at the same time as an end. (*GW* 4: 428)

Here, then, is his answer: the only thing that qualifies as an objective end is “the human being and in general every rational being.” Since all rational action has an end, no principle of conduct could be a practical law unless it specified an objective end, that is, something for the sake of which we must act regardless of our personal inclinations. And only one thing can qualify as an objective end, namely a person. By virtue of this status, persons have an ‘inner worth’ or ‘unconditional value’ that Kant calls ‘dignity’ and dignity is distinguished from ‘price,’ which is the sort of value possessed by everything else in the universe insofar as it can be treated by us either as a means or an object of delight (*GW* 4: 434–5).

If, then, there is to be a supreme practical principle, which Kant refers to as a categorical imperative, it must be one such that, from the representation of what is necessarily an end for everyone because it is an end in itself, it constitutes an objective principle and thus can serve as a universal practical law. The ground of this principle is that “rational nature exists as an end in itself” (*GW* 4: 428). This, according to Kant, is the basis for grounding his moral theory in respect for persons, for it is the recognition that persons, because of their rational nature, must be respected as ends in themselves and never merely as means to the ends of another.

“In accordance with this principle a human being is an end for himself as well as for others, and it is not enough that he is not authorized to use either himself or others merely as means... it is in itself his duty to make man as such his end” (*MoM* 6: 395). It also highlights the viewpoint of Kant that ethical principles and norms apply to the maxims of our actions, not to our actions directly. There still remains a deliberative judgment to be made regarding which maxim, understood in this particular context, will result in our determining the correct moral basis for our action that meets the demands expressed above. The central idea here is that ethical virtue requires us to act for the sake of a particular end. It does not require particular actions; but it does require that we guide our conduct by policies that treat this objective end as the reason for our actions. Kant believes that it is possible to construct a system of ethical duties on this foundation.

Because of our own status as persons, we are required to pursue our own perfection. This gives rise to duties to self. We fulfill these duties by cultivating those natural capacities that distinguish us from other animals and by cultivating our capacity for morality. And the existence of other persons and the need to base moral action upon universal rather than subjective ends requires us to adopt their happiness as one of our own ends. This gives rise to duties to others and seems to arrive at this conclusion based upon the empirical demand for consistency. We fulfill these duties by showing others an active (‘practical’) form of respect, by helping them satisfy their true needs and by refraining from interfering with their own (legally permissible) pursuits. In sum, persons really do have dignity.

And in order to get things right, we must respond appropriately to this value. The only way to do this is to adopt our own perfection and the happiness of others as our ends. Hence, these ends are obligatory rather than discretionary or optional. They are duties of ethical virtue.

Kant's form of moral realism is modest and may be understood as empirical. Kant says that persons have 'absolute worth' (*GW* 4: 428), but to say that they are valuable in this sense is not to say that they have mysterious ontological properties. Rather, to say that persons are unconditionally valuable is to say that there are empirical reasons to value them above all else.

But what is it about the 'nature' of persons that confers this unconditional value? The fact that human beings are capable of rational autonomy is a reason to treat them as ends in themselves, that is, to treat them as persons rather than as mere things. The possession of practical rational autonomy is empirically verifiable through observation, if what we mean by practical rational autonomy is measured by our ability to set goals (ends) for ourselves, make life-plans and so forth and then rationally (through thought or reflection) determine what we must do to bring these things about and then have the ability and power to make them 'happen.'

It is important to recognize 'capable of' as indicative of Kant's contention that human nature has this capacity innately and therefore, by virtue of being human, all persons are in possession of this innate capacity and thereby are ends in themselves and deserve respect. I think this is what Kant means when he says that the nature of persons "marks them out as an end in itself" (*GW* 4: 428). This capacity is self-determining in the sense that persons have the capacity for rational thought and through their command of practical reason are at least theoretically capable of setting ends for themselves.

Recognition respect for persons, then, is a matter of taking appropriate account of the fact that each human being is a person. This involves initially recognizing that something is a person and secondarily appreciating that persons as such have intrinsic moral worth and status, which leads to the understanding that because something is a person, we are constrained morally to act only in certain

ways in connection with her or him. Finally acting and being disposed to act in those ways out of this recognition, appreciation, and understanding of something particularly unique and valuable about persons, whether one's own person or all other persons, establishes oneself as a being that knows how to evaluate and value, that is, as a valuer.

The nature of persons gives us a reason to refrain from subordinating them to other pursuits because of their capacity to set their own pursuits. This capacity should be respected and valued above whatever instrumental value we might consider them to have through their being subordinated to serve the desires, goals and ends of another. Furthermore, the existence of such a reason does not depend on what any particular agent happens to think or feel about persons (or about any particular person).

For example, Ayn Rand has put forth a quasi-moral theory ('Objectivism' or 'Ethical Egoism') that values and legitimizes the selfish pursuit of one's own goals and desires. In giving persons sufficient warrant to act with disregard for others and to pursue self-serving actions that may adversely impact others, her theory violates the objective principle of respect for persons. Her view can be simplified to the title of one of her books, *The Virtue of Selfishness*, in which some have caricatured her 'philosophy' as, "Everyone should put herself first no matter what and do as she pleases. To heck with other people, think only of yourself." Regardless of whether this accurately portrays Rand's notion of 'selfishness,' the point is that even the modest moral realism espoused by Kant would be incompatible with this position on the grounds that there are objective moral obligations, grounded in respect for persons and the categorical imperative, that would judge such an attitude as not only heteronomous, but morally vicious.

Based upon the formula of humanity, the reason to treat persons as ends-in-themselves applies to everyone, both to self and to all others. And I argue that it is a reason that can be grasped by anyone looking at things from an impartial point of view. Further elaboration may focus upon a person's status as a full and equal member of the moral community and the bearer of certain moral rights. These rights arise from the recognition that persons are entitled unconditionally to respect that includes not only

their basic moral rights, but also their dignity. These ideas have been attributed to Kant as both a moral principle and a foundation for morality as such.

Though moral realism seems to offer the most natural interpretation of our evaluative and normative claim to the intrinsic value of humanity (as briefly discussed above), constructivists, such as Onora O'Neill, have their own argument as well, regarding the morally significant value of humanity. For an anti-foundationalist account of the Kantian critical project see O'Neill (1989).

Morality, according to Kant, is entirely socially dependent for its expression or manifestation in the world. This is because our only method of demonstrating its reality is via the demonstration of respect for persons. This clearly cannot be attained in an individualistic or atomistic universe. He understood, perhaps better than anyone after him, how significantly our social interdependence impacted our capacity to actualize our functional autonomy in our lives. Autonomy, in his view, revolves around duties and obligations to self and others, rather than around personal rights. Self-fulfillment, self-actualization and self-realization are not notions considered by Kant.

Autonomy, properly understood, entails a mutuality of obligation. The concepts of respect, dignity and autonomy require care and are normative principles of civility. To hold this view requires that autonomy, dignity and respect rely upon the development of Kant's concepts. Many thinkers following Kant have attempted to ground the dignity of persons (and respect for persons generally) in our capacity for autonomy. My reading of Kant, on the other hand, understands Kant to ground our duties and obligations and the capacity to autonomously fulfill them in respect for persons (which arises from the dignity and unconditional value of humanity). This in turn is grounded in and arises from the 'rational nature' of humanity.

Kant held that there are certain moral norms or maxims that spell out what we owe people that are not based on doing good for them. He also held that it is simply our moral duty to treat people in certain ways. Because it is the formal characteristics of these norms that determine what is morally right rather than the consequences, these views are sometimes called deontological, meaning that

certain behaviors are simply our duty even if they do not produce benefit. This, of course is a gross over-simplification of Kant's moral theory, but it is the commonly "received" view among contemporary bioethicists.

The value of persons is dependent on the existence of persons, so it is true that if there were no persons, there would be nothing in the world that has dignity. But the dignity of persons does not depend on whether anyone thinks or wants it to be the case that persons do or do not have dignity. And this is the sense in which Kant's line of thought seems committed to realism about the value of persons. Kant treats the dignity of persons as an objective fact, and he explains that fact by appealing to their nature.

The second component of Kant's moral realist viewpoint says that in order to get things right we must respond appropriately to a value that does not depend on what we think or want. Many of us assume that there is something about human beings themselves that makes it appropriate to accommodate their interests, preferences, opinions, and demands, regardless of whether they evoke our sympathy and regardless of whether such accommodation is in our own interests. Indeed, we assume that such accommodations are justified, regardless of whether we find relations of "mutual recognition" the least bit "appealing" (T. M. Scanlon, *What We Owe to Each Other* Cambridge: Harvard, 1998, p. 162). If the dignity of persons should be understood as an objective value, then several passages suggest that Kant accepts this second component of moral realism as well.

Respect for persons in more general ethical discourse is viewed by some as a moral principle, by others as a moral disposition and by others as merely an attitude or disposition which human beings should accord to one another without invoking the moral or ethical at all. Respect for persons is frequently conceived as the concept that all people should be given the right to fully exercise their autonomy. Showing respect for persons is a system for interaction in which one person has an obligation to do what she can to ensure that another has sufficient agency to be able to make a choice.

This concept remains somewhat abstract and vague, but describes the mindset that all persons, in whatever social setting, should have toward other persons (and toward themselves).

The morality of medicine develops this notion, not only in more specific and practically usable ways but also in more stringent and inviolable ways, without altering its basic governing principle, which is often expressed in terms of the “intrinsic value of humanity.” We have reason, it is said, to accommodate the interests, preferences, opinions, and demands of human beings (within the limits of the categorical imperative) because human beings have a special value; human beings have a value that exceeds both their value as a means to some further end and whatever value depends on the contingent evaluations of others. Human beings are valuable as “ends in themselves.”

According to this familiar idea, we cannot respect the value of humanity without treating other human beings and their concerns as a constraint on what we have reason to do. There is much to recommend this conception of respect as the appropriate notion for medicine and medical practice. It regards patients as having an intrinsic, absolute and objective worth that must always be respected and never sacrificed or violated.

It opposes purely consequentialist thinking and refuses to compare or aggregate relative amounts of dignity. It would therefore disallow murdering one person to prevent five murders and emphasizes honoring, cherishing and caring for human values that are committed to promoting and protecting it. It also emphasizes cherishing and caring for the human beings who are the bearers of those values. To do so in their hour of need may be the ultimate expression of respect. The duties of respect toward others are not only protections from the ways others can interfere with and undermine the respect we have for ourselves. We also have positive duties to show our respect in ways that build self-confidence and self-esteem. It is the duty of physicians to quickly identify remediable constraints upon a patient’s functional autonomy and act to remove that impediment.

Kant’s discussion of respect for others highlights a particularly egregious element of any acts against humanity and can readily be figured into an overall moral explanation for why they are wrong.

In addition to the pain and suffering that these acts typically involve, part of what is so reprehensible about raping, torturing or discriminating against someone is that the assailant is attempting to influence the victim to lose respect for herself, to become servile, to seek his approval, to doubt herself, to feel worthless and insignificant, to see herself as an object for his enjoyment or benefit. And, what may be worse, the attacker is by his deeds demanding that the victim cease to value herself as a rational person with dignity and so, on Kant's view, profoundly disrespecting his victims.

On the contrary, the form of respect involved in respect for patients as persons is a mode of valuing and appreciating the patient as having an objective worth or importance that is independent of and perhaps even at variance with our antecedent desires or commitments. In addition to the importance to both respect and acknowledge the subjective experiences of other "equal" beings is the need to attend to the way our actions are perceived by those persons we have reason to respect. If physicians intend to act respectfully toward someone who is their patient, it would be inconsistent with such respect not to recognize that how that person perceives the physicians' actions places a constraint on the range of acceptable behavior. That perception of others is itself an evaluative process, in which a doctor's actions are judged as either contributing to or detracting from both their appraisal of us and also of themselves.

In describing her physicians as disrespectful (scurrying around and answering pages in the midst of examining her), a patient explained that the behaviors reflect a failure to recognize the restrictions placed on doctors' actions merely by the interpretation of the patient to whom these doctors owe respect. Disrespect in the eyes of vulnerable patients, then, is not merely thoughtless or careless but is demeaning and damaging to that patient's own sense of self-worth. Thus our actions can be instrumental in either contributing to or detracting from the inherent sense of self-esteem that is particular to human beings (and perhaps some other highly evolved social creatures). Social conventions such as manners, in fact, exist largely in order to clarify these constraints and demands

that respect for others entails in social settings, by specifying what (certain) behaviors can be expected to communicate to others.

Respect entails certain specific duties and, in order to grasp clearly the concept of moral respect, we must draw a distinction between respect for persons and related concepts such as admiration, having regard for or “liking.” It is to be expected, for instance, that physicians will have a natural or instinctive preference for some patients over others. Such feelings are often couched in the language of respect. Physicians may remark that they have particular respect for patients who are able to persist in adhering to their commitments and responsibilities in spite of serious illness. On the other hand, intravenous drug addicts and alcoholics may be viewed quite differently because some may regard them as undeserving of respect. In moments of frustration, the rhetorical question is often posed: “How can you respect someone who doesn’t respect himself?”

What these examples have in common is that they employ the notion of “respect” to justify differential value judgments and treatment for certain people or types of people. Whatever else we might say about respecting people in this sense, it is clear that admiration is not something we could owe to everyone equally. We might aspire to find something admirable in everyone, something to relate to, but our ability to respect them cannot be dependent on the success of that endeavor. We will invariably find some people to be admirable or at least pleasant to be around, and others not.

Thus, while valuing respect with regard to persons is kin to esteem, admiration, veneration, reverence, and honor, its meaning is substantially different and unique. Respect, for Kant, seems also to be a separate category of regarding because Kant thinks we can demean, debase, humiliate or otherwise disrespect people by actions that, while inappropriate, immature and indefensible, are not overtly immoral (such as ridiculing with otherwise innocuous words and gestures, snickering behind their backs, calling attention to publicly accessible but embarrassing information about them and so forth). We may disrespect others by continually showing up late or not at all to scheduled meetings (or appointments) even though promising (or representing) to be on time.

Kant thinks there are mid-level duties of respect that follow from the supreme moral principle (stated in terms of the FH) that forbid the more specific wrongs of humiliating, ridiculing and debasing others. Kant claims we have duties of respect that prohibit acting toward others with arrogance (“not to demand that others think little of themselves in comparison with us” (*MoM* 6:4645)); defamation (“not to bring into the open something prejudicial to respect for others” (*MoM*: 6:466)), and ridicule (not to engage in “wanton fault finding and mockery” (*MoM*: 6:465)).

It is also worth noting that Kant has, in effect, two concepts of respect. One of them is respect as a feeling that is forced from us by the moral law and by those who exemplify it in their actions (*MoM* 6:394; *MoM* 6:402; *CPrR* 5:72-80). No one can have a duty to acquire this feeling, but we should all make ourselves worthy of it. The other is respect as valuing others and ourselves as persons with dignity. As I understand it, Kant assumes that we have a duty to respect ourselves in this second sense and argues from this that all have a duty to respect others (and all this entails) in this sense of respect as well. This leads me to conclude that for Kant, the duty of beneficence and of autonomy derive from the same root—respect for persons.

Respect for persons requires both the first and second formulations of the categorical imperative. We are naturally self-regarding which leads us to want the best in life for ourselves. We realize that this would be impossible to attain without the help of others. If this circumstance were to exist uni-directionally, then obtaining the help of others for our own selfish ends would be using them as means. If it were universalized, we (and all persons) would not only recognize the need for the help of others, but would also grasp that this entails that we be willing to help others in meeting their needs as well. This condition then, would satisfy the formula of universal law. We are human and Kant, in the *Groundwork*, made explicit that we are imperfect beings and do not have holy wills. Consequently, we would be tempted not to fully reciprocate unless these needs to both receive and give help were put in the form of moral oughts and, in fact, were understood as arising from the moral imperative.

...No imperatives hold for the Divine will, or in general for a holy will; ought is here out of place, because the volition is already of itself necessarily in unison with the law. Therefore imperatives are only formulae to express the relation of objective laws of all volition to the subjective imperfection of the will of this or that rational being, e.g., the human will (*GW* 4: 414).

Respect For Self And Others: The Duty Of Beneficence And Virtue Of Benevolence

The duties of beneficence and respect for others were also (at least partially) justified by Kant in the *Metaphysics of Morals* on these grounds – we are rationally disposed to pursue our own happiness and respect ourselves, but also to give the same help and respect to others in return for their help and respect. So duties of beneficence and respect for one another are justifiable to everyone in virtue of our self-regarding rational concerns.

Kant's argument relies on a substantive conception of what it takes to respect ourselves. His suggestion is that we have something like an ethical right to respect ourselves properly by regarding ourselves as persons with dignity. This right is not enforceable by law or protected by a court, but like other rights, it is strict, it is more or less determinate, and violations of it are clear enough (at least to our conscience) when they occur and are strictly forbidden.

In the case for beneficence, Kant develops his argument from the self-regarding rational dispositions that persons have innately in their rational nature to the universalization of these dispositions to our treatment of other persons who possess the same rational self-concern. In other words, in the *Metaphysics Of Morals*, Kant develops the idea that the moral obligations that we, as persons, have to others can be derived from our own natural self-interest. Historically, many have interpreted Kant's argument in the *Groundwork* as maintaining that, in order to discharge our moral obligations to others, we must deny our own self-interest.

Kant's key assumption in the Second *Critique* and in the *Metaphysics* is that our pursuit of happiness is a necessary part of our rational nature. Rather than being driven by external forces that control our animal, contingent inclinations to will our own happiness, at this juncture, he is arguing

that, as rational persons, we are naturally inclined toward the satisfaction of our permissible ends (*CPrR* 5:431). It would be impossible and so irrational for someone to have particular ends but refuse to will that they be satisfied, for to have an end, according to Kant, is to will its object. “As rational persons we necessarily seek the satisfaction of our own (permissible) ends” (*GW* 4:415; *MoM* 6:391; *CPrR* 5:25, 34).

This duty to self does not necessarily generate the reasons for others to do so as well. Just because we are rationally required to value ourselves in this way does not entail that others must value us in this same way. The duty of others to respect and value us, as a person (an embodied, unified rational being), arises from their own autonomous duties which, though identical to ours, arise within their own person. We do not have the power to demand of others, nor do they of us in matters of morals as laid out by Kant in the ‘Doctrine of Virtue.’

Determining for ourselves what our life goals and plans are constitutes autonomy, yet our dependence upon others for realizing our life plans is clearly to be seen as receiving their beneficence. Since this is mutually reciprocating (as we can understand the formula of humanity to stipulate), the imperative of respect for persons grounds both autonomy and beneficence in just this way. What we need, according to Kant, are universally acceptable moral principles that protect us from arrogance and self-conceit by affording everyone the moral freedom to respect ourselves and the ways we are rationally disposed to act and requiring each of us not to violate this freedom in others. This, according to Kant, is what it is to respect one another as persons, which requires us to “limit our self-esteem by the dignity of humanity in another person” and to “keep myself within my own bounds,” refrain from “exalting oneself above others” and refuse to “demand that another throw himself away in order to slave for my end” (*MoM* 6: 449-50).

The notion I am getting at in discussing the reciprocity of respect inherent in Kant’ theory is that it is up to individuals to find, within their own moral understanding, universally acceptable moral

principles that guard against their acting out of arrogance and self-conceit. Kant's argument for justifying why we should respect others in these ways is contained in the following quote:

But just as he cannot give himself away for any price (this would conflict with his duty of self-esteem), so neither can he act contrary to the equally necessary self-esteem of others, as human beings, that is, he is under obligation to acknowledge, in a practical way, The dignity of humanity in every other human being. Hence there rests on him a duty regarding the respect that must be shown to every other human being (*MoM* 6:462).

Here again is evidence that Kant held that respect was for humanity, not for rationality or autonomy (except as inherent in our humanity). This will have significance as I discuss the evolution of respect for persons to respect for autonomy in the contemporary bioethical theory introduced by Beauchamp and Childress.

These ideas taken together with Kant's lengthy discussion of duties to self and duties to others in the *Metaphysics* ("Such ends are one's own perfection, and our neighbors happiness" *MoM* 6:393), seem to establish Kant's argument for the duties of respect toward others. Thus, for Kant, the duty of respect toward others is based upon our rational self-regarding disposition to respect ourselves and upon the rational disposition to universalize, reciprocate and grant the same to others. So, all rational people are disposed, by virtue of their rational nature, to will their own freedom, self-respect, self-control and ability to think for oneself and they would will that this independence be respected and protected. Consequently, universalizing this, we would be willing to afford protections and opportunities to others if they are willing to do the same for us in return.

This interpretation of Kant's argument for the duty of beneficence has the added advantage that it provides a more compelling explanation for why we should give mutual aid and help to others, sometimes and to some extent (so long as it does not conflict with another wide duty such as our duty to self to pursue our own talents). This understanding of beneficence seems better suited to protect the ability of all to pursue their own happiness. Further support for this reading comes from a later passage where Kant elaborates on his discussion of beneficence and explicitly draws an analogy between it and the duties of respect for others:

Moderation in one's demands generally, that is, willing restriction of one's self-love in view of the self-love of others, is called modesty. Lack of such moderation (lack of modesty) as regards one's worthiness to be loved by others is called egotism (philautia) (MoM 6:462).

When we consider the duties of respect for others, we find the same argumentative structure at work, one that Kant uses to explain why we have duties to respect others and what it takes for us to do so.

For Kant, it is not only rational but our *duty* to act in ways that are self-regarding. Otherwise, there would be no incentive to pursue self-improvement, self-development and self-actualization. Consequently, our disposition of respect for persons (in the universal) offers an understanding of human interrelatedness entailing *duties* to one another merely by virtue of our shared humanity. Understood in this light, the first formulation of the CI no longer seems "too abstract to matter in real life." I understand formula of universal law (FUL) as a principle of reciprocity that relies on independent standards of rational self-regard that determine what we, and others, could rationally will as universal law. All rational people are disposed, by virtue of their rational nature, to will their own freedom, self-respect, life, ability to think for themselves and much else, so it would be irrational for a person not to protect her own life or her self-respect. But rational people are also disposed to afford protections and opportunities to others if they are willing to do the same in return.

Kant insists that the *duties* of respect toward others are not only *negative*, as non-interference in undermining the respect we have for ourselves or the right to informed consent. We also have *positive duties* to affirm and appreciate the value of others because of the wide duties to others arising from our respect for their rational humanity, embodied in their unified person.

This is the sense in which the experience of patients as persons is a moral experience. I wish to make clear that, while I would express some version of this moral obligation as one which we owe to all persons, I am specifically arguing for the application of this duty, emerging from respect for persons, in its applicability in medicine, either to patients or to persons who are subjects of clinical research.

I am assuming that the ethical practice of medicine should aspire to be a home to respect, empathy and mercy among other forms of attention, as desirable expressions of the value of the patient as person. Directing this line of thought specifically to the relational and inter-personal aspects of modern medicine helps to explain the inadequacy of previously formulated ethical theories for medicine which took autonomy to be actualized and operant and thus deserving respect.

It was autonomy as non-interference, so that patients might maintain control over their life plans and medical decisions that so mightily may (significantly) affect those plans. The error in this assumption is that it fails to acknowledge the reality of human illness and its consequences upon the level of functional autonomy of all persons who are sick. Some patients are affected to a greater degree than others. But the potential for even highly functionally autonomous persons, through the overwhelming effects of disease and suffering, to have that power of self-determination stripped from them gives us reason not to attach personhood, dignity or the worthiness of respect to functional autonomy or moral agency.

Limiting the benefits and entailments of respect for persons to only functionally autonomous patients that can achieve a certain degree of rational or moral agency excludes a large segment of patient population from the doctor's duties based in respect. In actual medical practice, caregivers are presented with countless situations in which patients, for whatever reason, fall short of meeting standards of 'agency' or 'autonomy.'

Respect for persons, rather than for autonomy (that we shall hear Beauchamp and Childress extolling), encompasses all persons under the duties of respect by basing a patient's personhood upon his Humanity. The concept of person for medicine must broadly encompass all patients as an intrinsic property. It is far more sensible, then, to attribute the unconditional value and deservingness of respect of persons to their human or rational nature, rather than to the actualization of their autonomy. This allows caring respect to be unambiguously owed to even the severely compromised patients who are comatose or in persistent vegetative states.

Subsuming autonomy and beneficence under the same grounding principle of respect (for persons) allows for the blurriness at the margins of a competent decisional faculty. Inclusion of patients in the deliberative and decision-making process should extend to the partially and minimally autonomous patients. Only those whose mental capacity is absent should be treated solely under the duty of beneficence. Even in that situation, the duty of autonomy of the doctor (as we have described its mutually reciprocal function above) ensures that beneficence be carried out under the auspices of respect. This avoids the hubris of paternalism and goes a long way toward improving physician-patient communication, fostering a climate of trust with patients and their families and improving the patient's overall care.

Kant's *Reverentia*: Reverential Respect For Persons Is The Only Moral Motive

My account of caring respect is based upon the recognition of patients as persons. This emerges from the unconditional value Kant attributed to humanity, which he also referred to as rational nature (that is the rational human nature possessed by human beings) and his intention, very clearly, is to include under this construct the individuated, embodied, imperfect beings we refer to as persons. Respect is richer and more interesting, however, than most prior accounts have given it credit, and it has significant and varied implications for clinical practice and research. In particular, there are ways to respect autonomous participants beyond respecting autonomy, and duties of respect exist toward non-autonomous participants that are defensible and are not limited to protection (as Belmont suggested and we shall examine). I challenge the idea that respect for autonomy (that B&C argue for) is a complete or self-sufficient expression of respect for persons or is a *prima facie* moral principle at all.

Respect for persons is not free standing but is derived from a concept of the good, which Kant located in the "good will" of human beings. I interpret Kant's good will as equivalent to human *reason* that I take to be a faculty of persons, but not the seat of human agency as such. I prefer to understand

this innate goodness of human, rational nature as *the* source of value in the world and human *practical reason* to be the instrument of valuing self, others and the world, though not through self-legislation but through the reverential recognition of the moral law.

In the *Groundwork*, Kant identifies the object of the feeling of respect as the moral law and says that respect for the moral law is the only moral motive (*GW* 4:400). Reverential respect is unlike any other feeling humans experience in that it is not dependent on empirical desires or any other contingencies of the individual agent's psychology, situation, or history. The unique moral feeling of reverential respect involves both the experience of the objective worth of the moral law (Wood 1999) and the experience of the supreme and absolute authority that the moral law has over us (Grenberg, J., 1999, "Anthropology from a Metaphysical Point of View," *J of Hist of Phil*, 37: 91-115). As a complex experience, in recognizing the moral law we are conscious of it in a way that involves being aware of the law as having absolute authority; we experience the subordination of our will to its commands. Where I diverge from the 'received view' of Kant's theory is in regard to his argument that the moral law is 'self-imposed,' and that we, as rational beings, 'are its only source,' via our autonomous self-legislation of the law. I rather side with Charles Larmore's understanding that moral autonomy speaks to a principle of respect for persons as being able to think and act for reasons which should be determinative in that:

Reason is not a (self-legislating) agent but rather a faculty that we, who are agents, exercise more or less well. To exercise the faculty of reason is to engage in reasoning, to adduce considerations we see as reasons in order to conclude that we should believe this or do that... contrary to Kant, reason is not therefore essentially autonomous or self-legislating, since it operates by way of responding to reasons (*The Autonomy of Morality*, Cambridge, 2008, p. 109).

On the other hand, while I agree that reason should not be so focused upon "self-legislation," the confusion may actually be Larmore's and those who read Kant as claiming that human autonomy (practical reason) is the author of the moral law.

My reading of Kant is that practical reason (or autonomy) represents our capacity for acting upon reasons rather than being causally determined in our actions. This practical freedom that reason

affords us, enables us to recognize the moral law and commit ourselves to it even though our non-rational desires and inclinations may interfere with our always acting from the moral law. We are committed to it nonetheless; it can be thought of as ‘weakness of will’ (*akrasia*) that interferes with always acting from the moral law. Kant’s argument is that human freedom from causal determinism makes human beings deserving of respect and gives us a dignity beyond price, despite our imperfections, constraints, inclinations and infirmities.

Furthermore, recognizing this faculty as one embedded in our rational human nature directs us, upon rational reflection, to the realization that the moral law is precisely that we treat all persons with respect and honor their freedom as well as our own. On this interpretation, the moral law is not authored *de novo* by reason, but rather is brought to light in the awareness that beings deserving of respect should never be treated as means only but always also as ends in themselves. That is, they should be cared for and cared about, not merely in order to ensure our own reciprocal treatment and respect, but because they are beings of value and every life matters.

Self-legislation for Kant need not entail self-creation of the moral law. Rather, it includes the power to use reasons to determine moral principles (rules or maxims) of our actions that arise from our respect for the moral law. All legislation of practical reason derives from and must comport with the moral law in order to be autonomous. When Kant says that we give ourselves the moral law, he means that we “could have done otherwise.” We could have acted from inclination rather than from reason, in opposition to the moral law (such as by using another as a means to achieving our own end), and thus immorally.

This understanding of the moral law is the basis upon which duty rests and is not our own creation through the use of our practical reason. The moral law, rather, is universal and binding because it unites all rational beings in a kingdom of ends. Morality, as Larmore describes it, is objective in that it transcends my rational capacity or my reasons for actions and imposes duties and obligations that I, through my respect for and love of the moral law, choose to embrace as my own.

My freedom to act on the basis of the moral law, rather than having done otherwise, is what it means for our practical reason to be reasons-responsive.

Through education, training and practical experience, it is up to us to learn to recognize for ourselves which principles of action are in accordance with the moral law (and are thus universal). Larmore's mistaken view of Kantian autonomy is that we are not beholden to a moral order independent of our practical reason. Larmore's conclusion that Kant fails to give objectivity to the moral imperative of respect for persons is thus in error. It is Larmore's misunderstanding of the objectivity of Kant's moral law that leads him to make a lengthy and excellent argument for human reason as involving a receptivity to reasons (which are ideas arrived at through our intuition and moral reflection) that is actually otherwise perfectly compatible with Kant's own theory:

Reason... involves a *receptivity to reasons*... the principles themselves count as rational only if there are reasons recommending their adoption... We cannot be moved by reasons unless we grasp their force and can hold ourselves responsible to them by judging, when need be, how well we are complying with them. Responsiveness to reasons is not a blind passivity. Yet the sort of uptake it requires does not consist in our endowing them with authority but rather in acknowledging the authority they possess... In the end, reasoning always requires responding to reasons, basing conclusions on reasons we suppose that we have discerned, not legislated... Some reasons we must acknowledge directly, if only to have grounds to espouse the principles that are ours... In some cases to be sure, finding reasons that favor a principle consists not so much in recognizing that the principle is valid as in conferring on it a validity it does not possess on its own... Laws or standards of this sort are indeed the work of "autonomous" reasons, but manifestly the reasons for adopting them do not likewise derive from reason's self-legislation... Sometimes moral "autonomy" means the capacity we have to grasp and to do what is right regardless of the threats or rewards that a higher power, human or divine, may hold over us... Sometimes individual "autonomy" denotes our right or ability to think for ourselves, instead of yielding to custom or coercion... Both these meanings of the term concern a person's relations to others and my aim here is not to oppose this usage or the views thereby expressed. But "autonomy" in the sense that Kant pioneered and that shapes the philosophical tradition he has inspired bears on a very different kind of problematic—namely, reason's relation to the authority of the principles by which it operates... I think the only coherent way... to defend their ideals is to recognize that reason consists in being responsive to reasons (ibid, 109-111).

To show that Larmore's and Kant's arguments are not inconsistent or incompatible, I think an examination of Kantian reverential respect (*reverentia*) will be helpful. That reason consists in a receptivity to reasons is exemplified in Kant's writing by the self-imposed force Kant attributes to our rational apprehension of what he designates as "the moral law." As a complex experience that is both the cognitive recognition of the moral law and an affective state (McCarty 1994), reverential respect is

the way, and the only way, in which we are aware of the self-legislated rational principles for action that unconditionally constrain our inclinations (Stratton-Lake 2000).

Stratton-Lake does not make clear what these self-legislated principles for action are and what they are not. They are not the moral law, nor are they the moral (categorical) imperative that takes this form because of the kind of beings we are (that is, fallible, imperfect and lacking a ‘holy will’). What they consist in, would, for Kant, be the ‘maxims’ of our actions that we might represent as mid-level, contingent moral principles and virtues that are a step removed from the abstraction of the universal and a step closer to those guiding principles that find their ground in respect for persons, but can better direct our actions with the specificity required in particular situations.

In recognizing the moral law, we are conscious of it in a way that involves two contrasting, yet simultaneously experienced, feelings. First, in being aware of the law as having unconditional authority, we experience the subordination of our practical reason to its commands. This consciousness of subordination requires that we constrain our efforts to satisfy our desires, to pursue our ends and to value ourselves independently of moral considerations.

At the same time, however, our awareness of the moral law involves the recognition that we are not compelled to abide by it, but do so willingly and respectfully due to the reverence that it engenders within us. The moral law thus appears to us not merely as constraint, but as the freely imposed self-constraint of holy awe. Reverential respect is the complex experience of the law as both unconditionally authoritative and self-imposed and of both a restriction placed upon our inclinations and the “sublimity” of our “higher vocation” to be self-legislating and self-governing (CPrR 5:87–88). It is in this way in which we are morally motivated by the law to do unconditionally and so freely what it commands. I think we fare better in capturing the compelling prescription of the moral law to acknowledge that, once apprehended and understood, to do otherwise would be to deny our having reason, for it would be to fail to respond to the compelling reasons, dictated by the moral law, for our thinking and acting morally.

Reverential respect is a unique feeling in that it is the only feeling that we can know *a priori* (according to Kant). By this I believe Kant merely means that we can know that the moral experience of every human agent is necessarily and inescapably one of reverential respect for the moral law, for we cannot be truly aware of the moral law except reverentially (Stratton-Lake 2000). The moral feeling of respect is unique also, in that our ability to experience it is “hard-wired” into human nature. In *Religion Within the Boundaries of Mere Reason* (1793), Kant calls reverential respect for the moral law as itself sufficient to motivate moral action and as the “original predisposition” in human nature that makes it possible for us to be moral beings (*MoM* 6:21–23). We are motivated to obey the moral law through the feeling or experience of reverential respect for the law. To recognize it is to grasp the duties it calls us to embrace. Rational awareness of a duty to others disposes us to view them and their needs more clearly, as well as motivating us to treat other persons with recognition respect as the law commands us to do.

In the *Metaphysics of Morals* Kant says that the feeling of reverential self-respect, which the law “unavoidably forces from” us (*MoM* 6:403), is part of the subjective basis of morality, the predispositions to feeling that make possible for beings like us to acknowledge that we have binding moral duties (*MoM* 6:399–418). Reverential respect for the moral law contrasts with the duty to give recognition respect to all persons in our attitudes and conduct, for the former is something we can't help but feel for the moral law, while the latter is a way we are obligated to comport ourselves toward all persons regardless of our non-moral feelings or inclinations and our assessment of their moral performance. We might, however, regard the two as linked, by regarding our recognition and appreciation of the dignity of others as involving a feeling that we can't help but experience and to which we commit ourselves to living up to in acknowledging the moral duty to respect persons just because they are persons (Thomas Hill, 1989).

Kant's View of the Paradoxical Nature of Respect

Respect can justifiably be designated a paradox because it is a feeling that is not received from outside influences, but one that is self-generated. That respect for persons is both self-affected and self-affection, Kant suggests, is paradoxical. Respect is neither completely sensible nor completely intelligible. It is a transient that eludes both poles of the opposition between reason and feeling as typically understood. Kant does not accord all feelings the same worth for the ultimate success of his practical philosophy hinges on his capacity to make qualitative distinctions between specific feelings. The qualitative feeling *par excellence* is respect. Kant distinguishes respect from awe, reverence, contempt, admiration, fear, hope, and amazement.

After introducing the famous proposition “duty is the necessity of an action from respect for law” (*GW* 4:13), Kant appends the following note:

It could be objected that I only seek refuge, behind the word respect, in an obscure feeling, instead of distinctly resolving the question by means of a concept of reason. But though respect is a feeling, it is not one received by means of influence; it is, instead, a feeling self-wrought by means of a rational concept and therefore specifically different from all feelings of the first kind, which can be reduced to inclination or fear. What I recognize immediately as a law for me I cognize with respect, which signifies merely consciousness of the subordination of my will to a law without the mediation of other influences on my sense. Immediate determination of the will by means of a law and consciousness of this is called respect, so that this is regarded as the effect of the law on the subject, and not as the cause of the law. Respect is properly the representation of a worth that infringes upon my self-love. Hence there is something that is regarded as an object neither of inclination nor of fear, though it has something analogous to both. (*GW* 4:14)

Respect is a self-produced feeling as opposed to one received from external stimuli, and that is what makes it different from all other feelings. The unmediated recognition of the validity of moral claims imposed upon us, as human beings, generates respect. The immediacy of this law means respect is felt as immediacy itself, as pure force, and this peculiar mode of immediacy is precisely what distinguishes respect from other feelings. In the words of Kant, respect is more “powerful than all... feelings together” (*MoM* 6: 209).

Respect is neither fear nor inclination but is "analogous" to both. In the *Critique of Practical Reason* respect takes center stage as the incentive for moral conduct. And Kant's discussion of it is one

of the longest sections in the middle of this book. In the section of the *Critique of Practical Reason* titled "On The Incentives Of Pure Practical Reason," respect, we learn, is the sole motive to moral conduct. "Respect for the moral law is ... the sole and also the undoubted moral incentive" (CPrR 6: 67).

But how is respect an incentive? "Sensible feeling...is indeed the condition of that feeling we call respect... Yet, respect is nonetheless produced solely by reason, by an 'intellectual ground'" (CPrR 6: 64). What it seems Kant is struggling with is the fact that respect has both cognitive and sensuous aspects (in other words involves both reason and feeling) and hence his designation of it as "moral feeling." The sensible aspect, as Kant sees it, is the sentient recognition that the duty called for by the experience of respect is the subordination of our own self-interested inclinations to the object of our respect. The rational aspect of it, in Kant's understanding is that it emerges from our comprehension of the authority of morality over our own desires, forcing us to give pause, out of respect, before considering pursuing our own ends (though it does not force obedience to it).

Combining this with Kant's viewpoint that it is presented to our sensibility "immediately" (unmediated by reason) indicates it to be something on the order of an "intuition." It gains rational justification, however, upon rational reflection (should we choose or feel the need to justify its power over us), but this is not necessary. Ordinary persons, throughout their daily lives, perceive its "presence" as directed toward all others (including ourselves) in such a fashion that it motivates actions and restraints from action in order for us to act morally.

Although respect is not pleasure, one is "elevated," and this corresponds to an "inner tranquility" (CPrR 67, 75). This is not so much a reward as it is a comfort Kant names *consolation* that is the result of recognizing and acting according to the moral law (CPrR 6: 75). A discussion of the relationship between duty and respect in the *Groundwork* initiated Kant's investigation of respect and most specifically with regard to respect for humanity.

The word ground has particular significance for Kant since respect is unfathomable for speculative reason and because he sought to provide a critical ground for practice (*CPrR* 6:68). With that in mind, the *Groundwork* has an astonishing “Concluding Remark,” which contains the following paradox:

And thus we do not indeed comprehend the practical unconditioned necessity of the moral imperative, but we nevertheless comprehend its incomprehensibility, and this is all that can fairly be required of a philosophy that strives in its principles to reach the very boundary of human reason. (*GW* 4: 66)

We are summoned by the moral law that we cannot completely grasp, even though we can nonetheless hear its command. The “voice of reason” is one that is “so distinct, so irrepressible, and so audible” (*CPrR* 32). The ground for morality cannot be rationally elucidated or grasped because it is freedom: freedom from causal determinism, freedom to have done otherwise, freedom to have chosen against acting from the moral law, while feeling the commitment to the law that transfers the human into a higher order. Despite this, however, because of the limitations of human faculties: “We shall never be able to comprehend how freedom is possible” (*GW* 4:60). But we should be satisfied “if only we can be sufficiently assured that there is no proof of its impossibility...” (*CPrR* 6:79).

The theoretical impossibility of completely conceiving freedom corresponds to the practical difficulty of it as well. On the one hand, freedom is the condition of the possibility for ethical practice, but, on the other, freedom is not a stable foundation. The undecidable character of freedom is, in the words of Kant, “a terrible thing,” not only because it is the condition of both good and evil, but because it undermines the stability of the fundamental ground for practice (*Lectures on Ethics*, 17).

But, and this is Kant's genius according to William Sokoloff:

The instability of freedom does not authorize ethical license. The fundamental un-decidability of freedom promises to generate modes of action that do not negate the freedom that initially permits these acts to be possible at all. There is thus a certain lawfulness that corresponds to the instability of freedom: A free will and a will under moral laws are one and the same (*GW* 4: 53).

But the reciprocal relationship between lawfulness and freedom does not efface the fundamental riddle of freedom. At the bottom of it all, freedom is the law, and the law can never be anything other than freedom (Kant and the Paradox of Respect, W. W. Sokoloff; *A J of Pol Sci*, Vol. 45, No. 4 (Oct., 2001), pp. 768-779).

We must “conduct ourselves in accordance with maxims of freedom as if they were laws of nature” (*GW* 4: 66). “That a human being should become not merely legally good, but morally good ... cannot be effected through gradual reform but must rather be effected through a revolution in the disposition of the human being” (*Rel* 67-68). Respect signals the impossibility of human moral perfection but without abandoning the aspiration for it. A distinctly human feeling of moral failure, respect reminds us that there is no secure position on which moral conduct can be based.

But even while serving as a sign of human moral fallibility, respect nonetheless names the possibility of the elevation of humanity, out of the causal mechanism and into a “kingdom of ends.” Although he is morally elevated, he is also embodied. He is free, but he cannot completely step outside of sensibility. For Kant, human persons are occupied by divergent forces that never entirely supply a standpoint that exceeds this paradoxical opposition. But the constraint of sensibility does not stop them from attempting to elevate themselves above immorality because the Kantian person also hears the “voice of reason” (*CPrR* 6:32).

Sokoloff proposed a novel understanding of respect as paradox. A Kantian ethic of paradox aspires to value universality and particularity at the same time. It thus seeks a middle position between advocates of abstract universalism, on the one hand, and particularity, on the other. This conception can bridge the gap between the subjective particularities of individual patient case studies (casuistry) and the universalizability of moral principles and duties, grounded in respect for persons via the moral imperative (deontology). One of the most significant attractions I see in this paradox for medicine is the further attention it draws to the latitude in legitimate deliberative processes, now tying casuists, deontologists and our earlier embrace of virtue theorists into the collaborative work needed to parse our way through this paradox. There are no clear battle lines to be drawn among casuistry, virtue, deontology and an ethic of care. Each has a significant contribution to make to the serious ethical work needed to give medical ethics a sound footing.

Sokoloff argues that at its worst, an overemphasis on universality results in “imperialism, homogenization, and universal domination: affirming the particular, taken to the extreme, produces nationalism, relativism, and subjectivism” (p.772). So we need to know the dangers and the value of both universality and particularity. This simultaneous embrace of the universal and the particular recognizes that universality is limited by valuing particularity, and particularity is drawn outside of its narrow focus by the universal. The one is always inscribed into the other. So it is not a choice between universality or particularity, but creating and enacting modes of thinking and ethical practices that value both at the same time. This is a remarkably insightful position that accurately characterizes the plight of practitioners of medicine, as well as their patients. The value of this recognition in medicine lies in giving physicians grounds to proceed in the only way they have known how – by respecting all patients as persons, while simultaneously respecting and attending to the one directly in front of them, with priority over all others.

What are the implications of this paradox on Kant's practical philosophy as a whole? Sokoloff gives us four considerations, but only the first is directly germane to medicine:

First, the paradox of respect may help us appreciate the essentially ambiguous status of fundamental elements of Kant's practical philosophy in order to attune us to the actual complexity of moral problems in the real world. The paradox, the one that reason and the will to meaning seek to annul, can open a space for reflection.

This observation comports well with the complexity of the moral problems in medicine that doctors face frequently. It offers some solace to those who struggle so mightily to determine their duty and muster the medical know-how and human courage to make difficult and split second decisions and expeditiously carry them out. The worn and misused enjoinder that physicians, “first, do no harm,” needs amending. I propose something on the order of “first, respect the person of your patient.” Person is shared universally, while patient must give an accounting of the uniqueness and particularity of each individual patient and her specific needs.

CHAPTER 3

BELMONT AND RESPECT FOR PERSONS

Respect for persons in medicine was articulated for the first time in an Official U.S. Government Report on Ethics, entitled *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* and was first published in the Federal Register on September 30, 1978. The report of the National Commission was issued with the intention of protecting participants and subjects in clinical trials and research studies from unethical behavior of health care researchers. The abuse of human subjects in research was not new, but after the horrific Nazi medical atrocities in World War II were finally exposed and judged at Nuremberg, it initially seemed that countries and global organizations had finally taken note and rendered what became classic ethical guidelines for the use of human subjects in research.

Given the extensive concerns today about the exponential increase in scientific fraud and misconduct, especially in clinical trials, and the flagrant violations of “informed consent,” it would serve all physicians, scientists and ethicists well to be able to recognize similar abuses in current research practices involving human beings. As many contemporary observers of these guidelines and abuses have noted, the whole world has now become one huge clinical trial – with no “informed consent.”

Two of those international guidelines (the Nuremberg Code and the Declaration of Helsinki) that preceded Belmont need briefly to be mentioned. The Nuremberg Code (1949) would not allow the use of incompetent human beings in research at all. The first of its 10 tenets reads:

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should... be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the subject matter involved as to enable him to make an understanding and enlightened decision... He should know the nature, direction, and purpose of the experiment; the methods and means by which it is to be conducted; all hazards reasonably to be expected; and the

effects upon his health of person which may possibly come from his participation in the experiment (articles of the Nuremberg tribunal).

The Declarations of Helsinki (1964) later modified this restriction to allow research on the non-autonomous, albeit strictly controlled. The gradual moves away from the details articulated in the Nuremberg Code in subsequent guidelines are stark. The 18th World Medical Assembly held in Helsinki, Finland in June of 1964 adopted the World Medical Association Declaration of Helsinki, which provided that: “In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation.” In situations where physical or mental incapacity makes it impossible to obtain informed consent from the patient, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with existing national legislation. Whenever the minor child is in fact able to give consent, the minor's consent must be obtained in addition to the consent of the minor's legal guardian.

The second of its 22 principles specifies that:

The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experimental protocol which should be transmitted for consideration, comment and guidance to a specially appointed committee independent of the investigator and the sponsor provided that this independent committee is in conformity with the laws and regulations of the country in which the research experiment is performed.

The Federal National Research Act of 1974, that called for Belmont’s inception, was prompted in large part by the ethical problems of design and implementation that were coming to public awareness in several U.S. research enterprises that violated this Helsinki mandate: most notably, The Tuskegee Syphilis Study (1932–1972) and The Willowbrook State School for the Retarded Hepatitis Study (1956 to 1972) Staten Island, New York.

These were egregious examples, involving American physicians and researchers, who engaged in human research that involved exploiting and abusing vulnerable populations and were both intended to further medical knowledge, without providing any benefit, or the prospect of benefit, to the research subjects, themselves. More importantly, perhaps, is that these large-scale studies were initiated without having adhered to the requirement of an independent, specially appointed review committee as

explicitly specified above. This lack of respect for the illiterate and the mentally retarded treated both subject groups as mere means, with disregard and disrespect for them as persons.

The 1974 Research Act authorized the formation of The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (which came to be known as Belmont). One of the charges to the Commission was to identify the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects and to develop guidelines that should be followed to assure that such research is conducted in accordance with those principles. In carrying out this charge, the Commission was directed to consider:

- (i) The boundaries between biomedical and behavioral research and the accepted and routine practice of medicine.
- (ii) The role of assessment of risk-benefit criteria in the determination of the appropriateness of research involving human subjects.
- (iii) Appropriate guidelines for the selection of human subjects for participation in such research.
- (iv) The nature and definition of informed consent in various research settings.

The Belmont Report attempts to summarize the basic ethical principles identified by the Commission in the course of its deliberations. It is the outgrowth of an intensive four-day period of discussions that were held in February 1976 at the Smithsonian Institution's Belmont Conference Center supplemented by the monthly deliberations of the Commission that were held over a period of nearly four years. It is a statement of basic ethical principles and guidelines that should assist in resolving the ethical problems that surround the conduct of research with human subjects. By publishing the Report in the Federal Register and providing reprints upon request, the intent was to make these guidelines readily available to scientists, members of Institutional Review Boards, and Federal employees.

The definition they drew of "research" is distinct from "standard medical care" and research can be either "experimental" or "therapeutic." These differ from standard medical care that has already been through several phases of clinical research trials. Just because something is termed "therapeutic" does not mean that it is not research. Most of these guidelines specifically apply to physicians (M.D.'s) only, not to non-physician researchers (Ph.D.'s). Traditionally, physicians are to protect their patients

from harm; researchers are to obtain "data." There are no ethical guidelines or even professional Codes of Ethics for Ph.D. researchers, for ethicists, or for bioethicists.

The report was purposefully brief, and its three basic ethical principles and concomitant applications were stated succinctly and with precision. Bioethicists generally agree that this report was and is a foundational document in the national and international development of research ethics (and has equally been applied to the physician-patient relationship and medical practice generally). Three principles, or general prescriptive judgments, that are relevant to research involving human subjects are identified in this statement: Respect for Persons, Beneficence and Justice.

They acknowledge that other principles may also be relevant. These three are comprehensive, however, and are stated at a level of generalization that the commissioners felt should assist scientists, subjects, reviewers and interested citizens in understanding the ethical issues inherent in research involving human subjects. These principles cannot always be applied to resolve particular ethical problems beyond dispute. The objective of Belmont was to provide an analytical framework that would guide the resolution of ethical problems arising from research involving human subjects. I will discuss these, one at a time, beginning with the first and generally regarded as the foundational principle: Respect for Persons.

The Belmont Report states that "respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents," and second, which is critical, "that *persons* with diminished autonomy are entitled to protection." The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge, promote and be responsive to the autonomy of persons who are capable of functioning as autonomous agents and the requirement to protect those persons with diminished autonomy.

Two components of Belmont's argument are worth special note. First, in their discussion of "respect for persons," the authors of the report distinguished between those with autonomy and those

without, but they presumed that the notion of “persons” applies to both. They did not define who is a person and who is not; they did not distinguish between “persons” and “non-persons.”

Second, the meaning of “respect” clearly entails different duties and obligations for doctors (and medical researchers) for persons with different levels of autonomy. Importantly, Belmont presupposed an inverse relationship between autonomy and protection. For Belmont the need for protection increases as the individual’s proximity to autonomy decreases:

Respect for the immature and incapacitated may require protecting them as they mature or while they are incapacitated. Some persons are in need of extensive protection, even to the point of excluding them from activities which may harm them.

Autonomy is certainly not co-equal with personhood according to Belmont. Respect does not apply to some, but not to others. A preliminary assessment of individual patients that is of utmost priority regarding its implications for showing proper respect in the clinical setting entails the determination of each patient’s status with regard to his capacity for functional autonomy.

I use the term ‘functional’ because autonomy is always incompletely actualized in persons, especially in patients afflicted with one form or another of infirmity. By the late 1970’s, the principle of respect for persons stood as one of the central principles in the emerging field of medical ethics.

Albert Jonsen was one of the primary contributors to the original report. He recounts the daunting task facing the commissioners in his later essay, “On the Origins and Future of the *Belmont Report*” which was the first essay in a collection of essays, *Belmont Revisited: Ethical Principles for Research With Human Subjects* commemorating Belmont and published 20 years after the original Belmont Report. “Several commissioners, who were familiar with the literature of philosophical and theological ethics, were aware that the notion of ethical principles was not a settled and simple one, nor easily transferred from the pages of philosophy books into their recommendations.” The phrase “respect for persons” was not widely employed in the technical vocabulary of medical ethics at the time of the National Commission discussions and was essentially introduced into medical ethics by Belmont’s Report.

Tristram Englehardt, one of the highly regarded ethical contributors, had used it in his educational essay for the original National Commission. Commissioner Karen Labacz and Albert Jonsen had previously taught a course during 1974 for Graduate Theological Union in which they used Robert Downey and Elizabeth Telfer's book, *Respect for Persons*, (1969), which explores the broad scope of Kant's concept of respect, though not in a specifically medical context.

The Commissioners listened to the words of those ethicists who had already made a serious effort to identify the ethical principles governing medical research. Fortunately, two of the era's most outstanding ethical scholars had made such an attempt, and, in Jonsen's words,

We had their work in our hands: Hans Jonas's "Philosophical Reflections On Experimenting With Human Subjects," written for the 1968 Academy of Arts and Sciences Symposium on Human Experimentation and Paul Ramsey's *The Patient as Person*, (1970), which was specifically devoted to respect for the sanctity and dignity of persons and the covenantal commitment of physicians to patients as persons (ibid)

Let us consider first the commissioners collaborative concept of a person: this concept embraces every human being, regardless of the degree to which he or she is autonomous. It is clear that this first of three principles holds primacy as the dominant principle. The obligation to respect all persons who are being considered for participation in clinical research entails (among many other things) the moral rule of obtaining their informed consent. Their further elaboration of the meaning of consent reaches well beyond individual autonomy. In its breadth, the Commission's concept of a person mirrors the inclusive scope of person in the work of theologian Paul Ramsey.

In his Introduction Ramsey asserts, "Canons of loyalty to patients or to joint adventurers in medical research are simply particular manifestations of canons of loyalty of persons to persons generally" (xii). Ramsey endeavors to explore the number of covenants "among men." Fidelity binds persons in covenants between physician and patient, between researcher and human subject, with the child in need of care, between the living and the dying and between the well and the ill, especially those in need of some extraordinary therapy. "We are born within covenants of life with life" (xii).

Ramsey, as theologian and Christian medical ethicist avows:

I hold, along with Karl Barth, that covenant-fidelity is the inner meaning and purpose of our creation...this means that the conscious acceptance of covenant responsibilities...for the roles we enter by choice...provides the external framework for human fulfillment in explicit covenants among men. The practice of medicine is one such covenant. Justice, fairness, righteousness, faithfulness, canons of loyalty, the sanctity of life, *hesed* [steadfast love], *agape* or charity are some of the names given to the moral quality of attitude and action owed to all men by any man who steps into a covenant with another man... (xii-xiii).

Ramsey's conception of the covenantal commitment of physicians, as a particular manifestation of the more general moral quality of attitude and action entailed by respect for persons and owed to all, conveys the basis for all moral commitments and moral principles argued for in this dissertation. Dignity, Ramsey argues, is but a sliver of a shield in comparison with the *awesome* respect required of physician/researchers in all of their dealings with human beings, "if man has a touch of sanctity in this his fetal, mortal, bodily, living and dying life" (xiii).

The final *Belmont Report* is, as it should be, a secular document. Nonetheless, it carries the same sense of the covenantal relationship of trust that should be fostered between physician researchers and research participants and the "inviolability of persons." Some medical researchers have made the argument that medical advancement is hampered because our "society" makes an absolute of the inviolability of the individual. This viewpoint, according to Ramsey, raises the specter of a medical and scientific community free from the shackles of that cultural norm and proceeding upon the basis of an ethos all its own.

At the time of the Belmont deliberations (1975-1978) some medical researchers argued that their major task was to reconcile the welfare of the individual with the welfare of mankind and that both must be served. Ramsey's response is that, "There is no guarantee that good experimental designs will always be morally justifiable" (xiv). His point is that the welfare of mankind is not sufficient warrant to transgress upon the dignity of and respect owed to the individual.

Numerous other physicians and scholars also weighed in. "In the end we may have to accept the fact that some limits do exist to the search for knowledge" (Freund, "Ethical Problems In Human Experimentation," *NEJM* 273, 10 (Sept. 1965). "The end does not always justify the means, and the

good things a man does can be made complete only by the things he refuses to do” (Dunlop, “Medical Science, Society and Human Values,” *BMJ*, Feb., 1966, 476). Finally, JP Scanlan, in “The Morality of Deception in Experiments” laments:

There may be valuable scientific knowledge which it is morally impossible to obtain. It may be necessary to choose between knowledge and morality, in opposition to our long-standing prejudice that the two must go together (Bucknell Review, March, 1965).

The many scholars who informed the research and study of the commissioners unanimously repudiated a pedestrian utilitarian approach to the subject. Hans Jonas had done so quite explicitly when he criticized the words of surgeon Walsh McDermott who had said, “The core of this ethical issue is to ensure the rights of society even if an arbitrary judgment must be made against the individual.” Stephen Toulmin, another commissioner, attempted to temper McDermott’s words in, “The Tyranny of Principles,” saying, “In summary, the central question is how to reconcile protection of individual rights with the fruitful pursuit of the collective enterprise” (*Hastings Center Report* 11, Dec 1981, 31-39). Contrarily, however, and somewhat ironically none of the scholars/commissioners had chosen to reconcile, at either the theoretical or practical level, respect for persons with either utilitarian or communitarian social principles.

Rather, they had come out loud and strong for the principle of respect for persons in its two forms: autonomy and the protection of non-autonomous persons. The dominance of that principle is clearly expressed in the Belmont report which affirms this view: “If research involving human persons as subjects is to be appraised as an ethical activity it must above all be an activity into which persons freely enter.” This essential element was captured within the broad scope of their conception of respect for persons.

The practice of applied medical ethics is fundamentally about actions, outcomes, and the kind of people we want to be, as physicians and researchers, in the course of this practice. It also encompasses how we want to serve those who have entrusted their care and/or themselves to us, as participants of the scientific endeavor, to find new and more efficacious treatments for disorders that

we have yet to discover a cure. We, as members of the medical/scientific community, ought to and must strive to give moral reasons – to ourselves and to others – for our actions that affect the lives of people for whom we bear some significant degree of responsibility.

Because ethics involves giving moral reasons, it is inseparable from communication. In the context of medicine, the giving of moral reasons to explain and justify the actions of ourselves as healthcare professionals takes place within a landscape that is infused with moral value, since healthcare is a value-loaded (not value-neutral) enterprise (Brock, D. W. 1991 “Facts And Values In The Physician-Patient Relationship” in *Ethics, Trust, and the Professions: Philosophical and Cultural Aspects*, p.128).

Communicating moral reasoning is therefore of central importance in medicine, and it is a process defined by the moral reasons we give to explain and justify the actions and policies that determine how patients and research participants are treated. Furthermore, these moral reasons must be open to public scrutiny and be shown to be rationally defensible. I submit that if they can withstand this publicity and scrutiny, it is only because they comport with the respect for persons of Belmont and with the formula of humanity of Kant.

Medicine is also characterized by the individual moral beliefs and values (moral particularity) of the diverse individuals it involves and by the contrasting moral frameworks (moral diversity) that arise when these variations result in different ways of assigning moral value to the choices that the provision (or the reception) of healthcare entails. We, as physicians, rely on these beliefs and values when deciding how to promote the goal of health, which requires close collaboration and shared moral purpose between those of us who provide healthcare and those who receive it.

The endeavor to make decision-making between health professionals and patients a genuinely shared process requires communication that manifests as listening, informing, explaining, justifying and authorizing – as well as recommending and persuading. These forms of communication reveal how inextricably intertwined communication and ethics are in the practice of medicine and in clinical

research. They show how significant moral communication can be as a means to express our respect for the moral dignity, agency and integrity of other persons who are our patients and research subjects, especially when disagreements arise.

It seems obvious to me, as a former medical practitioner and clinical researcher, that the two roles cannot be separated without a substantial loss in both our own humanity and in our regard for the humanity of those we perceive as patients and as subjects of our research. Of equal importance to this process of communication is the fact that patients cannot be viewed as a class, but are individuals with differing capabilities to communicate verbally or articulate their wishes rationally. Every modality of human communication with other humans must be factored into this schematic in order to account for and give credibility to the non-verbal and emotional ways patients may potentially express their autonomous wishes, which equally deserve to be respected.

My point is that human communication is too often over-simplified and narrowed to what we, somewhat hubristically, refer to as rational. This is not an argument for the irrational, but for the emotions, feelings, needs and wishes that can often only be conveyed by a touching of hands or by facial expressions, whether pleading or affirming, and may only be detected and interpreted by a doctor's own emotional, feeling, or intuitive capacities. This somewhat vague representation of the possibilities of person to person (patient to doctor) interaction should be kept in mind as we examine the bifurcation Belmont's principle of respect for persons proposes for autonomous vs. non-autonomous persons. In the next two sections I am presenting my own assessments of the distinctions between respect for autonomous and non-autonomous patients as persons. I then follow with an analysis of Belmont's conclusions.

Respecting Autonomous Patients

Recognition of autonomous agency is clearly central to respecting autonomous patients and is classically operationalized through informed consent and attention to privacy and confidentiality.

Really respecting persons, however, involves much more. Such respect requires appreciating the meaning of autonomous agency to persons as patients and can require the physician to play multiple roles in helping others to live lives consistent with their values and goals.

Some reasons such restraint is warranted may have more to do with considerations of happiness or well-being than respect for autonomous agency itself (Buss, 2005). Our lives are full of emotions, feelings, and reactions that are important aspects of who we are; respect for persons demands sensitivity to such subjective experiences when practicing caring medicine, especially sensitivities regarding physical examination. Practice behavior can make people feel valued, cared about, comfortable, or scared.

A basic implication of respect in practice is thus the obligation to attend to considerations of comportment. Looking participants in the eye can demonstrate that a doctor is engaged and takes patients' needs seriously. Speaking in understandable terms acknowledges the doctor's desire that patients understand their illness and avoids making them feel inferior. Not talking past them with other health professionals in the room recognizes patients' desire to be informed about what is happening to them and their need to know they are at the center of decisions affecting their welfare. Another related but important implication of respect in medical practice is the need to express the recognition that patients' time, effort, and participation in their own care are valued. Finally, behaviors as simple as not being preoccupied with a pager help patients to feel they are being taken seriously.

Some authors, such as John Harris, clearly suggest that autonomy incorporates considerations of well-being (2005). Others suggest that concern for well-being lies within the purview of beneficence and nonmaleficence and that ambiguity regarding well-being is one reason the principle of respect for persons is unhelpful (Beauchamp and Childress 2001; Beauchamp 2005).

Respect and beneficence entail concern for different types of well-being and this is best seen in considering the autonomous and the non-autonomous person. An important aspect of respect for autonomous persons is to be concerned with the patient's well-being as *he* defines it. Persons

determine their own critical interests and it is disrespectful to impose one's own understanding of what constitutes well-being or one's own understanding of how physical well-being ought to be valued.

Beneficence, on the other hand, is more appropriately concerned with a more objective notion of well-being in that it is seen as being more applicable in situations where patients are non-autonomous. Both may co-exist in the care of autonomous patients harmoniously, without paternalism, if taken together as mid-level principles that derive their meaning and functional applicability from caring respect for persons.

Although respect may be consistent with imposition of significant risk to secure the patient's well-being, if the potential for benefit (perhaps life-saving) is high and if the risk is truly understood and accepted by an autonomous patient, then both the person's autonomy and the physician's beneficence can be actualized. Of course, there always remains a question about harm (and thus a potential constraint exerted by the principle of non-maleficence) in determining whether some risks may be so extreme that exposure to them fails to recognize the inviolability of human life.

Respecting Non-Autonomous Patients

Respecting non-autonomous patients will often differ from respecting autonomous patients, but many demands overlap. Some non-autonomous persons, for example, still count as valuers (those capable of forming or holding values regarding goods and projects-as illustrated in the work of Agnieszka Jaworska). In examining patients with Alzheimer's Disease, she argues that these patients can be valuers without being competent to make decisions regarding medical care or research participation (Jaworska, 1999). Mrs. D, for example, was severely impaired but routinely expressed an altruistic desire to participate in research. Although not suggesting that Mrs. D should be allowed to enroll in any study to which she is willing to agree, Jaworska argues that helping Mrs. D to live out her values through research participation when possible and appropriate is an important part of respecting her as a person.

Respect for the values of people like Mrs. D may be seen as an extension of respect for persons to those patients with compromised or partial autonomy. Subjects who are valuers have autonomously determined critical interests that warrant respect, and Jaworska argues that the values entailed by 'respect for persons' maintains respect for their partial autonomy despite impairment. Regardless of whether one thinks Mrs. D is actually autonomous, the crucial point is that respecting incapacitated individuals like her can require more than simple protection.

Another similarity between respect for autonomous and non-autonomous research participants is in the domain of comportment. Severely incapacitated patients may still want to feel a part of conversations about their welfare or participate in clinical discussions, even if they cannot play a role in decisions about their treatment plan. For a doctor to talk past or fail to acknowledge a patient's presence in the room would fail to recognize the demands placed by the patient's need to feel important or valued and thus fails to respect him as a person.

Subjective experiences do not necessarily correlate with autonomous agency and, to the extent that non-autonomous persons have feelings, emotions, and psychological needs similar to those of autonomous persons, these needs place important demands on physicians interacting with them. All of these possible scenarios illustrate the blurred margins of 'personhood.' Those medical ethicists who see the distinction as more black and white and who believe there to be value in determining whether a particular patient 'qualifies' as a person or not lack sufficient clinical experience to realize the unproductive, if not counter-productive, consequences of such efforts. The focus needs to remain upon the aspects of respect and, at least in medicine, we need to acknowledge that 'person' is a concept that is largely a placeholder for human being.

More challenging questions regarding comportment arise when patients are unconscious or so impaired that they have no subjective experiences that can be influenced by others' conduct. In these cases, behaviors that otherwise would be perceived as disrespectful cannot concretely affect participants' interests because they are not observed. Most patients think that respectful treatment of

themselves in such situations dictates that doctors or researchers ought to treat them in a way that both recognizes their value as persons and is consistent with how doctors think that they would want to be treated. Others are less concerned, focusing on respect as the provision of quality care. Most of us appreciate that we all have unconscious lives that have value. Most would respect the unconsciousness of a person who is still alive because he has the potential to accomplish goals or aspirations, may still exist in relationship with others and would prefer not to be treated differently in a state of unconsciousness. At the very least, doctor's conduct must indicate proper and caring attention to what she is doing or, more importantly, the person to whom she is doing it.

The critical question is whether there is a respect-related moral constraint imposed on this doctor's behavior by the important and valuable features of the unconscious patient. It would seem that some constraint is placed on the doctor's behavior by the fact that the unconscious person, were he conscious, likely would express a preference to be treated with respect and all that it entails and, therefore, any behavior unbecoming of doctors or insulting to patients, were they conscious, would equally be unseemly and unacceptable when caring for those in an unconscious state.

Assessing the strength of an unconscious patient's claim to be treated according to his preferences is a complicated and contentious philosophical task, one interestingly explored in literature regarding treatment of dead bodies and practicing procedures (Feinberg 1985; Wilkinson 2002). I share a strong and commonly held intuition that there is at least a *prima facie* obligation on the part of the doctor to act in a way consistent with what she believes the patient would want if able to express a preference. Not to acknowledge any constraint, however, seems objectifying.

An important element of respect regarding autonomous persons is recognizing that most of us exist as members of society in significant ways. The same is the case for non-autonomous persons. Respecting them entails recognizing their place in the community. Respect thus may be consistent with enrollment of a non-autonomous person in research. The processes for ensuring respect for non-

autonomous participants may, however, differ substantially and should involve family or friends opinions and information about the patient and her wishes in this regard.

There is also a crucial distinction between respecting non-autonomous and autonomous persons with regard to respect-driven concern for well-being. Respect for autonomous persons encompasses a subjective notion of well-being, but more objective considerations become central in the absence of autonomous agency. Unless previously articulated and known to physicians, individual values, goals, and aspirations cannot play a role in doctors' decisions about treatment. As a result, non-autonomous persons can easily (and wrongfully) be objectified or instrumentalized in treatment/research by exposing them to risks that reflect a failure to properly appreciate and contextualize their well-being and their place in society.

This distinction actually offers an important explanation for the apparent incoherence several commentators in *Belmont Revisited* are quick to criticize regarding the original Belmont conception of respect for persons (National Commission 1979). Although I also argue that respect for persons is much richer, more interesting, and more multi-faceted than Belmont articulated, I nonetheless hold the highest respect for the effort of these pioneering medical ethicists in capturing this concept.

There is at least good reason for respect to entail protection for non-autonomous participants in a way that it does not for those who are autonomous. This distinction in concern for well-being conceptually supports stricter risk-benefit standards, such as those currently existing for patients in emergency settings and children. This same concern applies to research participants who are not autonomous. It is well known that existing risk standards are subject to varied interpretation and pose challenges to Investigational Review Boards (IRB's) and investigators trying to operationalize these children into research protocols (Wendler et al. 2005). Restriction of the range of risk to which non-autonomous participants can be exposed, however, embodies respect and represents a conceptually defensible attempt to avoid objectifying populations incapable of making decisions for themselves.

Belmont's Principle of Respect for Persons Applied to the Autonomous

The first part of Belmont's first principle of "respect for persons" involves the person of respect who is an autonomous moral agent and capable of making choices and decisions for herself. In this case, it relates to "informed consent" with regard to medical procedures and participating as a subject of clinical research. The Belmont Report goes on to describe an autonomous person as "an individual capable of deliberation about personal goals and of acting under the direction of such deliberation." To respect an individual's autonomy is to allow an individual to develop opinions, express goals and desires, make choices, and act upon these choices as the ultimate decision-maker regarding his own life. For the Belmont Commissioners there are no ultimate requirements for such choices to meet standards of rationality and a patient's reasons must be respected because they are his reasons. The only situations in which the physician is rightfully able to override such choices are when she judges his actions as clearly detrimental to others. The report states:

Respect for persons requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them. This opportunity is provided when adequate standards for informed consent are satisfied.

Informed consent provides more than an opportunity for choice; it provides choice based on adequate information. But why would it be disrespectful to offer choice without information, and how are we to judge when the provision of information is adequate? The report's answer is that persons with the capacity for self-determination (those capable of deliberation about personal goals and of acting under the direction of such deliberation) must be treated as autonomous agents and their autonomy must be respected. On this account, functional autonomy does not require patients to establish their 'rational' or 'moral agency.' The report explains that:

To respect autonomy is to give weight to autonomous persons' considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others. To show lack of respect for an autonomous agent is to repudiate that person's considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so.

Persons with a capacity for self-determination should thus be (1) free to act on their considered judgments as long as they don't harm others and (2) informed as needed so that they can form a considered judgment concerning how to act. Together, these statements imply that respect for autonomous persons requires informed consent. It does not demand that choices or decisions meet standards of rationality to be considered judgments (though it is decidedly preferable and the physician's duty to promote and foster the patient's ability to communicate his reasons in a way that is understandable by the physician and the patient's family).

It is less clear what to make of the Belmont Report's attempt to derive from that principle a general duty to inform, i.e., a duty not to "withhold information necessary to make a considered judgment." A duty to inform out of respect is inherent in specific contexts of personal and communicative transactions (particularly in medicine). For instance, when medical service is rendered, the provider must inform the patient about the service and its cost. The same applies, only with greater moral force, when the service carries substantive risks for the patient/research subject or is physically or psychologically invasive. It would be disrespectful to expect the patient to agree to such services without being informed about their nature or probable risks and benefits.

Such behavior would not only be disrespectful but also potentially harmful and deceptive to the patient. It is therefore quite possible that informed consent receives part of its justification from considerations of beneficence and justice. This is not the spirit in which it is presented in the Belmont Report, however, which explicitly states that "the moral requirement that informed consent be obtained is derived primarily from the principle of respect for persons." What I think needed to have been more explicitly stated (and was not) is that respect for persons undergirds and subsumes the other two principles that the commissioners identify independently.

The primary role of informed consent seems better understood as a way of respecting each person who enters into agreements as a moral equal based on honest information (justice). In its

secondary role, informed consent protects the subject's well-being because (1) judgments of what is burdensome or beneficial are often relative to the individual's conception of the good and (2) the experience of being coerced, deceived, or manipulated is generally considered to be detrimental to one's well-being (beneficence).

In typical cases of human subjects research, it would clearly be disrespectful and maleficent to omit informed consent. Infamous failures in this regard were indeed a major motivation for the establishment of the National Commission by Congress in the first place and for the subsequent regulatory framework for research ethics that received its justification from the Belmont Report. The authors of the report, however, chose to justify informed consent as morally required because it promotes self-determination, i.e. autonomy. It is only indirectly, by virtue of being one of the arms of their principle of respect for persons, that it may be seen as justified in a moral sense.

Informed personal deliberation that leads to the formation of a considered judgment is obviously valuable, but the mere fact that something is valuable does not entail a moral requirement to do whatever is necessary to promote it. There will always be a number of goals that we might have promoted but didn't, and this does not mean we have failed morally. Merely to point out the value of self-determination, as the Belmont Report seems to do in its arguments for informed consent to this point, has not been given a morally persuasive argument, beyond the assertion that respect for persons is owed to all persons and that this entails that autonomous persons have this respect satisfied through informed consent.

Communicating about underlying beliefs and values requires a willingness to grapple with challenges of accessibility (the degree to which particular beliefs and values are intelligible between persons) and translatability (the degree to which particular beliefs and values can be transposed from one moral framework to another) as words and concepts are used to communicate beliefs and values. Moral dialogues between professionals and patients and among professionals one to another need to be handled carefully, and sometimes these dialogues invite reference to underlying beliefs and values.

When professionals choose to articulate such beliefs and values, they can do so as an expression of respectful patient care and collaboration and as a means of promoting their own moral integrity by signaling the need for consistency between their own beliefs, words and actions.

Where is the argument that says the doctor must morally weigh these values in one way rather than the other? And what if the doctor can argue that omitting informed consent in this instance would ultimately lead to greater benefits to the patient, to society, or to mankind? Simply to assert that self-determination is intrinsically valuable is insufficient because any measures to promote self-determination will come at a cost to some other intrinsic value that might then just as well be presented as a ground for an opposing moral duty.

The value of self-determination can only be ranked in relation to that (or those) other value(s) because self-determination, protection, beneficence and justice are all subsumed under the grounding principle of respect for persons. So valuing self-determination (autonomy) in respect for persons is not, alone, a satisfactory justifying requirement for informed consent unless we establish beneficence and justice as entailments of respect for persons as well (as Kant did in his formula of humanity). The duty to treat all persons as ends-in-themselves entails that physicians, in respecting their patients, adopt their patients ends as their own and strive to assist their patients in achieving these ends (rather than any ends which the physician might judge to be superior).

In a morally committed, but diverse, society the challenge of communicating about ethics in healthcare can at times be daunting. Given the potential for deep contrasts between the beliefs and values that in a given case determine our assessments of the worth of different goals in medicine (such as the quality of a life vs. its duration) or the merits of different treatments (such as comfort-oriented vs. life-sustaining treatments), there is need for candid dialogue about the beliefs and values that guide such assessments. But the prospects for such candor may not be as good as we might wish.

Common approaches to reasoning in medical ethics may not address the underlying beliefs and values that define our moral frameworks; and even when efforts are made to articulate deeper levels of

moral justification, we may encounter problems of accessibility and translatability. Accessibility refers to the degree to which our moral reasons are intelligible to each other: does my patient understand the moral terms and concepts I rely on when giving moral reasons to justify my intentions and actions as her physician? Translatability refers to the degree to which particular beliefs and values can be transposed from one moral framework to another when moral justifications are not considered accessible between the persons involved: when my listener informs me that my moral terms and concepts are not understandable, can I transpose those terms and concepts into language he or she can understand? These problems raise doubts about the feasibility of moral dialogue in medical practice, both among professionals and between professionals and their patients (Kaldjian L.C., *Communicating Moral Reasoning in Medicine as an Expression of Respect for Patients*, *Communication & Medicine*, 10 (2), 177-83, 2013).

Belmont's Principle of Respect for Persons Applied to the Non-Autonomous

Not all human beings are capable of acting autonomously, yet, according to the bio-ethical principle of respect for persons in the *Belmont Report*, these persons are also due respect. The non-autonomous retain the status as persons according to Belmont. The ability to set personal goals, develop opinions, and make choices may be compromised at times in a person's life and, in the case of children, only develops over time. In other instances, individuals (such as the severely or terminally ill, mentally handicapped, and imprisoned) may lose the capacity for acting autonomously partially or completely or for a period of time. The second part of respect for persons is directed toward these non-autonomous persons deserving respect. It was more specifically intended to secure protection for such persons from harm and from being taken advantage of as a means to secure research data for the benefit (or self-interests) of others. Beneficence relates to assessment of risk and benefits and justice relates to selection of subjects.

What is key in their discussion, however, is that while they distinguish between those persons who have autonomy and those who lack it, they presumed that the notion of persons applied to both. They did not distinguish between persons and non-persons and it is clear that for them autonomy is not co-equal with personhood. Neither the relevant sense of respect nor of personhood applies to some and not to others.

Offering special protections for vulnerable individuals is also a major emphasis of the principle of justice (which is discussed later). The principle of justice requires that the vulnerable be extended special protections with regard to the distribution of the benefits and burdens of research. The vulnerable should be assured of receiving their fair share of the benefits and protected from having imposed upon them more than their fair share of the burdens of research.

Respect for these persons who lack autonomy, as defined by the *Belmont Report*, requires that these vulnerable individuals be offered special protections during that period when they cannot act autonomously. This understanding of patient-hood recognizes the imperfection of non-idealized human beings and human autonomy, further compromised by the need to seek medical care and thus to subordinate themselves to the care of others. Consequently, our notion of the person is non-ideal and we must remove the idealized conception of the fully rational and autonomous moral agent as a necessary criterion for self-determination or person-hood.

Given some capacity for autonomous action, physicians are obligated to make every attempt to make the medical condition and options for treatment comprehensible and acceptable or refusible by patients. This requires doctors to avoid haste and pressure and to help the patient overcome the intimidation of the technically bewildering and alien medical environments. In some situations, extraordinary care in providing information and proposing treatment can result in legitimate consent being given by significantly impaired patients, treated with respect as persons, rather than paternally. The onus on medical practitioners is also to be sure that patients, as they actually are, have the capability of giving consent before accepting their decision.

Respecting non-autonomous patients will often differ from respecting autonomous patients, but many demands overlap. Earlier I discussed the work of Jaworska with Alzheimer's patients. Respect for the values of people with compromised but not non-existent competence extends the duties of autonomy and thus of respect for persons to those patients with partial autonomy. Subjects who have critical interests, even if only incompletely articulated, warrant respect for these interests and the duty is to promote and aid in the clarification of what such interests are and what duties they entail for physician/researcher action. Respect for persons maintains respect for their partial autonomy despite impairment. The key point that is inadequately developed in the *Belmont Report* is that respecting incapacitated individuals can (and generally does) require more than simple protection.

Another similarity of the type of respect owed to autonomous and non-autonomous research participants is true also for patients in practice. Severely incapacitated patients may still want to feel a part of conversations about their welfare or participate in clinical discussions, even if they cannot play an active role in decisions about their treatment plan. For a doctor/researcher to fail to recognize the demands placed by the patient's need to feel important or valued fails to respect her as a person.

Subjective experiences do not necessarily correlate with autonomous agency. To the extent that non-autonomous persons have feelings, emotions, and psychological needs, these needs place demands on physicians interacting with them and reiterate the inadequacy of any operational boundaries of 'personhood' for medicine. The key value of the Belmont emphasis was that it did not, at any point, try to draw the distinction of who, or by what criteria, participants/patients qualified as persons. The focus needs to remain upon the aspects of respect and, at least in medicine, we need to acknowledge that 'person' is a concept that is attributable to all patients by virtue of their humanity.

Most non-autonomous persons also exist as members of families and communities as significant persons. Respecting them entails recognizing their place in the community and thus may be consistent with enrollment of a non-autonomous person in research. The processes for ensuring respect

for non-autonomous participants may, however, differ substantially and should involve family or friends opinions and information about the patient and about her likely wishes in this regard.

One example of a process that attempts to advance respect for non-autonomous patients is community consultation for treatment involving clinical research in emergency settings conducted without informed consent (a process that is required by federal regulations). This requirement is designed to solicit and respect the views of autonomous persons from the community regarding circumstances in which they, or persons like them, may be non-autonomous. It is also, however, a concrete expression of the recognition that persons who are unconscious and suffering from emergent conditions such as sudden cardiac death, stroke, or traumatic injury are considered valuable members of the community.

This process can help to ensure that treatment in which such persons are involved, whether also part of a clinical trial or not, does not subject them to inappropriate risks and is as beneficial as possible to them. The importance of community consultation for emergency research also illustrates the particularity of respect-related demands. This process recognizes that participants of emergency research are otherwise autonomous and consultation efforts seek to incorporate potential participants' values into study design and review.

There is also a crucial distinction between respecting non-autonomous and autonomous persons with regard to respect-driven concern for well-being. Respect for autonomous persons encompasses a subjective notion of well-being, but more objective considerations become central in the absence of autonomous agency. Unless previously articulated and known to investigators, individual values, goals, and aspirations cannot play a role in doctor's decisions about treatment. As a result, non-autonomous persons can easily be objectified or instrumentalized in treatment/research by exposing them to risks that reflect a failure to properly appreciate and contextualize their well-being and their place in social structures. This distinction in concern for well-being, in fact, conceptually

supports stricter risk-benefit standards, such as those currently existing for patients in emergency settings and children for research with populations who are not autonomous.

With all of the unresolved questions I have just raised, it seems curious that an appeal to the philosophical grounding Kant's ethical theory would have provided for their concept of respect for persons was not at least given lip service in this document. There are certainly other ethical theories in which respect for persons does not hold as the pre-eminent (or even a primary) position in the moral firmament. Utility comes readily to mind, but neither does it hold for communitarianism, virtue-theory, casuistry or for that matter, any non-deontological moral theory.

The Influence of Casuists Upon Belmont's Principle of Respect for Persons

The Belmont Report's final intention seems clearly Kant inspired and deontological. The absence of any mention of Kant or of Kant's formula of humanity as the ground upon which they wished for their conclusions to stand can only be explained by the fact that these commissioners were not philosophers. These commissioners, for the most part, did not appreciate the need for philosophical grounding of their arguments.

It has historically been thought that there were two dissenting casuists, among the members of the Commission. Albert Jonsen (a theologian) and Stephen Toulmin (a philosopher) have written extensively on casuistry and hold the particularist view that principles, if they are to be recognized at all, only gain moral force from having arisen from "paradigm cases."

Tom Beauchamp, a consultant to the National Commission acknowledges that casuist reasoning, more so than moral theory or universal abstraction, often did function to forge agreement during the National Commission's deliberations. Beauchamp also recounts that, "Commissioners would never have been able to agree on a single ethical theory, nor did they even attempt to buttress the Belmont principles with a theory."

The contemporary use of the term casuistry refers to the use of case comparison and analogy to reach moral conclusions. Casuists dispute, in particular, the goal of a unified theory containing general and universal principles. “Resolution of moral problems suffers from the gridlock of conflicting moral principles. This impasse could be avoided by focusing on points of shared agreement about cases rather than on principles” (Toulmin, *The Tyranny of Principles*, *Hastings Center Report* 11, Dec 1981, 31-39). The following is their prime example, drawn from their experiences during the four years of work with the National Commission:

The one thing individual commissioners could not agree on was why they agreed... instead of securely established universal principles giving them intellectual grounding for particular judgments about specific kinds of cases, it was the other way around.

The *locus of certitude* in the commissioners’ discussions...lay in a shared perception of what was specifically at stake in particular kinds of human situations...That could never have been derived from the supposed theoretical certainty of the principles to which individual commissioners appealed in their personal accounts (Jonsen and Toulmin, *Abuse of Casuistry*, pp16-19).

Jonsen and Toulmin maintain that casuist reasoning, not universal principles, forged agreement. They recount that the commission functioned successfully by appeal to paradigms and cases despite the diverse principles held by individual commissioners. Jonsen and Toulmin did acknowledge that commissioners often cited moral principles to justify their collective conclusions and they did unanimously endorse the Belmont principles late in the commission’s existence. The casuists continued to argue that these principles were and are less certain and less central than particular judgments about cases.

This interpretation gives insight into the National Commission, but it needs careful qualification to avoid misunderstanding according to Beauchamp. Beauchamp, in his essay for the 20 year retrospective, *Belmont Revisited*, stated that, “It is doubtful that Jonsen ever intended to deny the importance of principles, and their roles.” In fact Jonsen pointed out that casuistry is “complementary to principles” and that “casuistry is not an alternative to principles: no sound casuistry can dispense with principles” (Jonsen, *Casuistry: An Alternative or Complement to Principles?* *Kennedy Institute of Ethics Journal* 5 (1995): 237-51).

It seems apparent that the reason the *Belmont Report* failed to attempt to ground its principles in Kant's moral theory or in any moral theory, for that matter, was the input of these casuists. In the long run, I think we can see how unfortunate this compromise position turned out to be. Beauchamp, in his revisited essay continues that, "nonetheless, this methodological appraisal is consistent with a firm commitment to moral principles; the commissioners, including Jonsen, were emphatic in their support of and appeals to the general moral principles delineated in the *Belmont Report*."

This view, in my opinion, sets the stage for the problems Beauchamp later creates for himself, by adhering to the belief that moral principles, if firmly committed to, can stand and withstand the inevitable critique and demand for justification, even in the absence of an underlying moral theory. And worse, that theory was readily at hand. How these views of Beauchamp (and later shared by Childress) would shape the form of their four-principles approach to biomedical ethics and its consequences are the subject of the next Chapter.

Kantian Humanity and the Justification of Informed Consent

Fortunately, Kant's conception of autonomy differs greatly from the one indicated in the Belmont Report. The Belmont definition of autonomy (as self-determination) describes a psychological capacity for personal deliberation and action, a capacity that individuals may enjoy and exercise to various degrees. For Kant, by contrast, practical reason demands of all of us that we never use the humanity in our own person or that of another merely as a means but always at the same time as an end in itself.

Kant's formula of humanity is indeed relevant to the morality of informed consent because it implies a prohibition against coercing and deceiving human beings, as well as an obligation to benefit others and avoid harming them. The Kantian conception of respect for persons, in addition to being capable of providing the ethical support and argumentation for the normative principle Belmont held to be primary, also puts us in a better position to address the utilitarian researcher who values cost-

effectiveness more than the self-determination of his research subjects. If we assume that the researcher held respect for his human subjects as persons, in Kant's sense of the word, it would follow that he has an obligation not to deceive or coerce them, regardless of cost-effectiveness or the greater good of society or of humankind.

My many references to utilitarianism are to the pedestrian sort represented in this example and are not considering the sophisticated and nuanced utility of John Stuart Mill, who prized the liberty of self-determination highly and considered it essential for the attainment of happiness and the human good. Throughout this dissertation, when I contrast my Kant inspired notion of respect with utilitarianism, I never mean to imply that I am pitting Kant against Mill.

With the formula of humanity in hand, we are in a better position to consider when informed consent is required and what should count as "adequate standards of informed consent." Kant scholars generally agree that the most plausible candidates for Kantian duties are the duties not to coerce or deceive. According to Allen Wood, for example, "coercion and deception obviously violate the formula of humanity because they achieve their end precisely by frustrating or circumventing another person's rational agency and thereby treat the rational nature of the person with obvious disrespect" (*Kant's Ethical Thought*, Cambridge; 2002). Granting this, informed-consent procedures are justified by Kant's second formulation to the extent that they serve the purposes of non-coercion and non-deception.

The remaining question is which standards of informed consent are likely to serve these purposes? Onora O'Neill claims "informed consent is ethically important because it adds a tough safeguard by which individuals can protect themselves against coercion and deception" (O'Neill O., "Some Limits Of Informed Consent," *J Med Ethics* 2003; 29(1): 4-7). At the same time, however, she warns that the tendency to increase the amount and specificity of information and to insist on informed-consent procedures in every possible context is not warranted by this goal and can be

contrary to other morally important purposes, such as beneficence, public health, trust, and trustworthiness.

Her suggestion is that, instead of inflating informed consent in a misguided attempt to solve all moral problems through one instrument, we should try to make sure that patients, research subjects, and tissue donors have control over the amount of information they receive and whether or not to go along with a proposed course of action (therapy or research). The danger of their being deceived or coerced is effectively limited when they “know that they have access to extendable information and that they have given rescindable consent” (ibid).

In fact, much of public health research is conducted without explicit informed consent, despite the autonomy of most persons enrolled. An important part of the justification for such research is individuals' membership in the community. Although it is unclear what level of risk is acceptable, conducting research on this basis seems to be entirely consistent with respect. Some have even argued that respect for persons may be consistent with involuntary conscription in certain clinical studies (Harris 2005). And although not using the language of respect, Robert Truog argues that randomized clinical trials posing little risk may not require consent so long as the clinical investigator can honestly assert that the study stands in a state of “clinical equipoise.”

Clinical Equipoise

Clinical equipoise exists when there is genuine uncertainty about the relative efficacy of alternative treatments within the medical community as a whole. Ben Friedman claimed that a state of clinical equipoise is necessary for physicians to ethically enroll patients in clinical trials. The concept of clinical equipoise has been very useful in relieving the ethical tensions between clinicians and investigators in most types of clinical trials. To give an example, if I believe that a new β -blocker offers advantages over those currently on the market, I can, with a clear conscience, enroll my patients in a randomized trial that compares the new medication with another that is standardly available. I

simply explain to my patients that, even though I have a hunch that the new medication will eventually prove to be better than the alternatives, they should be willing to have their therapy determined by a flip of the coin, since there is as yet no convincing evidence to support my belief in the superiority of the new drug. (“Informed Consent And Research Design In Critical Care Medicine,” *Critical Care* 3(3): R29-R33, 1999).

Whether these proposals are consistent with respect requires a careful assessment of the constraints and demands resulting from the recognition of persons as members of society in light of the demands and constraints resulting from autonomy, subjective experience, and justice considerations. Caring emphasizes respect for the patient’s autonomy by fostering and promoting her ability to determine and articulate her own desires and goals. This notion of autonomy is understood as a capacity possessed by all (even minimally) rational beings and which must be nurtured and developed through caring. The report defined what it means to be an “autonomous person” (a phrase not considered to be redundant) and described what it would mean to respect or disrespect that autonomy.

Another interesting question pertaining to research participation has to do with whether respect constrains the range of acceptable risks to which autonomous individuals can be exposed for societal benefit. Do very high-risk studies, for example, instrumentalize or objectify persons in ways incompatible with respect, even when participants are eager to participate? Most of us would agree that exposing healthy persons to live HIV in a vaccine challenge study, for example, would be problematic, even if participants are eager to participate. And most would argue that such a study would also conflict with beneficence (National Commission 1979; Beauchamp and Childress 2009). Whether it would be disrespectful depends on the extent to which respect for autonomous participants entails considerations of well-being. It clearly cannot be reduced to non-interference.

Advisory Committee on Human Radiation Experiments

Belmont was the first, but not the only, Presidential Commission to study the ethics of research on human subjects in the U.S. President Clinton appointed an Advisory Committee on Human Radiation Experiments in January 1994. At that time the Belmont report had become the dominant framework for evaluating the ethics of research with human subjects. The importance of their initial work and the reason I mention the Advisory Committee in this context are the six basic principles that comprised the first standard of their ethical framework.

Two criteria were used to select the six principles. The first criterion was retrospective moral judgment and it was their intention to identify principles that even a moral relativist would agree were pervasive features of the moral life of the United States. Second, they were concerned to identify enduring moral principles that were particularly relevant to medical research. Their six ethical principles are as follows:

- I. One ought not to treat people as mere means to the ends of others.
- II. One ought not to deceive others.
- III. One ought not to inflict harm or risk of harm.
- IV. One ought to promote welfare and prevent harm.
- V. One ought to treat people fairly and with equal respect.
- VI. One ought to respect the self-determination of others.

I interject these six principles here because I find them so illustrative of both the negative and positive form duties of respect entail. It is obvious that each of these principles can be understood as emerging from Kant's Formula of Humanity. Whether one chooses to or not, these principles are all subsumable under respect for persons.

Some authors, such as John Harris clearly suggest that respect incorporates considerations of well-being (2005). Others suggest that concern for well-being lies within the purview of beneficence and nonmaleficence and that ambiguity regarding well-being is one reason the principle of respect for persons is unhelpful (Beauchamp and Childress 2001; Beauchamp 2005). This misunderstanding by Beauchamp and Childress stems from the fact that 'respect' in their four-principle system is for

‘autonomy’ rather than for ‘persons.’ The problems of conflicting contingent principles created by the mistaken conversion of respect for persons to respect for autonomy by Beauchamp and Childress is examined in detail in Chapter Four.

The fact that respect for persons includes all persons, autonomous or not, removes the potential ambiguity regarding purview of principles. Beneficence and Justice may be considered principles in their own right, but the conceptions of these duties entail proper concern for well-being and the just treatment of persons as ways of manifesting the respect they deserve. They are therefore derivative from respect for persons and, consequently, there should be no conflict of either principle, properly understood, with Respect for Persons.

The Belmont Report rightly insists that informed-consent policy is justified by respect for persons and considerations of autonomy are part and parcel of respect. The justification for physicians valuing, honoring and respecting patient autonomy via the doctrine of informed consent resides in the moral imperative of respect for persons. It is the unconditional value of human persons rather than the unconditional value of their functional autonomy that is to be respected.

The value of functional self-determination may of course have unrelated benefits, such as helping individuals protect themselves from harm, exert control over their lives and, as Mill holds, be contributory to human happiness. These benefits will not, however, justify the significance informed consent has been given in bioethics in the past few decades. I argue this point because of my belief that in contemporary bioethics autonomy as a moral concept and self-determination as a libertarian concept have been conflated. Insofar as an emphasis upon autonomy in medicine is justified, it rests on deeper considerations of real respect for persons and is decidedly a moral concept.

There are several reasons I hold this to be the case. In the first place, self-determination in most aspects of a person’s life has more to do with the kind of decisions of daily living that quite often are not moral ones, meaning that they are not decisions driven by one’s moral beliefs, commitments and values. Insofar as decisions regarding one’s medical condition and treatment do not engage the moral

sphere, self-determination in decision-making can be essentially equivalent. The impact of illness takes on a greater moral significance as the nature and severity of the impairment and the gravity of the prognoses of given diagnoses increases. In such situations, most lay persons as patients are also ill-equipped to intuitively navigate these potentially treacherous waters and come to depend upon a trusted physician to guide them through the often daunting and confusing process. There are financial, bureaucratic, administrative, technological and scientific barriers that inject a degree of uncertainty, anxiety and disorientation.

The once self-sufficient and self-determining individual is suddenly facing issues and questions that rock him to his moral core. External constraints upon that once autonomous person breed indecision and fear and maintaining one's cool, calm, collected clear-headedness is threatened. In these circumstances, self-determination, for the most part, has already fallen by the wayside, as one is led through a maze of unfamiliar and often impersonal encounters with machines, nameless technicians and physicians. At this juncture, it is safe to conclude that the libertarian notion of self-determination has lost substantial currency.

Moral autonomy as a relational concept, however, is open to the caring entry of physicians whose duty it is to help the patient regain his footing in this state of distress and confusion. By offering a friendly caring face and attitude and a willingness to "be of service," such health-care providers may and ought to have a positive influence upon a patient's restoration of self-esteem and aid him in regaining his moral bearings such that they can be autonomous participants in the direction treatment and care will take from here. This autonomy is not that of captain of the ship, but it is nonetheless grounded in the moral commitment to the patient whose life is that ship and the respectful role of the doctor is to assess and enable such patients to, little by little, regain control of their lives and express their goals, values and desires for where their care goes from here.

This conclusion is of more than mere academic interest because the formula of humanity will guide our judgments about informed-consent policy differently than the *Belmont Report* does. Policy

will no longer be based on how far it goes in the direction of offering people opportunities for personal deliberation. Instead, it will be rated by how well it protects people against deception and coercion. This difference in approach should certainly lead to policies that are different—perhaps less demanding and more flexible for patients and research subjects—than those that are naturally supported by the *Belmont Report*. Simultaneously, I contend that they should be more demanding of physicians/researchers in performing duties of assisting and promoting the competence of the partially or minimally autonomous.

An important aspect of respect for autonomous persons is to be concerned with well-being as the individual patient defines it. Persons define their own critical interests and it is disrespectful to impose one's own understanding of what constitutes well-being or one's own understanding of how physical well-being ought to be valued. Beneficence is also part of the duty of physicians to autonomous persons insofar as they are treated with caring concern and a genuine interest in aiding them in defining what well-being means to them and in finding the best available options for attaining their goals.

This duty of beneficence actually arises from the duties to others specified as emerging from the autonomy of the physician as described in Kant's second formulation. Both may co-exist harmoniously, without paternalism, if taken together as mid-level principles that derive their meaning and functional applicability from respect for persons and for patients as persons.

Respect may be consistent with imposition of significant risk to secure the patient's well-being. If the potential for benefit (perhaps life-saving) is high and if the risk is truly understood and accepted by an autonomous patient, then both the person's autonomy and the physician's beneficence can be actualized. Of course, there always remains a question about harm (and thus a potential constraint exerted by the principle of non-maleficence) in determining whether some risks may be so extreme that exposure to them fails to recognize the inviolability of human life.

Belmont's Understanding of Beneficence

The *Belmont Report* states that, “persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being.” Securing a research subject’s well-being falls under the principle of beneficence. Beneficence, as described in the *Belmont Report*, obligates the investigator to follow two general rules. The first is to “do no harm,” and the second is to “maximize possible benefits and minimize possible harms.” With respect to the first general rule of beneficence, the authors of the *Belmont Report* did not intend for investigators to reach the standard of “above all do no harm” (*primum non nocere*), which is said by some to be the first principle of medical ethics. In fact, however, first do no harm never appears in the Hippocratic corpus and is written in Latin, not the Greek of Hippocrates. Rather, the Commission intended to forbid the deliberate injury of a human subject for the purpose of developing generalizable new knowledge, no matter how important that knowledge might be.

The second general rule of beneficence obligates investigators to design their protocols so as to maximize the probability and magnitude of benefits to individual research subjects, as well as to society. It further requires investigators to minimize the probability and magnitude of injury to individual research subjects. It is during the process of informed consent that the risks of participation in research are disclosed and that a promise to pursue the individual or collective benefits is made with each potential subject.

Although beneficence is generally viewed as acts of kindness and charity which individuals are not obligated to pursue or bestow upon others, the Kantian view holds beneficence as an imperfect or wide duty such that it is an obligation that each person has the latitude to determine when and how he discharges the duty, but it is a duty of the formula of humanity as an end-in-itself. The National Commission viewed beneficence (to do or promote good) as a strict (perfect) obligation or duty in the research context because investigators consent or pledge to be bound by it. Investigators pledge to

promote good, by creating new knowledge or providing some benefit to subjects, when they accept public support for their work. In addition, during the process of informed consent, investigators pledge to pursue the benefits with potential subjects. It would be unethical to put human beings at risk without the prospect of creating beneficial new knowledge or promoting the social good and even in these circumstances, the risks must be clearly and truthfully conveyed to study participants without falsely suggesting potential benefits to participants personally that researchers do not truly believe have a reasonable chance of being actualized. In each of these cases, the foundation of these obligations is grounded in respect for persons. All research subjects are persons and must be treated as ends in themselves which entails informed consent and truthfulness and which cannot tolerate deception, inadequate information or education. Solid footing for this obligation, as dictated by the pedestrian utilitarian understanding of the principle of beneficence, cannot find moral justification.

Belmont's Understanding of Justice

The *Belmont Report* states that justice has to do with fairness of distribution or distributive justice. Distributive justice is concerned with the distribution of scarce benefits where there is competition for these benefits, as well as the distribution of burdens, particularly when it is necessary to impose burdens on fewer than all members of a seemingly similar class of people.

Justice, as defined in the *Belmont Report*, addresses the questions: Who ought to receive the benefits of research and who should bear its burdens? Injustice occurs when some benefit to which a person is entitled is denied without good reason or when some burden is imposed unduly. The *Belmont Report* states that, "another way of conceiving the principle of justice is that equals ought to be treated equally." Burdens should not be imposed on, or benefits provided to, fewer than all members of a seemingly similar class of persons without suitable justification.

Aristotle came up with the suggestion that distributive justice consists of treating equals equally and unequals unequally (Bk. V, Chap. VI). So, for example, if you have two patients in the

emergency room equally in need of aid and they came in at the same time and are equal in all other relevant aspects, according to Aristotle, you would have to either treat them both at the same time or devise a fair method of choosing who gets seen first (such as a random coin toss). This interpretation is an understanding of justice as impartiality. Whether intentionally or not, the concept of similarity in some “relevant respect” is left un-interpreted.

This raises several questions: Who is equal and who is unequal? What are similar classes of persons? Are there situations where unequal treatment is never justified? For example, many people feel that all people should have equal access to a basic minimal level of health care, but what is a basic minimal level? The answer to these questions, as they relate to research, can be found in the following statement in the *Belmont Report*:

The selection of research subjects needs to be scrutinized in order to determine whether some classes (i.e., welfare patients, particular racial and ethnic minorities, or persons confined to institutions) are being systematically selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied. Finally, whenever research supported by public funds leads to the development of therapeutic devices and procedures, justice demands both that these not provide advantages only to those who can afford them and that such research should not unduly involve persons from groups unlikely to be among the beneficiaries of subsequent applications of the research.

It would be unjust, for example, if one group in society incurred the risks of research and failed to benefit from the knowledge or application of such research.

This initial concept of justice has since evolved to include the concept of fair access. Fair access requires that individuals (from a class of persons to whom an innovative therapy or procedure applies) should have an equal opportunity to receive the benefits of the innovative therapies or procedures (such as those being developed for treatment of AIDS). This expansion of the concept of justice occurred in the 1980s when individuals with AIDS claimed that the only way they could gain access to the few drugs directed at the cause of the disease was to agree to be subjects in clinical trials designed to determine whether these drugs were safe and effective. Participation in these trials

exposed subjects to the risks associated with these drugs, but the trials also offered potential benefit, and there was an outcry for these trials to be accessible to all persons with AIDS.

Different criteria have been applied over time for distributing scarce resources. People have been treated differently based on their purchasing power, needs, ability, and age. The National Commission believed that the most morally relevant attribute was vulnerability. The vulnerable should be assured of receiving their fair share of the benefits and protected from having imposed upon them more than their fair share of the burdens of research. The National Commission believed that the vulnerable were also entitled to special protections to prevent them from being exploited.

Resolving Conflicts Between Ethical Principles

The three Belmont principles (respect for persons, beneficence, and justice) have been interpreted and described in a series of ethical norms. These norms operationalize the principles, describing actions that should or should not be taken when conducting research with human subjects. To conduct ethical research with human beings, investigators must incorporate these norms into their protocols. Investigational Review Board (IRB) members evaluate the procedures found in research protocols against these norms and ensure that the research will be conducted ethically (e.g., according to these ethical norms) before approving a protocol. If only life were this easy.

The National Commission intended for each of the principles to have equal moral force, and there is no rank order of these principles to resolve disputes when they conflict (which inevitably happens). While I think this was a significant shortcoming, they are essentially presenting autonomy, beneficence and justice in ways that show each of these principles to be implicitly grounded in respect for persons. It is unfortunate that they chose not to articulate their principles in this way, but they are clear that the *norms derived from the principles do not have equal moral force*.

The requirements of some norms must be met before others are even evaluated. For example, if the research design is poor or the investigator is not competent, the research will not result in

generalizable knowledge and there will be no benefit to society if the research is conducted. The IRB will not approve the protocol after reviewing the first two ethical norms (good research design and competent investigators), and there is no need for the IRB to evaluate the protocol for compliance with other norms such as a favorable balance of harm and benefits, informed consent, and equitable selection of subjects.

But what happens in cases where protocols have good research design, the research will be overseen by competent investigators, and other norms conflict? In these cases, the IRB must judge the forcefulness of the norms in conflict based on the facts before them and select, in its view, the most ethical solution. In some cases the Federal regulations have anticipated some common conflicts and provide guidance to the IRB. For example, an investigator may conduct a study reviewing medical records without the consent of the individuals whose data he or she is reviewing. In this example, the ethical norm (informed consent) derived from the principle of respect for persons and the ethical norm (favorable balance of harm and benefit) derived from the principle of beneficence are in conflict. The regulations allow for a waiver of informed consent in the interest of pursuing benefits if certain conditions are met. Implicitly the regulations say that beneficence prevails when there is very little at stake with regard to self-determination. In other cases there is no direct regulatory guidance on which IRBs can base their decisions. The weighing and prioritizing of conflicting ethical norms is a difficult task and is routinely carried out by investigators and IRBs as they write, review, and approve research protocols through discussion and debate. The ethical norms derived from the Belmont principles are binding unless they are in conflict with other norms or there is some other ethical justification for overriding the norms' requirements.

Belmont Revisited.... Again

Belmont Revisited: Ethical Principles For Research With Human Subjects, edited by Childress, Meslin, and Shapiro was a series of essays, 20 years after Belmont, on the investigative and

deliberative duties of this commission, including a statutory responsibility "to identify the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects." Jon M Harkness, a noted medical historian, commented in a brief review of this commemorative collection of essays that his chief disappointment with the book was the lack of an essay by a medical historian and so he set himself to the task:

I put on my historian hat for a half hour and did a little research with the use of a newspaper database. I searched for the phrase "Belmont Report" in the New York Times, the Washington Post, and the Wall Street Journal and found only the 2002 obituary in the New York Times for the chair of the National Commission, Kenneth Ryan. I found no information when I searched for "Belmont principles." I then did a combined search with the words "respect" (or "autonomy"), "beneficence," and "justice." I found only three articles related to bioethics that contained all these words -- and none made reference to "Belmont." When I searched for articles that included the word "human" and variations of the words "experiment" and "ethics," the database produced more than 1000 hits. Since 1979, it seems that the press has been giving considerable coverage to the ethical aspects of research with human subjects, but, as compared with discussions among bioethicists, it seems less clear that "The Belmont Report" or its principles have entered the realm of public discourse.

His conclusion is that, "it strikes me as a worthy project for someone...that 'Belmont' should be revisited – again." His search findings are illustrative, in that, one of the consultants to the Commission, who in fact claims to have written the bulk of the document, was Tom Beauchamp. Beauchamp and Childress published, in that same year (1979), the first edition of their now world-renowned text, *Principles of Biomedical Ethics*. It has garnered the lion's share of credit for the development of the principles that were originated by the members of the Belmont Commission.

The previously mentioned Advisory Committee on Human Radiation Experiments that concluded its findings in 1996 published their report. The document is over 900 pages in length, yet only mentions Belmont 3 times. This is consistent with the findings of Harkness. What is disturbing is that one of those mentions was in Recommendation 9 near the conclusion of the document. I will quote it verbatim from the publicly accessible document. In this recommendation, they are concerned with the increasingly large number of "clinical researchers" who are also "practicing doctors." Wearing two hats has created a disturbing number of opportunities for conflicts of interest. Even worse is that the patients are in relationships of trust with their "doctor." When she suggests that they

participate in a clinical research protocol, patients naturally believe that this is a recommendation clearly in their best interest or surely their doctor would not suggest it!

Recommendation 9

The Advisory Committee recommends to the Human Radiation Interagency Working Group that efforts be undertaken on a national scale to ensure the centrality of ethics in the conduct of scientists whose research involves human subjects. A national understanding of the ethical principles underlying research and agreement about their importance is essential to the research enterprise and the advancement of the health of the nation. The historical record makes clear that the rights and interests of research subjects cannot be protected if researchers fail to appreciate sufficiently the moral aspects of human subject research and the value of institutional oversight.

It is not clear to the Advisory Committee that scientists whose research involves human subjects are any more familiar with the Belmont Report today than their colleagues were with the Nuremberg Code forty years ago. The historical record and the results of our contemporary projects indicate that the distinction between the ethics of research and the ethics of clinical medicine was, and is, unclear. It is possible that many of the problems of the past and some of the issues identified in the present stem from this failure to distinguish between the two.

The necessary changes are unlikely to occur solely through the strengthening of federal rules and regulations or the development of harsher penalties. The experience of the Advisory Committee illustrates that rules and regulations are no guarantee of ethical conduct. The Advisory Committee has also learned, in responses to our query of IRB chairs, that many of them perceive researchers and administrators as having an insufficient appreciation for the ethical dimensions of research involving human subjects and the importance of the work of IRBs. The federal government must work in concert with the biomedical research community to exert leadership that alters the way in which research with human subjects is conceived and conducted so that no one in the scientific community should be able to say “I didn't know” or “nobody told me” about the substance or importance of research ethics.

Hence, it seems the case that, at least at the ground level of clinical research and probably clinical practice as well, these ethical lessons, from Nuremberg forward, have still not taken root in the practicing and scientific endeavors of physicians.

The suggestion of Harkness that someone revisit Belmont has indeed prompted this chapter and has brought to light some of Belmont's shortcomings, while uncovering deliberate efforts to either discount or disregard Belmont's wisdom in recognizing that respect for persons grounds the enterprise of medical ethics. In revisiting the *Belmont Report*, I am focused upon its first and grounding principle – respect for persons – in order to re-instantiate it as the ground and foundational principle of moral medicine and medical ethics.

CHAPTER 4

FROM RESPECT FOR PERSONS TO RESPECT FOR AUTONOMY (Beauchamp and Childress: The Problems With Principlism)

The Belmont Report names the principle of respect for persons as its first principle. Under this heading the Commission discussed informed consent, but also much more. Persons, for the Belmont Commissioners, included all human beings whether functionally autonomous or not. Functional autonomy was not, for them, a relevant feature of personhood, though it was clearly relevant to *how* persons were to be respected. They were explicit in the differing ways that respect is shown to the autonomous and to the non-autonomous.

With Beauchamp and Childress, the vocabulary changed. Beauchamp and Childress (B&C) likewise located the discussion of informed consent in their first principle, but they did not identify that first and foremost principle as respect for persons, but rather as respect for autonomy. That this shift in nomenclature marks a significant change in meaning is masked in their initial presentation of it in their chapter entitled “Respect for Autonomy.” They intermingled usage of the principle of autonomy with the principle of respect for autonomy.

Most readers and students of their approach to medical ethics come to a misguided understanding of autonomy and respect for it as a principle, in considering the two as synonymous. This is far from the way the authors viewed them. Beauchamp and Childress re-described Respect for Persons as Respect for Autonomy and the notion of respect for “all persons” was now narrowed in scope to only apply to respect for *autonomous* persons. As they noted, “the world of persons is delimited to those who are autonomous.” The principle of autonomy, by definition, applies only to the autonomous. As B&C stated explicitly: “It does not apply to persons who are not in a position to act in a sufficiently autonomous manner” (*Principles*, 1983, p. 64).

In their early editions of *Principles*, respect for autonomy was key among the 4 *prima facie* principles upon which their principlist methodology was based. In later editions, however, critics of this preferential treatment of autonomy led them to explicitly extoll an equal weighting for each of the four (which actually only makes matters worse). There were (and still are) proponents of beneficence (and the well-being of the patient) as the primary guiding principle of medicine. The ceaseless and often pointless discussions centering upon the irreconcilable differences led to irresolvable conflicts between respect for autonomy and beneficence over the past 30+ years might have been averted had they adhered to the concept of respect for persons so carefully laid out for them in The Belmont Report. In their presentation of these principles, respect for autonomy empowers the patient in decision-making, while beneficence empowers the physician. Yet, autonomy and beneficence are not (and need not be) irreconcilable or mutually exclusive and the notion that they are adversarial principles or concepts presents us with a false dichotomy.

In fact, under the auspices of respect for persons as the fundamental principle of medicine, both autonomy and beneficence are embraced and become synergistic. They both can be invoked by degree, such that, as the degree of compromised patient autonomy rises, the degree of appropriate physician beneficent involvement in protecting and actively working for the patient's well-being increases. But even this reciprocal relationship isn't necessary, for it makes perfect sense to promote and foster the autonomous functional status and decision-making competence as part and parcel of beneficently caring for the well-being of the patient.

Beauchamp and Childress, in *Principles*, made a brief and ultimately unsuccessful attempt to harmonize the conceptions Kant and Mill held of autonomy. Unfortunately they present an oversimplified (and erroneous) gloss of Kant's autonomy by equating it with personal autonomy and of Mill's conception as being essentially that of non-interference. Following this, they proceed in their text to a section entitled, "Respect for Autonomy and the Principle of Autonomy" (1979, pp. 58–60). Throughout this section, the words "respect" and "autonomy" appear frequently and in close

association. Not only did they establish a rhetorical association between respect and autonomy, they further reduced the meaning of respect for persons to respect for autonomy:

In evaluating the self-regarding actions of others we ought to respect them as persons with the same right to their judgments as we have to our own. This aspect of the principle of autonomy is often referred to as the principle of respect for autonomy . . . (Beauchamp & Childress, 1979, p. 59).

It had never before been referred to as the principle of respect for autonomy: they bear full responsibility for having introduced this notion and with awarding it the status of a principle. Upon reading this quote, one is initially led to believe that for Beauchamp and Childress the aspect of the principle of autonomy which leads to respect for others as persons is to be renamed, “respect for autonomy.” In fact, however, something subtler and more sinister is going on.

The first sentence can be unpacked with more clarity by re-stating it: We ought to respect others as persons because of their functional ability for agency which they describe as conceiving and enacting self-regarding actions (both moral and non-moral). The autonomy of patients entitles them to the same *right* to and *responsibility* for their judgments as we have to our own. Respect for patients as persons, according to B&C, now *depends upon* persons having their functional autonomy intact and of being fully capable of making and of being accountable for their self-regarding actions and judgments. Impairment of this capability below an unspecified (or specifiable) threshold, for whatever reason, renders them “non-autonomous.”

They have craftily redefined respect for persons as a sub-category of the principle of autonomy in their shift of the focus of respect from persons to the principle of autonomy itself. It is no longer the principle of The Belmont Report. In their brief description of respect for autonomy, this subtle but profound alteration in their principle has flown into common usage “under the radar.” It either went unrecognized to be materially different by medical ethicists and medical educators, or it was misinterpreted as insignificant in its implications. The principle of respect for persons, from which the principle of autonomy springs, then, became the principle of *respect for autonomy*. The implication of this, of course, is that those human beings who lack the ability to functionally act upon self-regarding

judgments are not worthy of respect under the principle of respect for autonomy. Furthermore, this alteration has us owing respect to a principle rather than to the person. I have outlined, via Belmont (and based in Kant), that nothing should be valued above human beings and that respect for persons was the act of recognizing that value.

Acknowledging the values and choices of individuals is a way of treating them with respect and, consequently, respect for autonomy is an important expression of respecting the persons who possess it functionally. But if one considers autonomy to be a capacity of all human beings, regardless of their ability to actualize it in the personal functional sense, it takes on not only a more universal applicability to all persons, but also a quite different meaning. The shift in language, away from respect for persons and toward respect for autonomy in *Principles of Biomedical Ethics*, suggests that “autonomy” has effectively supplanted “persons” as the object of respect and this change, I argue, is more than just semantic.

Respect for autonomy, as coined by Beauchamp and Childress, marks a substantive shift in bioethical thought by suggesting that we ought to regard functional autonomy as a more important determinant of “personhood” and thus who is deserving of respect than the humanity of persons (which takes into account the whole person). Health professionals may come to view patients on the basis of their goals and preferences, rather than on any deeper, more meaningful characteristics they have as beings of inestimable value.

This is an unacceptable state of affairs within the context of medicine, where every patient is a person. The medical profession does not and should not make judgments regarding which patients are “persons” based upon their level of functional autonomy. All patients, by virtue of illness and the need for medical care already have some degree of compromised autonomy due to the many physical and psychological effects of illness and suffering upon persons. This is not to say that all patients are non-autonomous, but it is to say that they are each, to some extent, functionally less autonomous.

If the criteria of the personal autonomy theorists (such as Frankfurt and those who have followed him) were the criteria of personhood in medicine as Beauchamp and Childress would have it, the numbers of patients judged to be non-autonomous would be staggering. Worse, however, it would be crippling to the ability of physicians to accept or allow judgments and decisions to be made by many of the patients that are considered to be competent to make decisions for themselves, despite the lack of the ability for functional autonomy. Personal autonomy theories place rigorous standards upon personhood and Beauchamp and Childress have chosen to discuss and think of autonomy in medical contexts in personal autonomous terms.

In essence, an exclusive or nearly exclusive focus on personal autonomy distorts our view of what persons are and actually undermines the larger goal of respecting persons. It may, in fact, lead us to disrespect persons. For example, when we view individuals through the lens of respect for autonomy, those with unacceptable goals (e.g., relapsing drug addicts) and those who seem to have few or no goals at all (e.g., infants and those with severe cognitive impairment) may not merit the full respect owed to “persons.” Doctors may be perfectly willing to respect those who are (or are at least working to become) what they believe patients ought to be, but these same physicians may be far less willing to respect those who are not what they would like patients to be or for various reasons are persons who lack the capacity to act autonomously.

I contend that this personal conception of autonomy is too limited to be the object of our respect as defined by B&C and as used in contemporary bioethical dialogue. The understanding being put forward by B&C seems to make autonomy conditional on whether a doctor admires a patient’s values. In those situations where the physician does not, the patient’s ‘right’ to autonomy is what is protected and honored by the doctrine of informed consent. This usage implies the recognition that, regardless of how strongly the doctor may disagree with the choice or decision of the patient, she must ‘respect’ that choice by ‘allowing’ the patient’s decision to be final. The only alternative that seems to be left to the practitioner is to declare the patient ‘non-autonomous,’ in other words acting irrationally,

and invoke the principlist notion of beneficence which frees the doctor to decide what is best, regardless of the patient's wishes. This seems clearly regressive and an unacceptable open justification for the very paternalism that all the fuss about autonomy was intended to address in the first place.

The understanding of autonomy as a right of patients creates another dilemma for the doctor concerned about the patient's competence. If she chooses not to declare the patient incompetent (which in practice is difficult to do unless the patient is severely impaired), the patient's right of autonomous choice results in a patient making decisions for himself when he is incapable of doing so (at least in an informed and unimpaired manner). The paternalistic invocation of beneficence and the overriding of the patient's autonomy need not (and ought not) be the only alternative to the abdication of one's duty as a physician to prevent patient harm.

When caring respect for the patient grounds the notion of patient autonomy, the physician will recognize her duty to provide hands-on guidance and promotion of patient autonomy by further education, communication and (when needed) persuasion. These measures strengthen patient autonomy rather than usurp it, so long as there is no element of coercion or manipulation. This engaged involvement is what I have been referring to as shared decision-making and is the meaning respect for persons ought to have within the physician-patient relationship. This caring and respectful action is far superior to the doctor 'respecting patient autonomy' by stepping back and respecting the patient's right to decide for himself, regardless of his functional capacity to do so. Shared-decision making is trust building, while pulling back and leaving the patient to his own devices actually exacerbates distrust between doctor and patient and creates an awkward environment for the doctor to carry out the wishes of the patient. At the same time, this 'respect for autonomy' leaves the patient out on a limb when he needs the doctor's assistance the most.

Respect for persons, conversely, provides the proper guidance for how to treat and regard one another with mutual respect. It fosters the extra effort to seek common ground that can help bring differences of opinion to convergence and to resolution. Resolving disagreement by the patient's right

to trump the physician should be a measure of last resort. This understanding of respect as respect for autonomy causes even more significant problems for the physician-patient relationship. According to Beauchamp and Childress, physician obligations to those patients who lack autonomy (who require the full actualization of self-directedness) are no longer based upon respect for the patient at all, but instead, fall solely under the guidance of the principle of beneficence. Beneficence in this situation should be understood as paternalism and is up to each physician to determine and carry out the actions she believes to be in the patient's best interest. Without any guidance provided by the principle of beneficence (in the absence of the duties of respect for persons) physician decisions may range from a benign to a malignant form of paternalism.

On this view, doctors are released from the sense of responsibility to work toward restoring whatever capacity for autonomy and self-determination patients may have. In addition, because respect for persons is not an operant principle in their four-principle approach to bioethics, it is difficult to justify intrinsic worth and dignity for patients lacking autonomy. Their re-articulation of the meaning of respect can be used to argue against the personhood of such patients, merely because the patients lack the capacity to qualify as "moral agents."

The broader focus upon respect for persons requires that doctors also respect people who lack autonomy and those who have abused their autonomy by making decisions that are objectively bad. Furthermore, even when a patient is given respect based on his functional autonomy within the four-principle construct, the nature of that respect is limited to respect for the right to autonomous decision-making. Some physicians assume that honoring patients' preferences and obtaining informed consent for any non-routine treatments or procedures is the sum and substance of respect. This 'procedure' is generally represented in contemporary bioethics to epitomize respect for autonomy. Such behaviors are compatible with respect, but there are many other important behaviors that result from a broader view of respect for patients as persons.

The language of respect for persons is better suited to describing how physicians should think about and act toward their patients. “Respect for persons” is already a historically well-established term in the discourse of bioethics (Kant, Ramsey, Belmont). It was identified as one of three ethical principles guiding human subjects research in the Belmont Report discussed in the preceding chapter and has been invoked frequently ever since.

Nonetheless, in contemporary usage, it has fallen by the wayside in its re-description by Beauchamp and Childress as respect for autonomy. This overt denial of personhood to all those patients who lack autonomy in the robust sense of B&C has contributed to patients’ and society’s substantial loss of trust in doctors and in medicine generally. While respect for autonomy requires an assessment of a patient’s capacity to think and act autonomously, respect for persons requires only an acknowledgment of the patient as a person.

As mentioned earlier, some philosophical accounts of “personhood” view autonomy as a necessary (and perhaps sufficient) criterion for counting as a person. Such personal autonomy theories, however, are focused on an entirely different problem regarding the conception of autonomy and of persons and are not applicable to medicine. The adoption of personal autonomy theory by B&C in their understanding of the kind of autonomy that is deserving of respect has set the bar too high for the context of medicine. Medicine must reject the notion that individuals must be functionally autonomous (in the sense used by personal autonomists) to qualify as persons, especially in the context of illness that generally produces a host of constraints upon a patient’s functional autonomy.

I maintain that it is the physician’s moral duty to respect all patients equally as persons. This is an extension of her universal duty to respect all people because of their unconditional intrinsic value as human beings. Furthermore, the type of respect that physicians owe to patients is independent of the patient’s personal characteristics and ought to be accorded to all.

Respect (for Autonomy) downgraded to the Right of Non-Interference

The sudden change of terminology promulgated by B&C subordinated the autonomous personhood of the patient to a ‘right’ of the patient to have his autonomy respected and entailed an obligation that the doctor respect that right. Beauchamp and Childress describe this obligation as “the duty to protect and foster a patient's free un-coerced choices.” In one fell swoop, autonomy (as a capacity of all human beings by virtue of their human nature) lost its moral authority to command dignity and respect for each person and all of humanity as moral equals. Kant insisted in several of his writings that the *capacity* for rational autonomy inherent in human nature (whether functionally actualized or not) is deserving of respect.

In the 4th edition of their textbook (1994), respect for autonomy is defined by Childress. His initial description is more of a caveat. “Autonomy, as a concept, is constituted by several ideas that can only attain a specific meaning in the context of a theory” (which is, in itself, a curious statement, since, as we shall see, they contend that their principlist approach is not a theory, but rests upon “the common morality”).

Joel Feinberg (in *Harm To Others*, p.44) helps us understand the breadth of these “several ideas” referred to by Childress.

Our conception of autonomy as an actual condition is sufficiently vague and uncertain to allow us considerable flexibility. We can think of autonomy as a capacity, a condition, an ideal, and a right, and as integrally bound up with such notions as self-possession, self-identity, self-selection, self-determinism, self-legislation, moral authenticity, moral independence, self-fidelity, self-discipline, self-reliance, self-generation (initiative), and personal responsibility.

So which of these ideas are incorporated in the sort of autonomy the authors of *Principles* have in mind? Within the ‘context’ of which ‘theory’ does Childress refer as giving autonomy its ‘specific’ meaning in his definition? These questions go unanswered. Childress, nonetheless, defines autonomy as the:

...personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding... The

principle of respect for autonomy should be viewed as establishing a stalwart right of authority to control one's personal destiny... (p.126, restated in 6th edition on p. 98).

Despite the breadth of our obligations to respect autonomy, the principle is not so broad that it covers non-autonomous persons (p. 127).

In public policy, the demands of distributive justice can easily outweigh the demands of respect for autonomy (p.128).

It is clear from this description that their conception is first, and foremost, one of 'personal autonomy' (in its contemporary philosophical usage of Frankfurt et. al.). Second, it is also primarily one of 'non-interference.' Respect for the right to make autonomous choices and the duty to protect it in others is the basis for liberty and is much closer to Mill's notion in *On Liberty* than to Kant's original conception of autonomy, which is without question a moral one, grounded in respect for persons.

To be fair to Mill, however, in *Utilitarianism* he provides a much richer conception of autonomy than non-interference. Mill describes it as a necessary component of happiness and as playing a significant role in determining the factors that bear on maximizing human well-being. Nonetheless, his notion of autonomy is not clearly given an intrinsic value. It significantly factors into the determinants of happiness that Mill proposes, but, on my reading, is along the lines of personal self-determination and is concerned with an instrumental, rather than an intrinsic value of autonomy (although at times Mill does consider whether self-determination is a necessary constituent of happiness). Autonomy is unequivocally instrumentally invaluable in contributing to maximizing happiness for Mill and this was a huge step forward in utilitarian thinking from the hedonistic Benthamite attention to pleasure and pain.

It is also clear from their text that for B&C the principle of respect for autonomy does not cover non-autonomous persons:

Our obligations to respect autonomy do not extend to persons who cannot act in a sufficiently autonomous manner (and who cannot be rendered autonomous) because they are immature, incapacitated, ignorant, coerced or exploited. Infants, irrationally suicidal individuals, and drug dependent patients are examples (6th edition, p. 105).

Autonomy is lacking or incomplete for parts of all lives (childhood), for greater parts of many lives (senility, some chronic illnesses and chronic psychiatric disorders) and throughout some lives (mental

impairments such as more severe manifestations of Down's syndrome). Since illness often damages autonomy, concern to respect it does not seem a promising fundamental principle for medical ethics.

Concern for patients' well-being has often been thought to be the more plausibly fundamental principle with regard to the non-autonomous. Beneficence, however, is only sufficient to guide physician duty if it is subjected to a higher moral constraint (the principle of respect for persons) that regulates its invocation. Were beneficence to be considered the only or the fundamental principle of medical practice (as argued by Pellegrino and Thomasma), it would have the potential to make irrelevant the wishes and consent of patients, whether they possessed functional autonomy, partial autonomy or no autonomy at all. This would make medical practice unambiguously paternalistic. Physicians would not be obliged or inclined to treat patients as persons and show them respect unless the principle of beneficence implicitly requires respect for the non-autonomous person.

Since illness is almost routinely associated with reduced cognitive and volitional capacity, it is fair to say that patients' impairments constrain and undercut some but not all possibilities for autonomous action. In other words, we must have an acceptable notion of partial autonomy with attendant reduction, but not absence of, agency for decision-making (moral and non-moral). To grant this, it is necessary that we understand patients as persons in the context not only of illness, but also in potentially borderline (but potentially valid and valuable) levels of functional autonomy.

This argues for an understanding of functional autonomy and moral agency as present in persons by degrees. It does not, however, argue in favor of the view that personhood (if it is being understood as the determinant of a particular, unconditional kind of respect) can also be a matter of degree. I wish to be clear that my argument for the personhood of even seriously impaired human beings is of necessity within the context of medicine and the delivery of medical care.

All human beings inherently (within the human genome) possess the rational capacity for autonomy and hence have dignity and are deserving of respect within this context. On the other hand, few persons, if any, possess fully unimpaired functional autonomy. I think most everyone would

assent to the personal feeling that there are some influences, external to our rational nature and our cognition, that constrain our being fully autonomous. Kant clearly admitted as much.

This is not intended to be an ontological claim but rather a practical one, in order that ethicists and physicians can be clear and in agreement regarding the duties and obligations owed to all human beings. This is also not intended to delimit either rationality or deservingness of respect to those beings that possess a human genome. I would extend to all creatures genetically capable of rational thought and decision-making both dignity and respect and as we learn more about the capabilities and genetic makeup of other animals we must be open to the idea of extending to them the protection, duties and obligations accorded human beings.

Persons such as minor children and teens desire and have petitioned to have their wishes for themselves count as reasons to override the surreptitious invocation of beneficence by doctors. Paternalism is most likely to rear its head in the hands of physicians who do not value the child's autonomy (partial though it may be) or judge it to be in conflict with what she, as physician acting under the principle of beneficence, believes to be in the best interest of her patient. These moral lacunae can be illustrated by the following not uncommon clinical dilemma which was made into a Medical Board Exam Question:

A 16-year-old girl is brought to a physician by her mother for a physical examination required for attendance at summer camp. The mother leaves the room before the examination and the girl says to the physician, "Could you also give me a prescription for birth control pills? I'm going to camp with my boyfriend and want to be prepared. And please, please don't tell my parents!" Physical examination shows no abnormalities and the patient has reached normal developmental milestones. Which of the following is the most appropriate response of the physician?

- A. How long have you been having sexual relations with your boyfriend?
- B. I can only give you that prescription if I have your parent's permission. Let's set up a time to meet.
- C. I'll be happy to give you a prescription but let's talk about some important issues first.
- D. I'm happy to give you a prescription and am pleased that you are responsible enough to be prepared. I see no reason why your parents need to know.
- E. I wish you would reconsider. Sex before marriage can become very complicated.

This question was only answered correctly nationally by 12% of the students taking the test. The same question was posed on a continuing medical education exam for family physicians and a similarly low percentage of respondents answered correctly. The correct answer is C.

States have traditionally recognized the right of parents to make health care decisions on their children's behalf, on the presumption that before reaching the age of majority (age 18 in all but four states) –young people lack the experience and judgment to make fully informed decisions. Yet it is well known that teenagers frequently become sexually active well before their 18th birthday. Establishing rules for minors' consent for medical care has been one of the more difficult issues to face policymakers and physicians.

On one hand, it seems eminently reasonable that parents should have the right and responsibility to make health care decisions for their minor child. On the other hand, however, it may be more important for a young person to have access to confidential medical services than it is to require that parents be informed of their child's condition. Minors who are sexually active, pregnant, or infected with a sexually transmitted disease (STD) and those who abuse drugs or alcohol or suffer from emotional or psychological problems may avoid seeking care if they must involve their parents. Recognizing this reality, many states explicitly authorize a minor to make decisions about his own medical care. Balancing the rights of parents and the rights of minors, however, remains a topic of debate.

At the federal level, the focal point of debate over minors' access to confidential services has been the Title X family planning program. Since its inception in 1970, services supported by Title X have been available to anyone who needs them without regard to age. As a result, Title X-supported clinics provide contraceptive services and other reproductive health care to minors on a confidential basis, although they encourage minors to involve their parents in their decision to seek services. These current practices at the level of the federal government are again coming under fire from a conservative faction of the Republican party and may come to figure into the debate over providing services of planned parenthood at all.

This test question example makes clear that, even in contemporary times, the combination of general physicians' lack of knowledge of the law coupled with their paternal medical insights

and priorities can lead to erroneous conclusions that may, through the acceptance of the consensus, be judged as morally correct. Neither wide reflective equilibrium nor coherence theory can guard against a majority opinion that is wide of the mark. It is far more likely that our moral thinking can guide us to correct moral judgments through respect for persons and the willingness to see the needs and desires of those who may be judged as merely partially autonomous. Physicians, without the necessary background training in ethics and philosophical reflection, are likely (as our example has shown) to draw the wrong conclusion.

Thus, our concept of 'person' within the practice and tradition of medicine of necessity must begin in the reality of impaired (or not yet fully developed) autonomy, at least to some extent. We cannot expect the abstract and ideal moral theories (such as personal autonomy theories) that are 'agent-centered' to be of much help to us when they portray an inaccurate view of the reality of 'patient autonomy.'

The principle of respect for autonomy in the four-principle approach of B&C fails because it assumes a generally idealized ability of patients to be functionally autonomous and then bases qualification for personhood upon this functional level of autonomy. Suggesting that physicians' approach to patients be guided by the understanding of personal autonomy as non-interference demonstrates an inexplicable lack of understanding of the clinical realities of medical practice. Perhaps this has arisen from the fact that neither Beauchamp nor Childress are medical practitioners or have direct experience of these realities. These contrasting shortcomings reveal the need for better medical education in ethics and for a strengthened collaboration between medicine and philosophy.

The reality is that, to the contrary, the patient needs all the help she can get from the physician and other healthcare workers to foster and promote whatever level of autonomy she is capable of (and all patients are different in this regard). This understanding of autonomy, within the doctor-patient relationship, sees it as relational and dependent upon numerous variables from

patient to patient. Guided by respect for patients as persons, the important role good physicians must play in optimizing patient autonomy is to recognize that respect for persons does not equate autonomy with personhood and respect for autonomy contributes to cloudy moral judgments.

This practical understanding of patient-hood recognizes that the imperfection of non-idealized human beings and human autonomy is further compromised by the need to seek medical care and thus the need of patients to subordinate themselves to the care of others. This is not a shortcoming or failure on their part to be an autonomous person, but it is the expected and typical consequence of being a fallible and imperfect rational being, as we humans are. Our notion of the individual person must acknowledge the non-ideal life circumstances of patients and we must eliminate the idealized conception of the fully rational and autonomous moral agent as a necessary criterion for self-determination or personhood.

Furthermore, it is not only an increase in the patient's understanding that is essential, but also an increase in the doctor's understanding and recognition of the values of the patient. Under the contemporary construct of 'respect for autonomy,' the understanding that information is a tool that can be used for healing or hurting disappeared under the new avalanche of truth revealed to patients. Truth telling is emphasized with little attention to, or guidance about, how best to parse this truth out to particular patients in often dire situations.

As is so often the case in relationships, the timing of the communication of such information is of crucial importance and can determine how the patient processes and responds to it. This is a special skill that physicians must develop with regard to medical information and must be based upon the caring respect for the patient as a person and not merely upon the duty to respect his autonomy.

The principle of respect for autonomy of B&C and as currently understood in contemporary medicine is too remote from these clinical realities. Physicians who have distanced themselves from their patients (through misguided notions of non-interference) cannot obtain this kind of personal knowledge of their patients. Decisions made by physicians and patients in the name of respect for

persons, as opposed to those made by patients in the name of respect for their autonomy, can result in quite different conclusions about the right thing to do. Only patients who are completely unable to understand or decide need complete paternalist protection. When there is a relationship of unequal power, knowledge or dependence, as is often the case between doctors and patients, avoiding manipulation and unacceptable paternalism demands a lot.

Respect for patients as persons must rely heavily on actual medical judgments to assess a patient's current capacity to absorb and act on information presented in a number of ways. It does not follow, however, that medical judgment or current medical standards can provide appropriate criteria for treating patients as persons. Professional medical judgment determines what constitutes respect for patients only when guided by concern to communicate effectively what patients can understand and respect the decisions that they can make in an atmosphere of caring.

When physician commentators point out that 'respect for autonomy' medicine dismisses the importance of the physician's personal judgment based on the evaluation of the individual patient in context, they are absolutely correct! The glaring oversight, however, is that they miss the hidden point of the unspoken goals our contemporary society has set for medicine. To a medicine guided increasingly by marketplace principles and the socially based ethics of justice, the loss of the personal has become irrelevant. The understanding that B&C have of distributive justice is evidence of this. This impersonalization needs, and will receive, further evaluation in this chapter. Next, however, we need to fully comprehend the import of the shift from respect for persons to "respect for autonomy."

Respect for Autonomy Unpacked: Respect No Longer Applies to the Non-Autonomous

Although for Beauchamp and Childress the principle of autonomy appeared to map the same ground as the principle of respect for persons, M. Therese Lysaught observes in "Respect: Or, How Respect for Persons Became Respect for Autonomy" that B&C introduced three key changes with their notion of respect for autonomy (J of Med and Phil: V. 29, 6, 2004). First, as both the name of the

principle and their discussion noted, it is not persons as such but autonomy that is to be respected. As they stated clearly, the difference in their understanding of autonomy and Kant is that: “For Kant a moral relation between persons is always one where there is mutual respect for autonomy” (1979, p. 59). Second, the universe of persons is limited to those human beings who are autonomous. The principle of respect for autonomy, according to the definition of Childress, applies only to the autonomous. Beauchamp and Childress stated explicitly: “It does not apply to persons who are not in a position to act in a sufficiently autonomous manner” (1983, p. 64). Third, respect in this context means “noninterference and correlatively an obligation not to constrain autonomous actions—nothing more but also nothing less” (1983, p. 62). The point they are making is that autonomy (or its respect) is not a moral consideration for them, but a juridical one. This understanding represents a substantial downgrade from the Ramseyan “fullness of respect.”

With *Principles of Biomedical Ethics*, autonomous and non-autonomous persons—so carefully held together by Kant, Ramsey and Belmont under respect for persons—are dissociated. Respect no longer pertains to the non-autonomous. Instead, their fortunes are determined by the principles of non-maleficence and beneficence. Protection from harm is a minimum requirement that is specified for non-autonomous patients by Belmont under the principle of respect for persons. Thus, while protection is itself insufficient, the other duties of respect for persons to care for and promote the reestablishment of their autonomy continue to regard these persons deontologically.

With Beauchamp and Childress we find the principle of respect for persons narrowed to respect for autonomy and what amounts to a willingness to “downgrade” a large cohort of patients (those who cannot exercise autonomy) from the ranks of persons. Neither beneficence nor non-maleficence are deontological principles and are therefore not committed to respecting the non-autonomous as unconditionally valuable. The non-autonomous have been excluded from the protection of respect and become subject to utilitarian mores of beneficence. This is not to say that utilitarians have no reasons to also show respect for patients for whom they no longer respect as persons. What it does intimate,

however, is that this respect is not grounded in the unconditional worth of persons. It does not value the non-autonomous as “conditions of pleasure” as autonomous persons are valued, but it does recognize the need for avoiding singling out any sub-group for disrespectful treatment as this harms the common good by creating the threat that members of other sub-groups may be next.

None of these reasons for showing “respect” to beings viewed as non-persons is very satisfying to anyone with the moral sensibilities that all patients are persons and all persons deserve equal respect and possess equal dignity. I will acknowledge, however, that I have not made the strongest of possible defense for utilitarian thought, as I fail to see the strength of any of its arguments as germane to individual patient care and the physician-patient relationship. I am likely guilty of making short shrift of utilitarianism and as this and subsequent chapters unfold, I do acknowledge the importance of consequentialism in the practice and evaluation of the outcomes of medical practice and show that there are points of potential unification of utilitarian and deontological perspectives, even if a bit strained and perhaps disingenuous.

It was within this lack of respect for patients as persons where American medicine’s most heinous sins against humanity (such as the Tuskegee syphilis study and Willowbrook) took place. There is no assurance or safeguard, absent the duties and constraints of respect for patients as persons, that the vulnerable will not be exploited for the “common good” again. In the previous chapter I have already provided additional instances where the lessons of Belmont went unheeded and exploitation of a minority for the “greater good” motivated further atrocities against Americans by Americans.

Beauchamp and Childress decoupled autonomous and non-autonomous persons vis-à-vis respect. In short, Kant has been turned on his head. Under the rhetoric of the principle of respect for persons—wherein persons ought to be seen as ends only and never solely as a means to others’ ends—for the non-autonomous we find instead the principle of utility. Respect, then, as a theoretical term within the academic discipline of bioethics seems almost as multivalent as its cultural/vernacular

usages. Rhetorical “commitments” and “un-substantiated guidelines” grounded in no theory at all, save the possible commitment to utility, has created an ethical morass.

The critics of principlism are legion and rightfully so. Casuists, virtue ethicists, feminist and ethic of care proponents, supporters of deontological theories from Kant to Ross to Ramsey and most certainly the narrativists and pragmatists openly reject the thin premises upon which this methodology, devoid of ethical content, rests. It is remarkable, in the face of so much criticism, that the wily resiliency of B&C has managed to keep their four principles at the forefront of Bioethics. Because of this fact alone, I want to be as fair-minded as I can. To avoid being charged with dismissing them “out of hand,” I will delve deeper into their propositions and explore what, if anything, is defensible and of value to the long term growth of medical ethics.

Over the nearly 50-year history of the contemporary discipline of medical ethics, at least two distinct and still irreconcilable meanings of respect have emerged. In one configuration (Kant, Ramsey, and Belmont) it is a highly substantive term, inclusive of all human beings, simultaneously promoting autonomy and protecting the vulnerable. It serves to protect individuals in inverse proportion to their ability to exercise autonomy. In a second narrower configuration (Beauchamp and Childress) respect is reduced to “noninterference,” functioning almost in a libertarian sense.

The notion of respect for autonomy operative in bioethics today was first characterized as a *prima facie* principle and but one of four equal principles by Tom Beauchamp and James Childress. It has become, through the writing of these authors, a form of personal autonomy and has been rendered much less effective in medical ethical deliberation by the extraction of its moral teeth. It has seemingly lost its moral dimension and become a ‘legal right,’ secured by the doctrine of informed consent and upheld by the Federal Court of Appeals. It is viewed by most contemporary writers in the bioethical space as a juridical concept rather than a moral one. Beauchamp wrote in 1994:

In recent years, a new idea has emerged that the proper model of the physician’s moral responsibility should be understood less in terms of traditional ideals of medical benefit and more in terms of the rights of patients, including autonomy-based rights to truthfulness, confidentiality, privacy, disclosure and consent, as well as welfare rights rooted in claims of

justice. The principle of respect for autonomy is rooted in the liberal western tradition of the importance of individual freedom, both for political life and personal development. Hence, the apparent arrival of a new health care ethics emphasizing autonomy rights and justice-based rights may not be a complete surprise when we consider the recent and contemporary social history (Beauchamp, T. L., in Gillon, R., 1994, p.4)

Beauchamp prefers to justify the concept of respect for autonomy politically as a right and based within “rights theory” as essentially non-interference (Liberty). Beauchamp rooted *patient* autonomy in the principle of justice with emphasis on the *individual rights of patients* as the “proper model of a *physician’s moral responsibility*.” This point of view, in the context of medicine, is not only well off the mark, but is actually wrong-headed.

To claim that non-moral, *juridical* rights are determinative of physician’s *moral* responsibility is incoherent. Juridical rights impose juridical duties, not moral ones. These duties are enforceable by legal action and do not enter the domain of the moral. Furthermore, in arguing that the attention to patients’ rights ought to be of greater ‘moral’ concern and of a higher priority to doctors than their commitment to the medical benefit of their patients, B&C have provided the impetus for the shift away from care, caring respect and moral concern for the person of the patient. Respecting persons is no longer the grounding principle of the physician-patient relationship, which has shifted toward a legalistic contractual model. Contractualism (as will be discussed in depth in the next chapter), is contrary to the medical intuition and insight of doctors and introduces a confused and internally incoherent moral imperative of sorts.

Respect for Autonomy and Principlism is Grounded in “Common Morality”

The view Beauchamp and Childress hold of ‘respect for autonomy’ is, it seems, generally accepted within bioethics (or at least tolerated). It is interesting to note that B&C, in fact, generally claim support for the principle of respect for autonomy from both Kant and Mill (6th ed. p.104) and even refer to Kant’s second formulation of the categorical imperative as the “substantive basis” for

their principle of respect for autonomy (6th ed., p.349). On the other hand, B&C argue that, “Kant’s theory of autonomy is not about respect for self-determination in general (as ours is).”

Rather, they argue, “Kant’s view is exclusively about *moral* self-determination” (p. 346). “His [Kant’s] theory of autonomy differs considerably from the theory of autonomy we developed as the principle of respect for autonomy” (p. 346). They emphasize that the concepts of self-determination and autonomy, in their account, are not essentially moral concepts, though they do argue, “that respect for the autonomous choices of other persons runs as deep in common morality as any other principle.” I am not sure what this means or if it can be consistent with the previous claim. In a section titled “Why the Common Morality is Central,” they go on to assert that they find the grounding of respect for autonomy (and their other principles) in common morality to be more secure than a grounding in philosophical theory (5th ed., p. 404).

If we could be confident that some abstract moral theory was a better source for codes and policies than the common morality, we could work constructively on practical and policy questions by progressive specification of the norms in that theory. But fully analyzed norms in ethical theories are invariably more contestable than the norms in the common morality. We cannot reasonably expect that a contested moral theory will be better for practical decision-making and policy development than the morality that serves as our common denominator. Far more social consensus exists about principles and rules drawn from the common morality (For example, our four principles) than about theories (ibid).

Beauchamp and Childress do not explore the reasons why common morality values personal autonomy so highly. My thought (as developed more fully elsewhere in this dissertation) is that the public’s perception of medicine (as now under the control of corporations and government and is increasingly market-driven) has them deeply suspicious of who they can trust and has forced them to retreat to the ‘protection’ of ‘rights.’ Under the auspices of the currently operative medical ethic, medicine is no longer considered a calling and the physician is no longer a trusted ally. Medicine has become a contractual enterprise with patients as consumers and the doctor as a technician for hire.

While in the understanding of Beauchamp and Childress common morality is not identical with public opinion, it seems fair to note that, as Callahan observed, the reason that the public values autonomy is largely because of skepticism. B&C’s clear expression of doubt about the possibility of

any moral theory being more informative or rationally justified than the “common morality” is itself an expression of skepticism. In addition, they have stated, “we are content to conclude here that justification successfully occurs in ethics” (though they do not explain what or how this takes place) “and that the right approach to justification is the coherence account.”

The coherence theory of justification advocated by Beauchamp and Childress requires that we start with considered judgments, “that are settled moral convictions in a broad expanse of ethics and then cast...the net more broadly in specifying, testing, and revising those convictions.” They contend that all convictions are ultimately revisable and they depend upon no fundamental unchangeable principles. They also insist that they are not seeking to establish any unchangeable principles.

This whole line of argumentation can be interpreted through two sets of lenses. The first is a partially stated vision of the 19th Century American Pragmatists, notably William James and Charles Peirce. This viewpoint in a nutshell contends that multiple social groups and communities will continue to endeavor to establish moral justification for their convictions and through some process of mutual melding of these competing social mores, something closer to the truth will gradually emerge and be adopted by a steadily increasing number of social groups and societies, thus furthering the morality of humankind.

The second (and more prevalent lens) through which B&C evaluate the moral landscape in contemporary “pluralist” terms expresses a strong skepticism regarding any possibility for an objectivity of morality or even normativity. Their (shallowly) pluralist convictions are internally incoherent with the numerous ethical points of view that they hold to be “self-evident.”

In attempting to ground their four *prima facie* principles in the common morality, they were especially wounded by the scathing critique of Gert and Clouser that posed important problems for their version of “principlism.” The common morality that B&C were encroaching upon is a domain within medical ethics that Gert and Clouser had already not only staked out, but were far better equipped to rationally defend.

Beauchamp and Childress have readily admitted the shortcomings of the four-principle approach which led them to adopt a process of ‘balancing’ and ‘specification’ to evaluate moral decisions when two of their principles conflict. ‘Balancing’ fits best with a conception of principles as *prima facie* binding, but potentially in conflict in particular cases. *Principles*, in its third edition, attempted to reduce the *intuitive* assignment of weights to conflicting principles in a situation by a more formal procedure for resolving conflicts among principles. This was, in effect, an overt rejection of the intuitivism of Ross (and likely of Audi as well).

Specifically, if two *prima facie* principles come into conflict, several conditions need to be met before one can override the other (Childress, Principles-Oriented Bioethics, An Analysis and Assessment From Within, in *A Matter Of Principles?* p. 81). Over the next several years and the fourth and fifth editions of *Principles*, both specification and balancing imploded under their own weight. Childress has also expressed skepticism that the “specified principlism” proposed by Richardson and DeGrazia can fare any better. (DeGrazia, D. “Moving Forward In Bioethical Theory: Theories, Cases, And Specified Principlism,” *J of Med and Phil*, 17(October); pp. 511-39).

Since Beauchamp and Childress say that the primary function of informed consent is to protect and promote individual autonomy, then one cannot give informed consent without demonstrating one’s autonomy. The addition of ‘autonomous’ actually causes the most problems for their approach, as non-autonomous choices are not included and one can override what are deemed to be non-autonomous choices with the principle of beneficence. This once again opens the door for beneficent (or not-so beneficent) paternalism.

If a physician deems that a patient’s refusal is irrational, claiming therefore it is non-autonomous, she may overrule it. Conversely, another physician may reason that although the choice is irrational, the patient is competent and therefore autonomous. Both could claim that they are ‘respecting’ the principle of respect for autonomy and therefore ‘respect for a principle,’ rather than ‘respect for persons,’ may erroneously endorse two opposing physician actions. The first physician, in

declaring the patient non-autonomous, may act with unjustified paternalism, depriving a person of freedom without adequate justification. Conversely, the second physician, in granting self-determination to someone who seems competent in her actions of daily living, may fail to recognize how deeply impaired her patient is by her life-threatening illness when it comes to thinking clearly and making decisions about her treatment options.

The principle of ‘respect for autonomy’ (in arguing that it is the principle, rather than the person, that is deserving respect) embodies a deeply dangerous level of confusion. This confusion is created by the lack of clarity regarding what criteria a doctor must employ to determine what counts as an autonomous action or choice. If it is autonomy, rather than the patient as person, that is to be respected, by what criteria are physicians and others to judge or determine what constitutes a person’s action or decision as autonomous? The consequent blurring of what has heretofore been considered a basic moral distinction reveals the truth of the clinical reality I have just discussed above.

The impact of illness upon the functional capacity of patients to maintain their autonomy and the challenges for physicians imposed by the imprecision inherent in attempting to assess the functionality of a particular patient’s autonomy suggests that autonomy ought to be conceived as a moral ideal, rather than respect for it being treated as a moral rule (or imperative). This unnecessary introduction of respect into the concept of autonomy results in making it more difficult to think clearly about moral problems from the perspective of the functional autonomy of a particular patient. More importantly, directing physician focus in dealing with their patients upon respecting their rights often inadvertently directs them away from recognizing the reality of the person who is their patient.

This juridical approach to the right, as emphasized by understanding the relationship as one of contract, is more likely to produce an arms length relationship, rather than promoting an inter-subjective relationship of caring. A person-centered approach that builds a bond of trust between doctor and patient, such as the covenant I am promoting, opens the lines of communication (verbal and non-verbal) such that the physician’s eyes are opened to the patient’s needs, fears and ignorance of his

medical condition. This fosters caring respect rather than juridical respect and creates the opportunity for shared decision-making, while also fostering the patient's functional autonomy so that he can still be able to have the final say in the direction of his medical care.

The goal of moral philosophy is to clarify our moral thinking, not to obfuscate an already contested concept like autonomy. Consider the same clinical situation from the perspective of respect for persons. Irrespective of the precise level of functional autonomy possessed by this patient at this given time, it is first and foremost the duty of the physician to respect this patient as a person. To do so entails that in the process of informing, educating and deliberating with him about his condition and the therapeutic options available to him, if a reasonable degree of understanding of the problem is exhibited by the patient, he can then only be respected as a person by having his wishes honored. This authority is irrespective of the physician's agreement with the patient's choice or its perceived irrationality. This by no means bars the physician from engaging the patient in further deliberation and consideration of additional relevant factors, in an effort to persuade the patient to change his mind. So long as the physician believes these additional considerations to be germane to the patient's decision and do not constitute deception, manipulation or coercion, she is free, and in fact encouraged, to pursue them.

In point of fact, the doctor has a duty to deliberate upon the clinical situation and to come to a determination regarding what she judges to be the best option for the patient. Without painting a distorted picture of the situation in order to influence the patient's decision, the physician is not only obligated to make a recommendation, but must also provide logical and understandable reasons for the guidance she is providing.

In this process of shared deliberation the doctor must also fairly reveal reasons that militate against pursuing one or the other of the available options. So long as tactics that are either manipulative or coercive are avoided, this interchange between the doctor and her patient exemplifies shared decision-making and is representative of the patient-centered approach to medical practice.

Ultimately, this form of interaction demonstrates the utmost of respect for the patient as a person. In the end, however, whether a joint decision can be arrived at or not, the final decision is the patient's. The doctor must not only recognize this and accept it, but must honor it as the autonomous choice of a person under her care. So long as the choice does not involve a physician action that violates the doctor's own moral commitments, she has a duty to carry out the patient's wishes regarding treatment (or lack thereof) without resentment or animosity. In fact, her duty is to recognize this choice, despite her disagreement with it, as not only informed and deserving of being carried out, but deserving of respect. This hypothetical scenario illustrates, beyond doubt, that in the end the patient has the power and authority to make his life decisions for himself. Respect for persons would not be satisfied with anything less.

Consider the alternate scenario in which the same patient exhibits not only extraordinary difficulty in understanding his condition and resistance to any efforts to help him grasp the fundamental nature of his illness and its import and ramifications. After a similar degree of education and attempted shared deliberation the doctor realizes that restoration of this patient's functional autonomy is not possible, despite her best effort to do so. In this situation a whole other set of duties is invoked that is still under the guidance of respect for persons, but which requires an entirely different set of behaviors from the doctor (as I have previously discussed). The key point is that both of these situations fall under the umbrella of respect for persons and, as such, do not precipitate a conflict between autonomy and beneficence. These principles ought to naturally co-exist harmoniously and the relation of patient and doctor ought not ever be threatened by a conflict (perceived or real) between these two mid-level principles.

Criticism of the Framework of Principlism

L.B. McCullough summarizes the effect of the current operant notion of autonomy in bioethics, as Beauchamp and Childress have described it as being:

More legal than moral and based on rights not obligations, (which) has caused irreparable harm to the doctor-patient relationship. This notion of autonomy reverts to the older model of a contractual relationship between the sick and medical practitioners not worthy of intellectual or moral trust (because such trust cannot be generated by de-professionalizing bioethics) and finally, collapses on itself... Bioethics based on its founding story is a mistake and should therefore be abandoned.

Rebecca L. Walker, in an essay entitled, “Medical Ethics Needs a New View of Autonomy,” laments this situation in her opening abstract:

The notion of autonomy commonly employed in medical ethics literature and practices is inadequate on three fronts: it fails to properly identify non-autonomous actions and choices, it gives a false account of which features of actions and choices makes them autonomous or non-autonomous, and it provides no grounds for the moral requirement to respect autonomy.... A general problem then arises: the notion of autonomy used in medical ethics is conceptually inadequate, but conceptually adequate notions of autonomy do not have the practical applications that are the central concern of medical ethics. Thus, a revision both of the view of autonomy and the practice of “respect for autonomy” are in order (Journal of Medicine and Philosophy, 33: 594-608, 2009).

Walker’s recognition of the problem clearly captures my own assessment and urgent sense that revision is needed. My project to reintroduce the grounding principle of respect for persons is aimed at addressing the challenge she articulates. I have proposed to subsume the concept of autonomy (and all mid-level, *prima facie* principles) under respect for persons, which is foundationally prior and is far less contested regarding its universal appeal. It can establish an ethics for medicine that is practically applicable under medicine’s broad and robust commitments to first treat all patients as ends in themselves (i.e. persons) and second to place the needs of patients above the self-interests of physicians. The logical first step is to subsume both autonomy and beneficence as derivative ethical principles grounded in and subordinate to respect for persons.

In the “commonly-employed” conception of the non-autonomous as non-persons and covered rather under the principle of beneficence (as we have previously discussed), physicians are authorized to act on behalf of a patient’s best interest. But here is the twist. The beneficent (paternal) physician, upon whom the care of the patient depends, is typically the sole judge of a) the patient’s competence for autonomous decision-making and b) where the patient’s best interests lie.

This potential conflict of interest ought to (and does) provoke great consternation for ethical physicians and ethicists (myself included). The worry lies in the question of who is best qualified and most impartial to determine the loss of autonomy of a given person and from what criterion (or criteria) is this determination derived. In general, it actually is most often the very physician who is treating this individual patient, but it nonetheless opens up the possibility of an improper invocation of beneficence played out in practice as paternalism. Ought there to be a consultation with an impartial third party to avoid this possible abuse? This is food for thought.

Although the current conception of autonomy, in recent editions of B&C's *Principles of Biomedical Ethics*, has been extended beyond physician non-interference in patient decision-making (due to external pressure from critics), the effect of this core view of autonomy as a 'right' of patients has demonstrably damaged the relations between physician care-givers and the already "damaged-humanity" of patients. The distancing created by this conceptualization of patient autonomy as a right precipitated a reaction within the physician community that has left medical practice with an arms-length contractual and legalistic grounding. This current state of affairs in which physicians must encounter their patients and deliver health-care has led to the outcome that any additional negative impact upon the relation from pre-existing cultural and/or social differences between doctor and patient has only been exacerbated.

Edmund Pellegrino (a well respected physician ethicist and devout Catholic) lamented in "The Four Principles and the Doctor-Patient Relationship: The Need for a Better Linkage" that respect for autonomy has shifted the center of gravity from the doctor more and more onto the patient (p. 354). The cause of this, in his estimation, was the increasing moral pluralism in our society, a decrease in religious forces and an overall mistrust of authority, coupled with the misuse of that authority by doctors. In that environment, juridical 'respect for autonomy' assures patients of participation in their treatment alternatives, the right to accept and reject any of them, and the retention of control of these intimate and

personal decisions. It also guarantees respect in multiculturalist societies with different moral reasoning (p. 355).

The emphasis on respect for autonomy has fostered contract-type doctor-patient relationships like the consumer-type and the negotiated contract. But the very nature of having a contract fosters mistrust in the relationship, even as it determines the conduct of the two parties. Indeed, Pellegrino asserts:

While these autonomy inspired models seem to protect individual rights they are in fact illusory and may even be dangerous since they are oblivious to the fact that the patient is in fact vulnerable because he is a patient; because of the power of the doctor's personality and charisma; and because there is the force of the social sanction of medicine and its monopoly of medical knowledge which operates regardless of the details of the contract. Moreover, because of the signal of distrust, the doctor may withhold or restrain her inclinations to be beneficent (p. 356).

In the following chapter, I will scrutinize this conception of the therapeutic relationship as contractual as I reject it in favor of a covenantal model of trust between doctor and patient. Pellegrino argues that respect for autonomy must be more closely linked to beneficence and justice. The four-principle approach has placed autonomy at loggerheads with beneficence. Pellegrino also makes note of the conflicts between autonomy and justice when it comes to dealing with third party payers (again pointing out the potential for justice to be interpreted in utilitarian terms).

'Respect for autonomy' has already resulted in such an erosion of patients' trust in their physicians and in medical institutions that it has become necessary, even prior to initiating treatment, that a concentrated effort be made to overcome these barriers to communication and the chance to demonstrate one's trustworthiness. The ensuing problems, encountered by both doctors and patients over the last 40 years, emanate from the inability of the currently operant conception of respect for autonomy to provide the needed moral respect for the patient and the needed moral guidance to the doctor to jointly deliberate and make morally and personally relevant medical decisions in an environment of caring and trust.

Am I right to lay all these problems between patient and doctor on respect for autonomy? This is arguable and there are numerous other factors that have also substantially contributed, so I must be

careful not to overstate their contribution, but the impact has nonetheless been so profound that it is not hard to imagine how things might have gone differently. During that watershed period of time in the “early years” of contemporary medical ethics had respect for persons retained its foundational role, it seems to me unlikely that the current state of affairs in medicine and in medical practice would exist today.

The term “respect,” following the ‘downgrade’ from respect for persons, has come to function increasingly as a rhetorical device in public bioethics discourse. Respect for autonomy, when conceived as ‘individual autonomy,’ means that clinicians and medical researchers must take into consideration the ‘rights’ of patients and research subjects to be treated as individuals who are self-directed in their lives and deserve to direct or make decisions regarding their own health and healthcare, as well as their participation in medical research projects, in an atmosphere of ‘non-interference.’ Even though such considerations do not accurately reflect the realities at the ground level of practice, the fear of even appearing to act paternalistically imposes considerable restrictions upon the behaviors of physicians and medical researchers.

Over the ensuing forty years and through seven editions of their text B&C have witnessed revolutionary changes in the way medicine is practiced and in the way it is regarded by the larger society. Beauchamp, as I have already mentioned, argues that, in the *current* social milieu, the proper model of the physician’s moral responsibility should be understood less in terms of the *ideals* of medical benefits and more in terms of the *rights* of patients. He continues to argue that an important part of morality—*respect for autonomy*—has traditionally been neglected.

I am incredulous of this defensive claim and I counter-argue that the mistaken notion of respect for autonomy has already been given far more attention than it is due. It is past time that we move beyond this fruitless and recurring debate regarding autonomy. Pellegrino argued that autonomy must be more closely linked to beneficence and justice. In addition, Pellegrino proposed grounding principles in the phenomenon of the doctor-patient relationship though he did not work out a mode

other than to suggest that beneficence be the trump principle. He argued for the primacy of beneficence since it has ‘traditionally’ been closest to the ‘phenomenon’ of the relationship. Elsewhere, with David Thomasma, Pellegrino argued for beneficence to be the main moral principle. In their book, *For The Patient’s Good: The Restoration Of Beneficence In Healthcare*, “beneficence remains the central moral principle of the ethics of medicine” (Oxford, 1998, pp. 7-8).

Some aspects of Pellegrino’s arguments are persuasive and I am in full agreement with his suggestion that we should ground our principles in the phenomenon of the doctor-patient relationship. Nonetheless, I have repeatedly stated that the therapeutic relationship is grounded in the principle of respect for persons. Autonomy – and for that matter beneficence and justice – each has a proper meaning for medicine only when understood derivatively, as secondary principles, grounded in respect for persons. This underlying grounding principle of respect for persons not only provides rational, defensible ethical support and normativity to mid-level moral principles, but also gives resonance to the moral intuitions, feelings, and emotions of both patients and physicians who are the living participants in the existential reality of the medical drama.

Otherwise, these hollow *prima facie* principles are subject to the countless revisions in their interpretation, interrelation and application that has plagued their usefulness in particular case situations since introduced in 1979. Furthermore, the conflicting and over-lapping ground each maps is irresolvable without a unifying conceptual principle that respect for persons provides. Without a proper philosophical foundation, these relics of the fledgling era of medical ethics are subject to, and become products of, the cultural and social vicissitudes within which they must be operant.

This “principle” of respect for autonomy demands the provision of the information necessary for patients to make informed decisions and then authorize informed consent. It also pre-supposes, however, that autonomous persons, upon finding themselves as patients and suffering from various maladies requiring medical evaluation, diagnosis and treatment, are prepared to hear, absorb and understand complex medical terminology and human physiology, in order to make informed choices.

In actual practice, however, “it ain’t that simple.” The limitations of time constraints, physician inabilities to accurately project risks and benefits of treatment options, and the challenges to laypersons as patients to maintain functional autonomy in the face of serious illness along with the myriad other complicating variables make achieving these results virtually impossible.

With today’s modern developments in diagnosis and treatment, patients comprehending the sophisticated technological and biological aspects of their disease and proposed treatment options pose a test for rocket scientists. This complexity makes it highly unlikely that “informed consent,” as idealized and envisioned in the early bioethical writing, is actually ever achieved, or even achievable. Respected bio-philosophers, such as Onora O’Neill, have expressed the “truth” that, at most, informed consent plays out as a right of “informed refusal.”

My point is not that it is wrong to educate and inform patients to the limits of their constraints, but that, in actual practice, many fewer patients are able to act from their functional autonomy in medical decision-making than the bioethical literature contends. Furthermore, many more patients have no desire (or will) to make these difficult and stressful decisions than is assumed in the bioethical literature. Patients will almost always fail at the task of individually achieving adequate functional autonomy, for gaps in patients’ knowledge are too great to overcome.

The relationship between physicians and patients is optimally therapeutic only if physician participation in shared decision-making and medical advocacy for the patient can be counted on and taken for granted. This depends, first and foremost, upon overcoming the tendencies of patients to view physicians with suspicion and to view the potential relationship with doctors as contractual and somewhat adversarial. This is not a matter of trust, but of trustworthiness.

The initial encounter that a doctor has with a prospective patient is critical in setting the proper tone and developing the proper atmosphere for a relationship of trust. If this can be initiated, there is hope for subsequent therapeutic meetings to build upon that initial trust and ultimately develop a covenantal relationship of mutual caring and trust. Efforts to make patients into fully autonomous

choosers fails to take serious account of patients' "constraints," which are both psychological and physical. The goal should be for doctors and patients to reassure each other – and themselves – that they are interacting as doctor and patient in a mutually committed relationship of caring.

Beauchamp and Childresses' version of respect, as honoring a legalistic understanding of autonomy, has primarily shaped clinical bioethics, despite its lack of supportive evidence for their contentions. In fact, it is sad and lamentable to acknowledge that much of contemporary clinical bioethics is not sufficiently philosophically grounded and, for decades, has not received the serious attention of the broader philosophical academic community, including moral philosophers with their roots in the traditional philosophical enterprise.

Little evidence of the older Kantian tradition or of respect for persons as partially developed by Ramsey and Belmont can be found in contemporary conversations and would probably have disappeared from the landscape of medical ethics altogether were it not for the yeoman's work of Onora O'Neill. B&C "trade" on the resonance that their misappropriated and ill-conceived "re-definitions" of moral principles might reasonably comport with the robust and pedigreed history of Kant and Mill. Meanwhile their current disrespect for the notion of respect for persons has been watered down to personal autonomy and (mis)-informed consent. O'Neill has argued against the view that informed consent is justified in terms of respect for personal autonomy. She is suspicious of contemporary conceptions of autonomy and respect for autonomy, which she finds variable, vague, and "difficult to tailor to acceptable requirements of informed consent that matches them." O'Neill argues that rules and practices, or rituals, of informed consent are best understood as ways to prevent deception and coercion; the process of informed consent "provides reasonable assurance that a patient (research subject, tissue donor) has not been deceived or coerced" (*Some Limits Of Informed Consent*, *J of Med Ethics*, 29 (2003), pp. 4-7). I question whether we can rest easy that it even serves to protect against these breaches of the moral imperative.

When autonomy is defined and understood in terms of negative autonomy (or non-interference), it is arguable that the general ethical right of liberty (as richly nuanced in the writing of John Stuart Mill) is at least defensible in social and political philosophy, insofar as there is a real value in making one's own life decisions, even when one chooses poorly. In medicine, however, this understanding of autonomy breaks down, due to the many real and perceived constraints upon one's ability to make good decisions (with potentially life-threatening consequences) in a vacuum of non-interference. In other life endeavors, we at least have the opportunity to learn from our mistakes and bad choices. In medicine, however, we may die unnecessarily due to similarly misguided, but 'self-determined' choices. Can we honestly interpret the value of "living one's own life" as equivalent in these disparate circumstances? I do not see how.

Coming to this realization, for me, is the basis for arguing in favor of an ethics of respect for persons that is particular to medicine in the way it conceives autonomy, with recognition that the particular duties and obligations incumbent upon doctors and researchers far exceed a principle like 'respect for autonomy.' A robust conception of 'respect for persons' (whether patients are functionally autonomous or not) befits the interests and needs of all patients and reorients the guidance medical ethics provides physicians toward treating all patients as persons. A covenantal relationship based upon trust is a caring relationship that is more demanding and has substantially greater expectations placed upon the physician than any description or iteration of the contractual models of doctor-patient relationships. Such a basis for the patient-centered delivery of care, within a covenant of trust, is needed to right this ship.

This dissertation seeks to bring about the return of medicine to an understanding and justification of the notion of respect that birthed the discipline of medical ethics. The goal is to simultaneously promote autonomy and to provide protection of the vulnerable. A bioethics loosely committed to a procedural methodology of attempts at balancing and specifying competing *prima facie* 'principles' lacks the tools and is unable to even identify, much less teach, the skills needed to

engage in authentic, substantive moral conversation between individuals with diverse backgrounds and perspectives; yet respect remains as an ironic presence. For insofar as it rhetorically invokes the traditions of ethics and insofar as it taps into common moral sense, its presence offers an internal critique.

The Criticism of Principlism by Clouser and Gert

Clouser and Gert provide one of the strongest criticisms of principles and principle based ethical theories. They lament a lack of any theoretical basis which principlism (the four principle approach of B&C) somewhat misleadingly tends to suggest. The utilitarian principle of John Stuart Mill and the principle of justice of John Rawls are not summaries of comprehensive and unified theories underneath them. Rather, Clouser asserts that each principle functions more as a reminder that there is an ethical value the agent ought to consider.

The principles do not tell the agent how to think. Receiving no guideline the agent then determines, interprets and gives his own weight to each principle. Clouser asks where the principles come from, whether there is a priority and to what does one appeal when they conflict. He concludes that, “It looks as if each principle simply focuses on the key aspect of some leading theory of ethics: justice from Rawls, consequence from Mill, autonomy from Kant, and nonmaleficence from Gert” (Common Morality As An Alternative To Principlism,” in *Kenn. Inst. of Ethics J.*, vol. 5, no.3, pp. 223-225).

Thus they represent some historically important emphases, but without the underlying theories—and worse, without an adequate unifying theory to co-ordinate and integrate these separate, albeit essential, features of morality. If we still feel the need to couch our self-legislating capacity as extending all the way up, we misunderstand Kant in the way of first time readers of the *Groundwork*, who smugly interpret the takeaway message as each person self-legislating the moral law for herself. So long as we can ‘convince’ ourselves that we are fine with the maxim of our actions becoming

universal law, then all manner of atrocities can be justified until might equals right. Kant is so butchered by readers of only his *Groundwork* that there is no wonder that the best ‘respect for persons’ can hope for is to be kept, along with the other ‘failed’ ethical theories (utility, virtue, justice and the rest), and be allowed to remain a part of the process of reflective equilibrium in Bioethics 101: what a travesty.

Clouser continues,

They parade before the reader a variety of theories of ethics—Kantianism, deontology, utilitarianism, other forms of consequentialism, and the like— and say, in effect, choose whichever of the competing theories, maxims, principles, or rules suits you for any particular case. Just take your choice! They each have flaws—which are always pointed out—but on balance, the authors seem to be saying, they are probably all equally good!... But when dealing with an actual problem one would find oneself confused” (ibid).

Clouser makes a valid criticism of principlist theories in general. In fact, I have already taken issue with the four-principle approach of Beauchamp and Childress and find Rawls ‘Theory of Justice’ similarly problematic, in that both make attempts at unification of principles through a method of wide reflective equilibrium, grounded in a theory of coherence.

A Kantian theory of respect for persons is attractive because it is indeed grounded and unified by a single, central attitude of respect toward persons backed up by a defensible claim that locates unconditional worth in the universal conception of humanity and in the particular expression of that concept in each individual human person. I would argue that respect for persons and its entailments actually do tell us how to think about ourselves, about other persons and about the place of humanity in the world. It informs us of the value of each individual person by virtue of the capacity of human nature to think rationally and to deliberate and ultimately to attribute value to one’s self, to other persons and to an otherwise value agnostic universe. In so doing, it gives us guidelines as moral agents, to interpret our duties and obligations in terms of how well they fulfill the universal commitment to respect the unconditional value of human rational nature.

It not only appeals to reason, but also is sensitively reliant upon moral feelings, emotional intelligence and the power of human intuition. If one allows that the principle of respect is

foundational and that all operant mid-level principles and virtues are derived from it, then we can conceive of respect for persons as grounding a comprehensive moral theory. It is not only comprehensive in its completeness, but in its openness to the contributions from virtue-ethics, ethics of care, feminism and even consequentialism. If purged of the maximizing principle at the core of utility, consequentialism has an important role to play in the overall evaluation and assessment of respect for the autonomous goals of patients that are in general linked to good outcomes.

Contemporary Medical Ethics: A Crisis In Coherent Ethical Thinking

Medical ethics has been steadily being nudged toward being a methodology for practical decision-making without a proper theory of ethical practice. Beauchamp and Childress, through each successive edition of their text, have more forcefully and explicitly rejected moral theory and metaethics in favor of a loosely held conception of common morality. Many current commentators refer to the four-principle approach to medical ethics of Beauchamp and Childress as an anti-theory.

For too long medical ethics has been drifting toward instrumentalism, to practical decisions without a proper theory of praxis, toward the resolution of conflicts and dilemmas without a proper theory of resolution (other than consensus itself). In this process, the articulation of our ethical convictions in medical ethical discourse has been subtly shifting toward cultural, ethical, and historical relativism. This steady erosion of any recognizable unified basis in moral theory can only end in the very destruction of medical ethics as a recognizable discipline.

This disconnect is disturbing to me, for it suggests one of two failings. Either the ethics of medicine and its grounding have gone unheeded by the physician world, which finds the current articulation of the ethics of medicine (conveniently) abstract, inapplicable, and thus irrelevant to what they are doing in the “real world,” or, that the currently accepted articulation has failed to capture their full attention because it is internally incoherent. Either or both could be correct, but the continued

heated debating between and among bioethicists seems to be only secondarily concerned about the impact their thinking and writing has on the behavior and practice of clinicians.

The ethically incoherent principle of respect for autonomy introduced by Beauchamp and Childress is the likely culprit for the misrecognition of the entailments of respect for persons that physicians owe to patients. The incoherence of respect for a principle, rather than for a person, begins in the misperception that “respect for autonomy” is a principle in the first place. At the very least, B&C should include the person who bears this highly respected autonomy within their principle. *Respect for autonomous persons*, however, clearly raises the issue that these authors have tried to avoid – the question of what about non-autonomous persons. The lack of respect for the non-autonomous by B&C arises from the individualistic conception they hold of autonomy. These authors fail to adequately articulate (or even recognize) the relational characteristics of autonomy espoused in the care-based model for interaction between doctor and patient. They have failed to respond to the understanding of communication and collaboration as critical for health delivery to be caring as emphasized by the proponents of an ethic of care.

For these reasons, it may be better argued that the respect for autonomy of B&C is actually about *respect for autonomous choice*. It has been the position of those who understand autonomy as non-interference that the fact that a choice or demand is freely made is reason to give special or added normative weight to that choice or demand. It is the principle of respect for autonomous choice as an action that I believe Tom Beauchamp intended when he articulated the principle of respect for autonomy in his essay, “Who Deserves Autonomy, And Whose Autonomy Deserves Respect?”

He wrote, “My analysis of autonomy is not focused on traits of the person, but on actions. My interest is on choice rather than general capacities for governance” (*Personal Autonomy*, ed. James Stacy Taylor, Cambridge, 2005, p. 311). Inconsistently, however, he continues on the same page:

To maintain coherence with fundamental principles of morality a theory of autonomy should be kept consistent with the substantive assumptions about autonomy implicit in the principle of respect for autonomy. To respect an autonomous *agent* is to recognize with due appreciation that *person's capacities and perspective*, including the right to control his or her affairs, to

make certain choices, and to take certain actions based on personal values and beliefs. Such agents are entitled to determine their own destiny, and respect requires non-interference with their actions. Respect involves acknowledging decision-making rights and enabling persons to act. This does not entail that, from the moral point of view, we are to respect only the morally good intentions and actions of agents. Many acts of individual autonomy are morally neutral, yet are also owed respect (ibid, p. 311-312).

There is a troubling lack of clarity here that is difficult to tease out, but which seems to covertly disguise the incoherence he claims to be avoiding. Whereas his initial assertion claims to be concerned with *respect for autonomous choice* and is explicitly not focused upon traits of the person or capacities for self-governance, he quickly shifts, on the very same page, to discuss what it is to *respect an autonomous agent* with reference to that person's capacities and perspective.

The confusion and incoherence of his argument lies in his identification of two independent objects of respect (autonomous actions and autonomous agents). He claims to be both disinterested in (not focused upon) traits and capacities of the person and at the same time concerned with how to show respect for the person as autonomous agent (by recognizing with due appreciation that person's capacities and perspective). This lack of consistency leaves us wondering whether he is concerned about the personal autonomy of the agent or not.

Beauchamp attempts to be consistent with his substantive assumptions implicit in the principle of respect for autonomy yet he argues that autonomy is deserving of respect regardless of whether the intentions and actions involve morality or not. It would thus seem that for him, respect for autonomy is not about respecting autonomous choices, but is rather about honoring the choices of another, simply because they are another's. He fails to address the possibility that this notion of respect for autonomy may even require us to 'respect' the immoral actions of others. All that said, his final sentence of this essay leaves it utterly unclear what he actually means his principle of respect for autonomy to encompass: "The moral value of respect for autonomy precedes and is not the product of theory, and no theory is acceptable if it conflicts with this value" (ibid, p.327).

What is clear from the above quotations is that for Beauchamp, respect for autonomous choice is essentially about non-interference and that his theory falls into the category of an “individual autonomy theory.” Respect for autonomy, as utilized by Beauchamp and Childress, implies that autonomy is respect-worthy because it ensures non-interference with the choices of others and therefore is only instrumentally worthy of respect: we should respect people's decisions not because they are good choices, but because doing so will have the beneficial consequence of contributing to the person's freedom (or liberty). In this view, respect for the choice of others does not depend on it being the best or the right choice in the eyes of the physician to be honored. The doctor may view it as a terrible choice, but it is to be respected and honored just because it is the patient's own choice, so long as it does not bring harm to others. This idea of respect for autonomy is much closer to Mill's notion of liberty in *On Liberty* (though it does not do justice to that notion either). These features of respect for autonomy distinguish it substantially from the intrinsic value of Kant's respect for persons as ends in themselves.

James Wilson, in his essay “Is Respect for Autonomy Defensible?” argues that this conception of respect for autonomy leads to a different understanding of the meaning and value of informed consent. For Beauchamp and Childress the justification of informed consent “is not that the decisions that people make as a result of informed consent procedures will be autonomous in such a way as to render these decisions intrinsically worthy of respect, but rather that it would be wrong and counterproductive in nature to attempt to enforce a particular conception of the good, and the best way to avoid doing so is to allow each person the privacy to make decisions in line with their own values.” Wilson concludes that, “we (would) do better to rethink autonomy and informed consent in terms of respecting persons as ends in themselves, and (adopt) a characteristically liberal commitment to allowing individuals to make certain categories of decisions for themselves” (*J Med Ethics*. 2007 Jun; 33(6): 353–356).

The expectation of patients' decision-making acumen by contemporary bioethical theory is unrealistic and fails to address patient dependency. Autonomy is a concept that is actually rich enough to generate competing conceptions and, out of the theoretical resources provided by collaborative efforts, could be understood to revolve around the patient as not merely a choosing or autonomous individual self, but as also a person contextually situated in relations of inter-dependence.

The inappropriate imposition of individualistic patient autonomy represents the antithesis of caring. Childress is explicit: "However general our moral principles – for example, *respect for personal autonomy* or justice – we interpret them in part by formulating them more specifically or by delineating the types of cases that we believe fall under them" (Methods In Bioethics, ed. Steinbach, B., The Oxford Handbook Of Bioethics, Oxford 2007).

The notion of respect for personal autonomy further compounds the incoherence of this proposed moral principle. Contemporary personal autonomy theories are explicit in refraining from making moral or normative claims with regard to personal autonomy. Their concerns are rather with individual self-actualization or personal authenticity. They generally maintain strict criteria for the attainment of autonomy that are self-centered rather than concerned with relationships or interactions with others.

Respect for persons asserts that a caring relationship, which balances respect for patient values and beneficent guidance based on practitioner's clinical expertise, protects the moral integrity of both patient and practitioner. The model of the physician-patient covenant that I espouse views the patient as a socially relational self rather than merely as a choosing self. The relational and contextual situation of the patient is brought into the relationship, allowing for autonomy to be not only a principle of choice, but also one of caring concern and of interpersonal duties of respect and care between the doctor and patient. The goal is not one of individualistic decision-making, but one of inter-subjective collaboration. This removes the additional stress placed upon the patient by the expectation that he understand his medical problem sufficiently to know what is best for him and

which option he wants for himself. Instead it allows for the physician expert to facilitate and guide the reflective process of deliberation with the goal of achieving the patient's genuine understanding of what he wants for himself and why.

The conception of autonomy and the functioning of informed consent in mainstream bioethics must be overhauled. Bioethics must be able to make substantive moral claims and become a moral theory rather than a procedural methodology. Contemporary bioethics needs to question its own assumptions and current place in the tradition and practice of medicine and recognize that the only way it can do this is by grounding itself differently. Medical ethicists need to recognize and take into account certain moral commitments that can and should be rightfully understood as paramount to medicine, particularly respect for persons. Moral medicine must hold these moral precepts as co-existent with, but independent of, juridical and political precepts and rather as subsumed under the grounding principle of caring respect (and the attendant duties to suffering humanity). At the same time, moral medicine must be committed to the virtues and duties (such as benevolence, agape and caringness) which are capable of strengthening the moral resolve and character of care-givers who are charged with living up to the heady moral and inter-personal goals of medicine.

By grounding medical ethics in caring respect ethicists can do justice to the ethical concerns and commitments that led to its creation in the first place. This alternative framework I am proposing actually allows medical ethicists to make substantive moral judgments and to engage in robust ethical debate without giving up a commitment to autonomy, understood as a moral and relational concept with entailments that are all directed toward the proper fulfillment of respect for persons. This view of autonomy will better allow medicine, as a tradition, and physicians and other care-givers, as practitioners, to achieve the goals of protecting the vulnerable and allowing individuals to make choices that are authentically their own, within a caring and nurturing relational context. Finally it will provide bioethicists with the basis upon which to offer the ethical guidance that justifies their claim to have an important and unique kind of expertise and contribution to make within the tradition of

medicine. It is for these reasons among others that rethinking the concept of ‘respect for autonomy’ is so critically needed.

The model for the patient-doctor relation that I propose can functionally be understood as built upon ‘caring’ respect and dependent upon a caring and trustworthy physician. I envision the practical application of this covenantal patient-physician model as a strategy to correct for all of these negative tendencies in medical practice simultaneously. Moral respect in medicine both subsumes and entails the moral duties to equally respect the freedom and well-being of all human beings in their dual capacity as persons and patients. Universal morality would always take precedence over the ethical duties that I occasionally refer to as particular to medicine (were they ever to come into conflict) for the simple reason that universal morality is also foundational and based on the same moral disposition of respect for persons as.

In general, respect is an attitude one adopts towards someone or something, which is characterized by the judgment that the respected thing or person places legitimate limits on what one may do with it or to it. Something that is worthy of respect can be either intrinsically or extrinsically worthy of respect. When something is extrinsically worthy of respect, it is worthy of respect instrumentally. In this case, the object is respected as a means to another end that may itself be considered intrinsically worthy of respect. Some philosophers think this is the view Mill held of autonomy, as a means to enhancing a person’s intrinsically valuable well-being or happiness and thus, as a means toward achieving happiness, autonomy is extrinsically or instrumentally valuable.

Something that is intrinsically worthy of respect, on the other hand, is worthy of respect just by virtue of what it is. Kant thinks persons are worthy of respect by virtue of their humanity. He sometimes substitutes the phrase “rational human nature” for the term “humanity” in order to pinpoint what it is about human beings that is intrinsically respect-worthy. Conversely, the claim that any and all choices that individuals make are intrinsically worthy of respect is implausible. Some choices are “self-centered, pig-headed, impulsive, random, ignorant, out of control and regrettable or unacceptable

for these and many other reasons” (O’Neill O. *Autonomy and trust in bioethics* Cambridge, 2002 p 28). So it is clear that we cannot let just any old choice count as autonomous if we are going to claim that all autonomous choices are intrinsically worthy of respect.

For an account of autonomy to be intrinsically respect-worthy, it would have to be sufficiently demanding that actions which meet it are worthy of respect for their own sake. Unfortunately, this account will be too demanding to allow the vast majority of the choices that patients make about their healthcare in a hospital setting to count as autonomous. However, if the account is sufficiently lax as to allow the ordinary choices of patients in a hospital setting to meet it, then we will no longer have reason to think of such choices as worthy of respect in their own right. Most medical decisions that patients make fall within the liberal principle of allowing each person to pursue his own conception of the good. This places no requirements upon the patient or the decision to be rational, or rationally justified, or justifiable. Even decisions made by patients that a physician does not agree with or respect (or may openly disagree with) are expected to be honored, so long as they do not cause harm to others. This expectation is not grounded then, in respect for the autonomous nature of the decision or for the autonomy of the patient, but out of respect for the patient as a person and is in accord with Kant’s formula of humanity, which is grounded in the perception that human beings are intrinsically valuable and hence respect-worthy.

When Beauchamp and Childress (defenders of the intrinsic respect-worthiness of autonomous choice in medicine) talk in terms of why autonomous choices should be respected, they give a fairly demanding account of autonomy (referring to authenticity, second-order desires, self-mastery, and so on). But when they come to apply their principle of respect for autonomy in practice, they tend to be much more permissive and assume that respect for autonomy is appropriately operationalized through the seeking of informed consent. However, as O’Neill argues, it is highly implausible to think that informed consent requirements could provide the appropriate response to the intrinsic respect-

worthiness of autonomous choices (ibid). Informed consent does nothing to ensure that autonomous choices are respected or respect-worthy in a way that non-autonomous choices are not.

This whole line of argumentation indicates that it is fruitless and indefensible to argue that autonomy as decisional non-interference is intrinsically respect-worthy or that honoring patients' autonomy through seeking their informed consent is anything more than extrinsically and contingently respect-worthy. The justification is not that the decisions that people make as a result of informed consent procedures will be autonomous in such a way as to render these decisions intrinsically (morally) worthy of respect, but rather that it would be (morally) wrong and counterproductive in nature to attempt to enforce a particular conception of the good. The best way to avoid doing so is to allow each person the privacy to make decisions in line with his own values. This is respect for the patient as a person, not respect for the patient's autonomy.

That being the case, it is respect for persons that qualifies as a moral principle in medicine, not respect for autonomy. These difficulties suggest that insofar as informed consent is justified by respect for persons and considerations of autonomy, as the Belmont report maintained, the justification should be along the lines of Kantian autonomy and not individual autonomy. This misrepresentation of the object of respect by B&C devalues the respect owed to patients as persons and has created the contemporary crisis in coherent ethical thinking in medicine, both in how it is being taught to medical students and how it is exhibited in the practices of our teaching hospitals and research facilities. This misrecognition of respect for persons as respect for autonomy in bioethical thinking is exemplified in a purely technical or biomedical model of care, where the physician is seen merely as the technician who delivers interventions and performs procedures. Some refer to this as the engineering model in which the physician's abilities and skills are commodities and the person of the physician is disregarded. This model of the physician-patient relationship, along with several others, will be contrasted with the covenantal model I espouse in the next chapter.

CHAPTER 5

THE COVENANTAL PHYSICIAN-PATIENT RELATIONSHIP AND ITS CHALLENGERS

At the core of the practice of medicine lies the physician-patient relationship. Historically this has been variously interpreted, with conceptions that revolved around the Hippocratic tradition of medical paternalism. Over the past four decades, however, this understanding of the therapeutic encounter has sustained serious and relentless challenge with the emergence of bioethics and a concern for patient rights. Both of these influences fostered the primacy of autonomy and its manifestation in patient self-determination as a right. In *A Theory of Medical Ethics* (1981), Robert Veatch argued that current medical codes such as the *Hippocratic Oath* are too restrictive and lack sufficient support for comprehensive use in the medical profession. The solution, he argued, is that medicine can no longer be based on a professionally articulated code. I am in complete agreement with this viewpoint.

Medicine and the ethics of medicine have unfortunately struggled to find an adequate grounding for the numerous models of the doctor-patient relation presented in the literature over this time frame. Absent a fundamental starting point, none of the proposed ways of conceiving this relation have been able to afford physicians the kind of wide-reaching guidance required to address the patient properly in the rapidly changing medical, social and technological landscape of the contemporary era. There are many contributing causes for the difficulty of grounding this relation that will be touched upon through the course of this chapter. Of the many, in my assessment, there are two primary reasons for this difficulty. The first is that most of the models have focused on only one aspect of the physician-patient relationship: the balance between patient autonomy and physician paternalism. The second is a consequence of the first in that these models are not so much models of the physician-patient relationship as they are models of physician-patient decision-making.

In actual medical practice, however, isolated decisions are only one part of this multi-dimensional relationship and, as I have argued throughout this dissertation, are neither the central nor

the most important aspect. Moreover, contemporary bioethics continues to focus on this autonomy-paternalism balance as a consequence of the glorification of the principle of ‘respect for patient autonomy’ by the Four-Principle Approach of Beauchamp and Childress previously discussed.

The re-orientation of respect away from the deeper moral commitment of ‘respect for the whole person’ toward ‘respecting autonomy’ has resulted in a crisis of trust and the public perception of physician-patient relationship as being adversarial and counter-productive. Furthermore, in medical practice, the functionally effective autonomy of patients is often incompletely developed or operative and is challenged, thwarted and constrained by the effects of illness, suffering and the loss of self-determination that occurs (to some extent) upon entering the highly mechanized contemporary healthcare arena as a ‘patient.’

As this dissertation has already demonstrated, patient autonomy is not and cannot be the last word in contemporary medical ethics. The re-evaluation of patient autonomy, the role of rights in society, the emergence of ethicists from among the ranks of clinicians, and the ever widening dissatisfaction with the principlism of Beauchamp and Childress (the current prevailing approach to medical ethics) are some of the factors contributing to the need for an understanding of respect for persons as the grounding principle of medicine. This recognition calls for the re-characterization of the therapeutic relationship as covenantal.

This dissertation has, as one of its key objectives, the provision of a prescription for changing physicians’ understanding of this central relation in medicine. In order to succeed, physicians must take a cold, hard look at the way medicine has drifted, without deliberate intent, but also without sound guidance, toward a monetary criterion of success for family practitioners and medical specialists. This incentive has pushed physician thinking back by decades, to the self-interested days when the doctor “knew best” and called the shots with little, if any, resistance from patients. Of course not all physicians (or even most) acted paternalistically with malice aforethought. Physician ethical behavior simply, for the most part, went unexamined and despite the efforts of physician, academic and

religious ethicists and medical educators, this condition still exists today among rank and file practicing physicians and medical school faculty.

A review of the early history of American medicine is astonishingly devoid of medical ethics. Even the *Codes and Principles of Ethics of the American Medical Association*, founded in 1847, required patients to place total trust in their physician's judgment, to obey promptly, and to "entertain a just and enduring sense of value of the services rendered." Such a bold assertion of the authority of the physician and the gratitude of the patient seems unimaginable today, yet vestiges of this attitude continue to rear their heads. The failure to establish 'respect for persons' as the proper ground of medical ethics left open the option of unrestrained physician beneficence (paternalism) to rule the day.

It was not until 1980 that a major rewriting of the *American Medical Association's code of ethics* was given an entirely new reading, "a physician shall deal honestly with patients and colleagues...." The medical 'professional guild,' for the first time, explicitly endorsed honesty. The AMA's position was revised in 2001 and softened to read, "a physician shall...be honest in all professional interactions...." While the statement of principles has become more ambiguous, the more detailed opinions and annotation retained the earlier wording: holding that "a physician should at all times deal honestly and openly with patients."

Statements in medical ethics codes and charters are tainted with an arrogance of condescension and superiority. The section on the Obligations of the Public to Physicians in the 1957 iteration of the AMA code of ethics captures this arrogance:

Clearly the duties of the patient are founded on what he has received from the doctor: The members of the medical profession, upon whom is enjoined the performance of so many important and arduous duties toward the community, and who are required to make so many sacrifices of comfort, ease, and health, for the welfare of those who avail themselves of their services, certainly have a right to expect a just sense of the duties which they owe to their medical attendant.

Thus the picture presented of the physician is one of a relatively self-sufficient benefactor, who, out of the nobility and generosity of her disposition and the gratuitously accepted conscience of her profession, has taken upon herself the noble life of service.

To be sure, the positions adopted by the AMA do not always reflect the current views of the American public or even those of American physicians. They surely do not describe actual behavior in all cases. They are, however, the most important consensus statements of organized professional medicine in the United States.

It was against this backdrop that early modern era medical ethical thinkers began to consider ethical models for the central relation of doctor and patient. Paul Ramsey's position in his 1970 seminal work, *The Patient as Person*, is that the proper interaction between patient and doctor could only be achieved within a covenantal relationship. For Ramsey, this proper interaction is ultimately articulated as fidelity to fellow human beings. Though he did not cite Kant as his source, Ramsey's understanding is grounded in Kant's formula of humanity. Ramsey paraphrases Kant's second formula, "Regard for patients as persons, a particular case of regard for men as ends in themselves, is a central tenet of all ethics, not some new discovery" (1970, p.xi). Ramsey focuses on this theme, not to refine or develop an ethical theory, but to bring the regard for human beings into the world of modern medicine where it is too often "lost amid complexity." Although he is a theologian, Ramsey appeals to a secular interpretation of the covenantal relationship. He states, in fact, that his primary appeal is to the "community of moral discourse concerning the claims of persons" (1970, p. xii).

Ramsey captures an important insight. My intention is to develop an understanding of covenant as a sacred, yet secular relationship. This distinction needs to be made in view of the many persons who view their value system to be naturalist, humanist, spiritual, familial, philosophical and so forth. All of these 'world views' are value systems that one could argue are grounded in respect for persons while being independent of religious categories.

Gordon Lynch, in his recent book, *The Sacred in the Modern World* (2012), attempts to rehabilitate the 'sacred' as a viable academic concept. Lynch effectively demonstrates that the sacred is not an exclusively religious category. As Kim Knott (2013) writes, citing Viikko Anttonen:

The 'sacred' (or its equivalent in other languages) can be attributed by people in non-theological as well as theological contexts, irrespective of the nature of their belief systems: 'It

is not a uniquely religious category...’ (Anttonen 2000, ‘Sacred’. In *Guide to the Study of Religion*, ed. W. Braun and R. McCutcheon, 271–282. London: Cassell)

Knott continues, in a quote that captures the sacred notion of covenant I am proposing:

“... those forging social identities in secular contexts – who draw on non-religious commitments and beliefs including... humanism and secularism – mark as ‘sacred’ those occasions (such as marriage), persons (a lover), things (a ring)... and principles (equality and justice) that they value above all others, and that they see as set apart and inviolable: those things that may be deemed to be both secular and sacred.” (2013. *The Secular Sacred: In-between or Both/and?* In *Social Identities Between the Sacred and the Secular* ed. A. Day, G. Vincett, and C. Cotter; Ashgate).

Unfortunately, among the models for the physician-patient relationship that have been put forth in the literature of medical ethics during this era of the emergence and development of medical ethics as a discipline in its own right, the covenantal model has (for unclear reasons, but perhaps due to its religious connotations) received little attention, while the contractual model seems most favored in the current medical ethical milieu of “respect for the autonomous rights of patients.”

Robert Veatch, in reference to the covenantal model of William May, asserts that

One could object to the covenant metaphor on the grounds that it is too exclusively a religious term... Moreover, covenant is a term that can be interpreted so ethereally, almost mystically, that it is meaningless for many secular people, even those who should be open to the model for medical ethics that May has inspired us to pursue” (“Challenging the Power of Codes,” Hastings Report 1986).

Despite these objections, however, Veatch proposed what he initially described as a “covenant” theory of medical ethics that resembled the traditional social contract of philosophers such as John Locke, Thomas Hobbes, and Jean-Jacques Rousseau and was deeply influenced by John Rawls. Ultimately, he abandoned the term covenant in favor of contract. This chapter will analyze the contractual model that Veatch ultimately adopted and contrast it with the covenant model most thoroughly developed by William May and Paul Ramsey.

Paul Ramsey *In The Patient As Person* and William F May in “Code Covenant Contract Or Philanthropy” and *The Physician’s Covenant* both employ the concept of covenant as the fundamental metaphor for understanding the central medical relationship. It is simply counterproductive to characterize the relationship in ways in which the physician is viewed as a threat to the rights and interests of the patient. Many of the models (including the contractual one) focus too narrowly on

decision making, ignoring other important aspects of the relationship. There is little, if any, discussion in the previous models of such important aspects of the physician-patient relationship as trust, communication and caring respect.

The thesis I defend in this chapter is that the covenantal model of the doctor-patient relationship, when grounded in respect for persons as obligations of sacred trust, provides the most ethically compelling metaphor for properly understanding physician duties that include the physician's clear responsibility to put the patient's welfare before his or her own. Furthermore, the nature of contractual agreements is to provide a vehicle to equally satisfy the self-interests of both parties. The metaphor of contract does not account for the inherent inequalities of knowledge and power between doctor and patient and risks that the self-interests of the more powerful physician may incentivize physician behavior to the detriment of the patient. In a subsequent section of this chapter, I will build upon Paul Ramsey's discussion of this imbalance of power as he emphasizes the profound importance of informed consent for protecting the vulnerable.

The Patient-Physician Covenant and Contemporary Fee for Service Medicine

"Medicine is, at its center, a moral enterprise grounded in a covenant of trust." This is the initial claim of *The Patient-Physician Covenant*, a succinct document that was drafted over a period of five years in discussions among a group of concerned physician thinkers and commentators and reads more like a mission statement. These doctors came together out of shared concern, although from different perspectives, to confront their perceived threat to the sacred responsibility of physician to patients. It was first published in the *Journal of the AMA* in 1995:

...Today, this covenant of trust is significantly threatened. From within, there is growing legitimation of the physician's materialistic self-interest; from without, for-profit forces press the physician into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the physician's responsibility degrade the physician-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the physician's role as healer, caregiver, helper, and advocate for the sick and for the health of all (Ralph Crawshaw; David E. Rogers;

Edmund D. Pellegrino; Roger J. Bulger; George D. Lundberg; Lonnie R. Bristow; Christine K. Cassel; Jeremiah A. Barondess).

Much of the discussion among physicians about the tumultuous changes in the environment of medical practice in 1995 related to the increasing penetration of managed care. Many of the same (or similar) issues are the topic of current physician conversations in doctor's lounges and dining rooms in hospitals (private, public and university) and abound with complaints about the bureaucratic intrusions into the physician-patient relationship and the pressure on physicians—in some cases, in the form of direct financial incentives—to withhold indicated diagnostic or therapeutic measures to keep costs down.

In practice, cost-containment strategies (then and now) often ultimately degrade the patient-physician relationship. In some managed-care settings, the clinical encounter is deliberately "managed" such that physician's interests are at odds with the patient's interests. Central to this notion is the destruction of the traditional patient-physician relationship in which the interests of the patients come first. For example, in some managed-care organizations, physicians are required to sign a loyalty oath and gag order. The loyalty is to the managed-care organization, and the gag order is for patients. These orders prohibit or limit clinically meaningful discussion with patients. When these rules are coupled with payment schemes that reimburse physicians to limit care, they dramatically undermine the trust between the patient and the physician.

It is arguable that managed-care organizations should not be blamed for these cost-containment measures. The directors of a for-profit corporation have a fiduciary duty to put the interests of shareholders over their own interests and the interests of their employees. The fiduciary relationship, director and shareholder or between a trustee and a beneficiary, is held to extremely high ethical standards. For these reasons I do not mean to imply that the problems of trust in contemporary medicine can be laid at the feet of managed care providers, insurance companies and hospital administrators. To make such arguments is naïve and overly-simplistic.

Physicians, however, should be faulted for submitting to external pressures and for betraying the trust granted to them by their patients. The relationship between the patient and the physician is based on the expectation that the physician will put the needs of the patient first – over and beyond the interests of the physician or any third party. This relationship is the foundation upon which the practice of medicine is built.

Patients, the medical profession, and society all suffer when the interests of a third party become the first priority of physicians. The third party can be the physician's employer (including Schools of Medicine) or the government. For example, physicians in the United States have done harmful experiments with radiation and toxic chemicals on unsuspecting persons for the benefit of the government. These cursory observations and tentative conclusions about the present lead us to the stark awareness that this observation from 1995 still rings eerily familiar today:

The Covenant does not oppose managed care. Physicians do share with the rest of society the challenging responsibility to make health care affordable for all. Current trends are toward increasing numbers of uninsured persons, decreasing eligibility for Medicaid, and increasing beneficiary costs for Medicare. All of these lead to decreasing rather than increasing access to health care. More responsible cost containment could lead to broader access, and managed care, if done openly and with maximal concern for patient welfare and actually improve collaboration among specialists and primary care physicians, leading to rational clinical decisions based on cost-effectiveness. Managed care is not the problem; profit is the problem (Cassel, CK, Editorial, NEJM 1996).

J.E. Bailey's analysis, "Asklepios: Ancient Hero of Medical Caring," identified the core value that the Covenant affirms: "the fiduciary (founded in trust) responsibility of the physician to the patient." Bailey also drew attention to the fact that in ancient times (3000 years ago) the same threat to medicine existed that confronted medicine in 1996 (and continues to threaten medicine today): "pecuniary inducements to put self-interest before the values of the profession" (Ann Intern Med. 1996; 124:257-63). "The Patient-Physician Covenant" continues:

...By its traditions and very nature, medicine is a special kind of human activity--one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark physicians as members of a moral community dedicated to something other than its own self-interest.

Physicians have not always upheld their responsibility to put the needs of the patient first. The well-being of patients and the profession of medicine have suffered when physicians have put their own interests or the interests of a third party before the interests of their patients. Greed, prestige, and power have all succeeded at some time in displacing patients as the top priority of physicians. These lessons from history are all too relevant today.

When the pursuit of wealth or money becomes the first priority of physicians in a fee-for-service environment, patients may be subjected to unnecessary diagnostic tests or therapeutic interventions. In a capitated payment environment, concern about the protection of the physician's own livelihood can lead to withholding clinically needed care.

None of these latter characteristics cited in Bailey's analysis are inherent or even visible in the modern corporate structure of health care. The motive of caring respect for patients as persons disappears when health plans consider themselves to be driven by "market forces." The market has no explicit or corporate responsibility to provide healthcare for someone who is sick but cannot afford to pay. The corporate business model in health care behaves such that growing numbers of uninsured and underinsured people will have nowhere to go once market forces are allowed to completely take over.

To make matters worse, The Affordable Care Act, intended to provide healthcare coverage to the 50 million uninsured Americans, appears to have backfired. The initial thinking of those who conceived it was that the competing third party payers (insurance companies) would bear the brunt of the un-reimbursable medical expenses and attempts to recoup these costs by raising their rates would price themselves out of the marketplace. These companies, however, have responded by devising low-cost plans (such as any of the "bronze" plans on the "exchange") that can keep their premiums low by cost-shifting the added expenses to the patients in the form of astronomical co-payments and huge front end fees for expensive medical procedures and surgeries.

It is the case, in many major healthcare markets, that patients are required to pay 3 to 5 thousand dollars up front for expensive "elective" procedures such as back surgery, hip and knee

replacement and even arthroscopy, endoscopy and colonoscopy procedures. This fee has drastically reduced the number of such procedures being performed and has caused a logistical nightmare for hospitals in discerning which patients truly cannot afford these added expenses and which patients just refuse to pay them, despite having adequate means.

Meanwhile, physicians are being re-incentivized from fee for service and relative value units (RVU's) to a new model called "fee for outcome." This model reimburses on the basis of a patient's recovery and return to a normal productive life which on first blush, is consequentialist in theory and is not sufficiently grounded in respect for patients as persons. It is possible, however, to understand the incentive to be based in Kantian consequentialism as a way of dis-incentivizing interventions such as hip replacements in octogenarians with terminal cancer or Alzheimers. These procedures are generally incentivized by secondary gain and not out of respect for these patients who often die within a few weeks of such interventions. In fact, such operations are disrespectful in that they are focused upon the hip, rather than upon the good of the patient, and are using this person as a means to the physician's own end (namely financial reimbursement).

Sadly, however, this has been observed instead to inadvertently incentivize physicians (within the arms-length, contractual model of doctor-patient relations) to seek out the younger, healthier patients upon whom to operate. While this might seem like a better use of available resources, it now accounts for the increasing number of such interventions that are unnecessary and/or manageable by less invasive and costly modalities. Physical therapy, life-style modification and regular exercise may be sufficient to return a large number of these current "candidates" for expensive interventions to normal activity and productivity. Physicians who place self-interest ahead of respect for persons and who have no awareness, much less commitment, to "The Patient-Physician Covenant" are increasingly incentivized by the positive influence performing procedures on the "healthy" has upon their percentage of successful outcomes (and thus their income).

These are but a few examples of the widespread changes in healthcare delivery and reimbursement that are already having a profound influence upon physician practice patterns. Market forces will continue to have the upper hand until a better, more just and humane system for the allocation of healthcare resources is developed. In the meantime, it is more crucial than ever that a caring, covenantal conception for the doctor-patient relationship is adopted and medical trainees educated in this manner of perceiving and caring for their patients.

The Sacred Trust Of The Covenantal Relationship And The Destructive Force Of Greed

What, then, is the responsibility of medicine and of the physician? This is the moral question that faces us so starkly. Modern physicians battle the conflict between the sacred trust of the covenantal patient-physician relationship and the destructive force of greed. Many young persons are attracted to medicine because it promises meaning and a moral significance to the activities of healing and caring that goes beyond the need to make a living. “This is more than a job,” physicians still commonly say and believe. It is a way of helping people and contributing to the improvement of the human condition.

Families or patients who have had a good doctor will affirm the human significance of that relationship, especially if they have faced serious illnesses. The physician's role in the lives of patients, at its best, can and ultimately does have spiritual dimensions. The trust of the patient and the public may be irreparably damaged if personal gain and corporate profit become primary concerns. The care-based, patient-centered, covenantal model (as I develop it in this chapter and contrast it with the most contemporarily favored contractual model articulated by Robert Veatch and others) marks a significant improvement over the previously offered doctor-patient models.

Veatch attempted to secularize the language of covenant by employing the language of contract and claimed the near identity of these concepts, but his assertion is unconvincing. There is much of the physician-patient relationship that is either inadequately or inaccurately incorporated under Veatch's

model for the relation of doctor and patient as contractual partners. The improvement offered by a Ramseyan understanding of covenant begins in its commitment to fidelity to one's patients. Covenant can achieve the goal of a conceptual understanding of this relationship as one of sacred trust and one that optimally recognizes the fiduciary duty of physicians. Pragmatically, it is a model that can only be fulfilled through a caring, covenantal commitment that is concrete, is robust and is owed to each and every patient out of respect. Another significant advantage of grounding the covenantal relationship in caring respect is that it begins with a more basic and fundamental characterization of physician commitment than the starting points of the other models.

In *The Patient As Person* (1970), the notion of "consent" is the fundamental form or expression of covenant faithfulness in the doctor-patient relationship according to Ramsey. He views consent as the primary requirement of loyalty to the covenantal relation, both between physician and patient and between researcher and subject. In his view, it is a demand of justice and a minimum requirement for protecting the sacredness of persons, especially the weak and the disadvantaged, providing evidence of his unwavering commitment to the protection of persons as the core of his ethics (1970, p.5).

Consent is necessary in both of these contexts because of the tendency of human beings, according to Ramsey, to "overreach one side of the equation and to dominate, manipulate, or even subordinate the other for the sake of good consequences" (1970, p.6). In a contractual model based on self-interest, these "good consequences" may not even be beneficently (or paternalistically) to the benefit of the patient, but rather serve the self-interests of the physician. Such behavior is a clear violation of Kant's formula of humanity.

Ramsey's understanding of consent is not a single action on the part of the patient after being informed, but rather is ongoing and must be continuously repeated. He argues that consent is a deontological claim and is one without exception in ordinary medical practice, except in emergency situations. Ramsey held that, other than perhaps in extreme situations, the future will not reveal any morally significant exception, but will actually further elucidate what this canon of loyalty means and

what it entails in new situations (1970, p.9). One of the primary reasons Ramsey held the consent requirement without exception is in order to protect the more vulnerable party of the relationship (namely the patient or research participant). Consent, alone, is insufficient to safeguard the vulnerable or to ensure respect for their autonomy. It is for this reason that I have adopted the broader requirements entailed by respect for persons and held by Ramsey to be of utmost importance in establishing the covenantal physician-patient relationship.

Can Physician Self-Reflection Be Guided by Covenantal Thinking?

It is often held that medicine and physicians are self-policing and do not need external oversight. Whether this assertion is defensible or not, I suggest that each physician examine his actions by addressing three questions.

Are you a caregiver or a gatekeeper? The caregiver provides care and concern to a person in need, healing if possible, helping always. To sick persons, the caregiver is a guide through some of life's most difficult journeys. In contrast, the gatekeeper minds the gate, letting some persons through and keeping others out. The function of the gate is to restrict access. The gatekeeper serves the interests of the owner of the gate, not of the people trying to get through the gate. Physicians are just beginning to realize that the gatekeeper serves entirely at the whim of the owner of the gate.

As a physician, which principle governs your relationship with your patients: morality or the market-place? The term "morality" refers to the basic human concept of right and wrong. For physicians, morality means doing what is right for their patients and speaking or acting out against what is wrong. No such moral absolute can be found in the market-place. The market is driven by revenue, profit margins, and market share. No patients exist in a market-driven practice of medicine – only consumers for whom the watchword is *caveat emptor*.

A great danger to the practice of medicine is the transformation of physicians to interchangeable, dispensable workers accountable only to their employers, each other and the financial

performance of the institution that employs them. In this setting, physicians and health care are simply commodities – sold and without compassion. The greatest danger, however, is not loss of the physician's autonomy, degradation of the profession of medicine, or transformation of health care to a commodity. The greatest danger is the transformation of the patient to the status of commodity. Raw capitalism (market-forces), as Marx has pointed out, has the potential for such commodification of human beings.

Finally, doctors, what is the relationship between you and your patient? Is it a covenant or a contract? The group of clinical ethicists that drafted “The Patient-Physician Covenant” defined the practice of medicine as "a moral enterprise grounded in a covenant of trust." Webster's Ninth New Collegiate Dictionary defines covenant as a "formal, solemn, and binding agreement." For a more complete understanding of the term "covenant," we must return to our professional ancestors in ancient Greece. During the time of Hippocrates, the Greek term for covenant (*diatheke*) was not used to describe a usual agreement or contract between two parties. The term *diatheke* was used almost exclusively to signify a very special relationship – a will and testament.

A last will and testament involves parties who have a special and close relationship with each other; a contract involves strangers. A last will and testament is based on trust; a contract is based on mistrust. A last will and testament is a relationship between two unequal parties in which one party is concerned about the welfare of the other. A contract is between two equal parties, each concerned only with his own welfare. In its essence, a will and testament is a beneficent promise, a trust offered by one party to another. For physicians, this promise is to put the interests and needs of the patient first.

Covenant, according to Ramsey, is indicative of the nature of human beings as existing in relationships as well as how they ought to relate to others. At a minimum, this relation should be just and preferably should embody a faithful love aimed at meeting the neighbor's need. Agape requires a disinterested love of the other, which Ramsey considers the utmost respect for the sacredness of the other. Covenant fidelity is the basic moral imperative in all relationships and it is the task of ethics to

discover what that imperative entails in concrete situations. Finally, any action that is not consistent with covenant fidelity cannot be right regardless of the good consequences it might produce.

The term "covenant" aptly describes the relationship that ought to exist between patient and physician. Physicians should have the conviction and courage to defend this covenant not only against external threats, but also against internal threats of fear, ignorance, and complacency. Rather than beginning as a contractual arrangement, a fiduciary duty or a priestly or parental relationship, the covenantal model begins in the underlying respect of the physician for the patient as a person, antecedent to her concern for the patient's illness. This respect begins to be made manifest in the physician's attitudes and behaviors before a diagnosis has even been made.

The Patient As Person As the Starting Point of the Patient-Doctor Relation

As will become evident, each of the proposed doctor-patient models I will discuss starts with the question, "How should patient autonomy and physician beneficence be balanced in the physician-patient relationship?" The starting point, however, should instead seek to answer the simple question, "How should physicians relate to, regard and respect their patients?" Approaching the issue in this way allows the relationship to start from a non-adversarial and more productive position and opens the door to dealing with many other issues from a relational point of view rather than viewing them from an individualistic, "rights-based" perspective.

As Ron Hamel characterizes it:

Covenant is a rich concept... and it can offer much toward understanding core dimensions of the interaction between physicians and patients. This is especially true at a time when patient autonomy has widely been taken as the defining characteristic of the relationship, and when legal and economic factors are increasingly coming to shape it as well. The covenant model can serve as "corrective vision." It can broaden understandings of the relationship, while centering attention on some of its central and indispensable features. It interprets the clinical relationship with a breadth and depth that the contract model does not.

But if the (biblical) concept of covenant is going to be an effective metaphor for understanding and shaping the clinical encounter, it must also encompass the insights of other appropriate models and pay serious attention to the realities of the clinical setting. Covenant is not sufficient in itself, nor can it remain abstract and disembodied. It must, for example, rigorously probe what

it means to entrust one's well-being to a stranger and what faithfulness means between a doctor and a patient in the current climate of healthcare delivery.

The care based duties and virtues of this covenantal method of interrelating with patients can manifest themselves differently in different contextual settings of patient independence and functionality, from the comatose and other highly dependent patients to the highly educated, intellectual and self-directed. In this model, any practicing physician with direct patient contact is enjoined to develop caring relationships with all patients. This interdependence characterizes covenant, regardless of the particular constraints operant upon patient autonomy.

Interestingly, in my research for this dissertation, I came across another dissertation from 2003 that has numerous similarities, but is significantly different in its thesis and in its conclusion. That difference centers upon the reliance of its author, J. Breslin, upon care as the sole ground of the doctor-patient relation without the recognition of or a foundational commitment to respect for persons.

Breslin wrote:

My thesis is that 'care' serves as the ideal conceptual basis for a model of the physician-patient relationship. Thus, the main task of this dissertation is to philosophically examine the concept 'care' and to apply it to the physician-patient relationship in order to develop a care-based model of that relationship. A new concept is needed to serve as the basis for the physician-patient relationship, one that can emphasize the collaborative ideal of the relationship while capturing the important and valuable features of the concepts of autonomy, beneficence, and paternalism. I argue that 'care' is the appropriate concept, and so I propose a care-based model of the physician-patient relationship. I maintain that a care-based model of the physician-patient relationship will have normative force in that it will serve as an ideal for physicians to adopt with their patients, and will also have descriptive force in the sense that it will realistically reflect the subtleties and nuances of actual physician-patient interactions (The Physician-Patient Relationship, PhD (Philosophy, 2003) McMaster University, Hamilton, Ontario).

While in this dissertation I often refer to patient-centered care and occasionally to care-based practice, I utilize care as caring respect with the understanding that care and caring facilitate the particularization of the universal foundational principle of respect for persons to each individual patient. In the next chapter I will present an argument to support my viewpoint that care alone, as a foundational principle, is insufficient unless coupled with respect to ground the relationship central to the practice of moral medicine.

Historical Models for the Patient-Physician Relationship in Contemporary Bioethics

Almost 2500 years ago in a remarkable passage in book IV of *The Laws*, Plato recognized that good doctor-patient relationships were required to achieve the goals of medicine. Plato described inadequate physician-patient relationships, which he called ‘slave medicine,’ as follows:

The physician never gives the slave any account of his complaints, nor asks for any; he gives some empirical injunction. Treatment with an air of finished knowledge in the brusque fashion of a dictator, and then is off in haste to the next ailing slave...

Plato contrasted this inadequate patient-doctor relationship with what he called the physician-patient relationship for freemen, in which:

The physician treats their disease by going into things thoroughly from the beginning in a scientific way and takes the patient and his family in confidence. Thus he learns something from the patient. He never gives prescriptions until he has won the patient’s support, and when he has done so, he aims to produce complete restoration to health by persuading the patient to comply (trans. T. Age, London: Dent, 1943 pp. 104–105).

Plato tells us that the best clinical medicine is practiced when the scientific and technical aspects of care are placed in the context of a personal relationship in which the physician must win the patient’s support and trust. In this regard, the professional values described by Plato and those described by contemporary physicians are remarkably similar. Both require a medical relationship with the patient in which the physician’s core professional values are clinical competence and respect for the patient as a person.

The first ethics essay on physician-patient relationship models was A Hastings Center Report article in 1974 by Robert Veatch. Veatch offered four models of the physician patient relationship, centered largely upon the balance of physician control and patient autonomy (“Models for Ethical Medicine in a Revolutionary Age,” *Hastings Center Report* 2 (1974): 5-7). Numerous other authors have also presented various conceptions of physician-patient relationship models, including William May (1983), David Thomasma (1983), James Childress and Mark Siegler (1984), Edmund Pellegrino and David Thomasma (1987) and Linda and Ezekiel Emanuel (1992).

Countless articles have been written examining the more specific underlying issues surrounding the concept of patient autonomy: How should we understand the concept of patient autonomy? How autonomous should patients actually be? How do we find the appropriate balance between autonomy and paternalism (or autonomy and beneficence)? Some authors have argued that the traditional concept of patient autonomy is unrealistic and undesirable for medical ethics, while others have argued for varying degrees of justified paternalism within the physician-patient relationship.

The result of decades of literature on the topic of the physician-patient relationship has been a seemingly never-ending tug-of-war between beneficence and autonomy, in which the relationship between physician and patient has become characterized as adversarial and antagonistic, rather than collaborative. It is my view that this is an unfortunate consequence of the obsession with (and glorification of) the concept of patient autonomy and, thus, of the focus upon finding the balance point between patient autonomy and physician beneficence. I have been arguing in this dissertation that attempts to strike a balance between autonomy and beneficence have failed due to the *prima facie* and ‘self-evident’ nature of these principles in the work of Beauchamp and Childress, which have been adopted as ‘bioethical dogma.’

The balance of mid-level *prima facie* principles requires the instantiation of the concept of respect for persons in medicine as the foundational disposition and principle and as the basis for the physician-patient relationship. Through this Kantian notion, a covenantal model can emphasize the collaborative ideal of the relationship while capturing the important and valuable features of the concepts of autonomy, beneficence, and justice. I argue that ‘caring respect’ is the appropriate practical concept, and so I propose a trust-based covenantal model of the physician-patient relationship that is directed toward patient-centered care. I maintain that such a model of the relationship will have normative force in that it will serve as an ideal for physicians to adopt with their patients and will also have descriptive force in the sense that it will realistically reflect the subtleties and nuances of actual

physician-patient interactions. Models previously offered fall short either as being unacceptable or undesirable as ideal models or they represent unrealistic and/or unattainable models for actual medical practice.

The Evolution of the Debate Between the Contractual and Covenantal Models

More than 40 years ago, Robert Veatch and William May debated the character of the doctor-patient relationship. Each described what he took to be the most appropriate model characterizing the moral structure of medical care and in so doing revealed the difficulties of reducing this complex interaction to its ethical essentials. Before examining the physician-patient relationship debate itself, it is important to take a step back and briefly explain why a model of the physician-patient relationship is important.

In an article criticizing the models of Veatch and May, K. Danner Clouser questions the whole approach to developing models:

What would really be helpful is to be told what would be immoral to do to a patient. It is wrong to deceive a patient. It is wrong to deprive a patient of freedom or opportunity... These can happen in any of the models; it is mistaken to believe that the 'right' model could prevent it. (K. D. Clouser, "Veatch, May, and Models: A Critical Review and a New View," in E.E. Shelp, ed. *The Clinical Encounter*, Reidel Publishing Company 1983 p. 95)

After demonstrating some of the weaknesses of the models by Veatch and May, Clouser concludes that the "models approach" is a lost cause because no model can possibly possess the prescriptive or normative force needed to guide physicians in their interactions with patients. Instead of asking physicians to adopt a certain type of relationship with their patients and hoping that they do the right thing, it would simply be easier, according to Clouser, to give physicians a list of rules telling them what they should and should not do. He does not see the point of developing a model of the physician-patient relationship in the first place.

I agree with Veatch and May that rather than defending a free-standing list of rules for physicians to follow (e.g., do not lie to patients; do not treat patients without consent), the models

approach influences the moral behavior of physicians by altering the kind of relationship physicians have with their patients. The models approach is influenced by the deontological concern with how physicians ought to treat and behave toward their patients as persons. It is also virtue influenced, in that it aims at altering the commitment to certain virtues of physicians (especially caring and respect) that underlie particular actions, rather than aiming directly at altering the actions themselves. I believe the models approach is more fruitful than the “normative rules” approach of Clouser for two reasons.

First, no list of rules could possibly capture all of the actions that physicians should or should not perform. We could narrow the list down to the most important rules, but such a list will inevitably leave physicians without guidance in many situations. Moreover, there would have to be some account of how a physician should guide his or her actions in situations in which rules conflict with each other. A list of rules such as Clouser would defend paints an absurdly simplistic picture of physician-patient ethics.

The second reason why the models approach is more fruitful than the rules approach is that I think the right model of the physician-patient relationship, if adopted by physicians, would be more successful at encouraging moral behavior among physicians in their interactions with patients. Although Clouser is skeptical that a model could prevent immoral behavior, he is naive to think that a list of rules will succeed in that goal. A paternalistic physician, for example, may still be inclined to treat a patient against his or her will regardless of what rules the physician was taught to obey. However, if physicians are trained from early in their education to cultivate a certain relationship with their patients, they will be more likely to act morally when the situation calls for it. The ethical thrust is that if we become moral (virtuous) people, through education and practice, we will do the moral thing when situations arise. Similarly, if a physician learns to cultivate a certain type of relationship with her patients, that physician will behave morally in her interactions with her patients.

Clouser does raise a legitimate question in that it is probably true that too much can be made of models of the physician-patient relationship and that the actual experience can get lost in debates about

which is the most appropriate. Nonetheless, particular interpretations not only describe varying aspects of the interaction between doctor and patient and its essential characteristics, they can also serve to shape how the interaction is perceived and what occurs within it. A contractual model is different from a covenantal model. Each has its own features. Each emphasizes certain qualities of character and modes of behavior. Both in turn differ from a priestly (or paternalistic) model and from other proposed models. How we conceive the nature of the relationship does make a difference in how we conceive the goals of the therapeutic encounter, the roles of the participants, their respective duties and responsibilities, and the dynamics of the interaction. My argument in this chapter is that the appropriate type of relationship is a caring relationship of trust. Therefore, in response to Clouser's challenge, the point of a covenantal physician-patient relationship is that it serves as the best model upon which to build physician-patient ethics. As such, it is far superior to a list of rules to be guided by.

The Physician-Patient Models of Robert Veatch

Veatch used the metaphors of the priest, the colleague, the contractor and the engineer to describe four types of relationships. In the 'priestly' model the physician acts as a priest – someone who is authoritative but (supposedly) altruistic and virtuous. The priestly model is actually the traditional paternalistic model in disguise, grounded in the principle of beneficence. The 'collegial' model is based on the idea that physician and patient are colleagues, working together to achieve the common goal of eliminating illness and preserving health. In the 'contractual' model the physician and patient are seen as equal parties entering into a contract for the purpose of eliminating illness and preserving health. Finally, in the 'engineering' model the physician is viewed as an applied scientist or technical expert, who is obligated to use his or her technical expertise to pursue the goal chosen by the patient.

Veatch's article is notable for several reasons. First, the models as described by Veatch clearly illustrate the shift in thinking about physician-patient ethics from a paternalistic to a more patient

autonomy-based relationship. In Veatch's article, only one of the four models was paternalistic, two were based on a collaborative relationship, and the fourth was a model characterized by full patient decision-making control.

The second thing that is notable about Veatch's discussion is the emergence of the first physician-patient relationship model based on patient autonomy rather than physician beneficence. In the engineering model it is the patient who decides what course of action to pursue and the physician is obligated to apply his medical expertise to achieve that goal.

Third, Veatch took the basic idea of a model of mutual participation and offered two examples of such a model, the collegial and contractual models. The positive aspect of these models is that they do represent a decent attempt to characterize the physician-patient relationship as collaborative rather than as a relationship purely of either physician or patient control. Finally, with Veatch's article we see the completion of the autonomy-paternalism spectrum that would become the background against which many other models and discussions of models would be analyzed.

In Veatch's article the spectrum has been completed with the priestly model at the paternalism end of the spectrum, the collegial and contractual models in the middle, and the engineering model at the patient autonomy end. Although Veatch's collegial, contractual, and engineering models have been influential in terms of their contribution to the shift towards patient autonomy-centered physician-patient ethics, they have shortcomings that make them objectionable as ideal models for the physician-patient relationship.

After presenting his four possible models, Veatch began his analysis by rejecting three of these models. The engineering model suggested that the basic relationship was valueless and regarded the physician as a scientist or technician. The priestly model was rejected on the grounds that it captured the paternalistic dominance of the physician. The collegial model is rejected on the grounds that it assumes an equal understanding and an equal knowledge of the patient's medical problem by the patient and the physician.

The Engineering Model

It is worth a closer look at the engineering model. I find a number of important reasons why such a model (or any model based on complete patient control) would be undesirable as an ideal model. This model clearly captures the rampant shift toward patient autonomy in the very early days of present-day medical ethics. A second problem, nicely illustrated by Kluge, is that to put full decision-making power in the hands of the patient would be to expose the patient to unnecessary risks since patients do not possess the medical knowledge and expertise that is integral to making important health care decisions (E. Kluge, *Biomedical Ethics in a Canadian Context*, Prentice-Hall, 1992, p.86). Physicians are more than just technical experts who have the requisite skills for pursuing courses of action; they also have knowledge and experience that is vital to making decisions to pursue certain courses of action.

The third problem with the engineering model, noted by Veatch himself, is that there is no room in such a model for the values of the physician – the patient chooses the course of action to pursue and the physician is obligated to apply her medical skills to achieve that goal. Thus, the physician is essentially a tool or employee of the patient since she is not free to object to a particular course of action chosen by the patient or to withdraw from the relationship if the physician's own values conflict with the chosen course of action. For example, Veatch argues that a Catholic physician who believes abortion is murder should not be obligated to perform an abortion for a patient. Since the physician is a moral agent, she must not be obligated to pursue courses of action to which she objects on moral grounds.

Fourth, the engineering model makes the mistaken assumption that the values that will come into play in making health care decisions are both well defined and known to the patient (Emanuel and Emanuel, "Four Models of the Physician-Patient Relationship," *JAMA* 267,16 (1992): 2212-2226). One problem with this assumption is that most people likely do not question or

examine their values consciously until they find themselves in a situation that requires such introspection (i.e., when faced with a terminal illness).

The engineering model assumes that patients come into the physician-patient relationship fully conscious of what their values are. All they need are the facts and figures to decide what course of action will fulfill those values. The other problem with the assumption that values are well defined and known to the patient is that illness can interfere with one's thought processes to the point that patients may express ambivalence or even contradictory values or preferences (Childress, "The Place of Autonomy in Bioethics," *Hastings Center Report* 20, 1 (1990) p.13). Both can make decisions extremely difficult if control over decision making lies entirely with the patient. It is exactly because values are often not well defined and known to the patient that there needs to be some room in the relationship for the physician to engage actively in the identification and clarification of patient values.

One final problem with the engineering model, which is related to the problem discussed above, is that the model is based on a very simplistic view of patient autonomy. The view of patient autonomy that underlies the engineering model is rooted in the Libertarian values of independence of thought and action – the patient is supposed to make his or her decision, free from physician influence, and the physician is obligated to pursue that course of action. This extreme view of patient autonomy was articulated and defended in response to the dominant paternalistic tradition in medicine: to protect patients from unwanted intrusion by powerful physicians, patients must be given full and independent control over medical decision making, "or else the bogeyman of paternalism will appear." (Agich, *Reassessing Autonomy in Long-Term Care*, *Hastings* 20, 6, 1990, p. 12-17).

Autonomy is different from liberty (freedom of action). Since patients can be mistaken about their values or can express conflicting values, autonomy should involve some degree of critical self-evaluation. Illness and vulnerability interfere with a patient's reflective ability, therefore physicians should at least help patients in their process of reflection. Finally, patients do not possess the knowledge and experience in medicine that is integral to making significant health care decisions. As

long as patients are free to accept or reject them, patients need their physician's recommendations (Quill and Brody, "Physician Recommendations and Patient Autonomy," 766).

The Collegial Model

The collegial model goes a long way towards avoiding many of the problems with the engineering model since it proposes a more collaborative view of the relationship between physician and patient. Nevertheless, this model has further problems that also make it undesirable as an ideal model for the physician-patient relationship. This model depicts the physician and patient as equals (colleagues pursuing mutual goals). This model fails to account for the difference in knowledge and power in the relationship.

The most obvious problem is that it is inaccurate to describe physicians and patients as colleagues. The metaphor of colleague implies two people of equal standing who share the requisite knowledge for pursuing a common goal and are on an equal plane in terms of authority and control. This is obviously not the case with physician and patient; with the typical physician and typical patient there is a significant imbalance in knowledge and experience in health care, and the authority and power that comes with that knowledge and experience. No matter how much the physician informs the patient about his or her clinical situation, the patient will never know as much about health care as the physician; even patients who are themselves physicians will often have to (or choose to) depend on the knowledge and expertise of the physician taking care of them.

Every model for the doctor/patient relationship establishes not only a certain image of the doctor, but also a specific concept of the self. The image of the doctor as priest or parent encourages dependency in the patient. The image of the doctor as skillful technician prompts the patient to think less in terms of his personal dependence, but it still encourages an impersonal passivity with the doctor and his technical procedures. It leaves the patient as the only serious agent in the relationship. The image of physician as fiduciary encourages the often beneficent behavior of physicians as "protector,"

but does so at the expense of paternalism and the denigration of patient autonomy. The image of the doctor as covenanter or contractor engages the patient to become more personally involved in his own care. He must bring to the relationship the willingness and desire to mutually collaborate with the physician in their joint effort to restore him to health.

There have been numerous other models proposed, but each is a variation on one of the themes presented here. It does not serve my purpose to elaborate further. The point I have intended to make is that the only two plausible models for the medical relation are contract and covenant.

In the next section I discuss Veatch's contractual model and then contrast it with the covenant model of William May. Veatch proposed that a contractual model was most appropriate, where physician and patient negotiated a sharing of ethical authority and responsibility and each would fulfill those stipulations. (The Case For Contract In Medical Ethics in *The Clinical Encounter: The Moral Fabric of the Patient-Physician Relationship*, E.E. Shelp, ed., p.105–112, 1983).

The Debate Between May and Veatch

Veatch's contractual model clearly defined the specific obligations and duties which were incumbent upon both parties. He was also responding to his perception that most healthcare was administered in anonymous institutions and the doctor-patient relationship was hardly intimate or premised on the physician as friend model (The Physician as Stranger: The Ethics of the Anonymous Patient-Physician Relationship in *The Clinical Encounter: The Moral Fabric of the Patient-Physician Relationship*, p.196). It is understandable that Veatch might come to this conclusion, given the contemporary notion of "respect for autonomy" of the patient as epitomizing the physician's role to which he (and most bioethicists at the time) subscribed. This presupposes certain characteristics of the patient as a moral agent, the basis of which lies in certain assumed normative capacities, without which one could neither be capable of, nor responsible for, moral action. The interaction required

between physician and patient, guided by respect for autonomy, is one that presumes that most patients, most of the time, are able to make autonomous decisions.

This basic assumption (as detailed in the discussion of the engineering model) fails to account for all of those patients constrained or otherwise incapable of autonomous decision-making. It raises an initial question of whether this creates a limit to the applicability of contract and fails to account for those patients who come up short of the criteria for moral agency (much less for entering into a contract of “equals”). Veatch, however, in contrast to his own critique of the engineering model, envisioned the idea of the contractual model without addressing this important question. The contractual model views the relationship as one between two parties who enter into a contract for the purpose of pursuing a certain goal. This understanding seems, at the outset, to require patients to be able to exercise their functional autonomy.

Nonetheless, there are particular features of the contract metaphor that improve upon the colleague metaphor. First, there is no longer the assumption that the physician and patient will share a particular common goal; the metaphor of the contract implies that the physician and patient will negotiate early in the relationship what goal is to be pursued and set the terms of the “contract” around that goal. Second, the language of the contract implies that there are responsibilities and obligations for both parties, and the binding nature of a contract implies that there is protection for both parties, particularly the party on the weaker side of a knowledge/power imbalance. This is obviously important for the physician-patient relationship, as the typical patient will always be on the weaker side of that imbalance.

Moreover, the contractual model improves upon the collegial model with the simple recognition that the two parties in the physician-patient relationship are not typically of equal standing and with the attempt to ameliorate this inequality (or at least compensate for it).

His model is characterized by mutual agreement between equals and grounded in informed consent with special emphasis upon rights, conditions and qualifications. The contract establishes the basis for

legal enforcement and offers each party some protection and recourse under the law to make the other accountable.

The goal of Veatch here is to dispense with a nebulous sense of charity or beneficence to account for physician responsibility and to define the dignity of the patient within a specific set of legal parameters that are both definable and enforceable (Veatch, 1972; 1983). The concluding paragraph of the Introduction to *The Patient As Partner: Part 2* states:

The contractual/partnership model should not just be taken as a polite appeal for more respect and a more caring attitude on the part of health professionals. Far more, it is an appeal for a whole new basis for lay-professional relations, one that views patients and physicians as full, active partners negotiating a contract to pursue mutually shared objectives within a larger framework of cultural and subcultural commitments.

According to Veatch, the “premise” of his contractual model is trust and confidence, yet the notion of a contract would seem to imply a lack of trust. The reason we need contracts in professional relationships is precisely because we cannot trust people to do what they say. The contract protects us from people breaking their promises or going back on their word. I would argue that the metaphor of the contract makes the physician-patient relationship at least appear adversarial due to the implication of the metaphor that the patient needs the contract because she cannot trust the physician to keep his word (or trust him to act in her best interests). Of course, since contracts are designed to protect both parties in the relationship, the metaphor also implies that the physician cannot trust the patient.

Ron Hamel, in his essay “Interpreting The Physician-Patient Relationship: Uses, Abuses, And Promise Of The Covenantal Model,” makes this apt observation: “If Ramsey’s understanding of the therapeutic relationship can be characterized by ‘covenant with a hint of contract,’ then Robert Veatch’s can be described as ‘contract with a hint of covenant’ (though Veatch himself might not agree with this)” (*Theological Analyses of the Clinical Encounter*, ed. McKinny, G.P. 1994, p.13). The language Veatch utilizes to describe contract is quite similar to that generally used to characterize covenant. The contractual relationship for Veatch is premised upon trust and confidence as well as a basic assumption of the faithful fulfillment of the contractual obligations. He attempts to ground his

contractual model in the “moral equality between partners and fidelity to promises made” (*The Patient As Partner* p.38). In *The Patient As Partner, Part 2*, Veatch insists, “the contractual agreement and the partnership relation will necessarily have a moral foundation” (p. 3).

Veatch, however, understood this moral foundation from a more particular concern with the development of a universal basis for making medical decisions and he argued against professional codes (and the code of the medical profession specifically) as unable to ensure this (Part 2, pp. 20-28). In other words, the personal/verbal commitment of physicians to engage in shared decision-making with their patients is insufficient without the backing of a legally binding contract.

Veatch’s Triple Contract

Veatch's major point remains: no satisfactory ethic of medicine can be rationally grounded in pronouncements within the profession of medicine (or any profession) or in knowledge that in principle is open to professionals only; it must be based on moral principles that would be agreed to by professionals and lay people alike. With this neither May nor I would object.

Veatch lays out the triple contract as a way of determining what rational parties taking the moral point of view would agree to as binding moral principles, and showing that the Hippocratic principle fails the test. In applying contract theory to medical ethics, Veatch argues for the need for “social relationships among laypeople and health professionals built upon complex layers of mutual loyalty, fidelity, respect, and support.” Though what he is proposing is, in his mind, a contract, he nonetheless recognizes certain limitations of this notion.

He argues that physicians must invest more of their person and fate in their work than the term contract implies. The very idea of contract, however, implies that obligations are limited to those defined by its provisions. Veatch acknowledges that his idea of contract does not have “the solemnity and moral force conveyed by the religious connotations of covenants.”

Veatch's proposal for a contractual medical ethic argues that contemporary relationships between patients and physicians fall short of the ideal because the only principles available to regulate them are either those of the "mores of physicians," enshrined in the physician codes that are unilaterally created and enforced such as the AMA's principles and the opinions of its judicial council. He argues there is no reason why laypersons should accept these principles, yet laypersons should have a role in these important decisions. Patients have a stake in the way physicians make decisions and a rightful claim for involvement that has led to the support for patient autonomy as presented by Beauchamp and Childress. Veatch is making the claim that all elements of society should have a say in the formulation of medical ethics.

This viewpoint is well understood, but the new foundation he proposes lacks soundness and practicality. In the absence of a general social contract, the medical contract he envisions would be too weak for a number of reasons. Veatch presents us with three contracts. The first, a social contract, envisions members of society agreeing on principles of social interaction as a covenant of sorts. Based upon the first, a second contract is proposed between society and the medical profession. Finally, a third contract between individual doctors and patients derives from the second contract which itself is derived from the first (A Theory of Medical Ethics, this theory is worked out in Chapter 5, "The Triple Contract: A New Foundation For Medical Ethics" (pp.110-126).

He describes this as a "synthesis contract theory" and attempts to demonstrate that it would be acceptable in the major traditions of medical ethics (both those that maintain that morality is created by convention and those that postulate an objective moral order, Divine or natural, to be discovered by revelation, reason or the moral sense). At the conclusion of his argument Veatch asserts:

There is a convergence between the vision of the people coming together to discover a pre-existing moral order—an order that takes equally into account the welfare of all— And the division of people coming together to invent a moral order that as well takes equally into account the welfare of all. The members of the moral community thus generated are bound together by bonds of mutual loyalty and trust. (ibid, p. 125).

John Kultgen disagrees with Veatch's conclusion and argues in *Ethics and Professionalism*:

Veatch's theory fails because he neither demonstrates the convergence of the traditions on his concept, nor the soundness of the concept itself. He creates the illusion of convergence by dismissing the theories in the discovery tradition that do not find in the objective moral order a requirement for the impartial treatment of everyone and theories in the creationist tradition that do not make the factual judgments that self-interest requires a stable social order and that only an order that treats all impartially will be stable. After excluding those who do not stipulate impartiality, he claims that the theories remaining will converge on the principle that the welfare of all members of society should be considered impartially (1988, U. Penn, p.168).

It certainly may be the case that patients would only want to negotiate contracts with physicians from various traditions who share this moral point of view. Veatch, however, must also assume much more in order to demonstrate logical convergence. Representatives of the various ethical traditions must arrive at the same conclusions about the meaning of impartial treatment, welfare and so forth. Furthermore, they would have to agree on which principles necessarily required incorporation into this so-called social contract to actualize these values. This would have to occur across traditions that rely upon revelation, practical reason, common morality, or self-interest. The history of ethical thought gives us no reason for expecting this to occur. These disparate sources of moral authority are in some cases incommensurable (or at least are viewed as such by their adherents). Unfortunately, nothing like a social contract exists.

The concept of covenant, which I have proposed for the doctor-patient relation, does not require an actual social contract at all to provide its basis. Rather, it is grounded in the universality of respect for persons, which should be acceptable within each of the various moral traditions. I will argue this point further in the following chapter on caring respect, in which I take on Lawrence Blum's commitment to impartiality and justice as providing the moral ground for an ethic of care.

The proposal of Veatch is useful in reinforcing the need for physicians to disregard their own self-interest as well as pointing out the need to recognize our own fallibility and listen to the arguments of others. We are also reminded that, ultimately, we are seeking principles that will be worthy of adherence by all rational people rather than merely crafted for our own use.

Kultgen concedes that the idea of a professional (medical) covenant is not foolish. But in the absence of a clearly articulated social contract, he asks on what would they be based? "What might

they use as its foundation?" (p.173). The principle of respect for persons, as I have been advocating, is the most acceptable candidate for the foundation of covenant in my view.

Veatch also proposed a "draft medical ethical covenant" that helps to dispel some of the erroneous views about contract theories of medical ethics—that they must invariably produce a minimalistic and legalistic approach antithetical to sensitive and caring medicine. It is one thing to make such assertions regarding the nature of an ideal contract theory from his perspective, and quite another to defend that view, in light of the way efforts at actualizing “contract-medicine” have played out. I think the covenant relationship simply postulates a greater degree of care for one another in the therapeutic relationship and a corresponding readiness on the part of the professional to go beyond carefully defined responsibilities in securing the good of the patient.

Veatch believed in the universal basis of the social contract, but held it to be invented and argued there was no agreement that anything such as the moral law existed to be discovered (pp. 28-32). This construction of a professional contract should not be the sole purview of the medical (or any) profession according to Veatch. “In the end, society will outline its terms for granting the privilege of licensure.” How did Veatch come to this conclusion?

In December 1977, the AMA House of Delegates drafted a new version of its Principles of Medical Ethics. This code was initially adopted in 1847 and revised in 1903, 1912 and 1947. In 1957 a major revision resulted in a list of 10 principles that were again significantly revised in 1977. Veatch commented upon these revisions in a Hastings Center Report entitled *Professional Ethics: New Principles For Physicians?*

In the preamble to this draft the AMA asserts that “a physician must recognize responsibility to society, to patients, to other health professionals, and to self... a physician shall respect the rights of patients, of colleagues, and other health professionals.” Thus, for the first time, the responsibility of the medical professional had been linked to the rights of patients and others. It is also stated that the ethics of the profession is derived from more general universal ethical norms by determining what those more universal norms mean for the professional role. That role will be defined increasingly by society. If that is the case, then it seems essential that society must have an important role in determining what is ethical in the medical professional role. It recognizes on both theoretical and practical grounds the importance of the layperson in determining what is ethical in the relationship between laypersons and professional. This seems to set the stage for collaboration between the two.

Code ethics, and the sense of an ethic articulated unilaterally by a professional group to be imposed on laypersons, makes no sense given the insights the committee has gained. Code ethics does not work even if the professional group thinks it has incorporated the ethical principles of the broader society. The committee's report, however, does not go quite far enough. It does not propose that code ethics be abandoned in favor of a process that would form a social covenant between society and the profession. Given the important theoretical growth that has already taken place, I do not see why the profession of medicine cannot move the rest of the way (The Hastings Center Report, Vol. 10, No. 3 (Jun., 1980), pp. 16-19).

The contractual agreement between patient and doctor Veatch espouses for the therapeutic relationship, as the third and most particular of his triple-contract theory, emerges from the second, broader social contract that he argued existed between medicine and the American people. He goes on to argue that the therapeutic contract itself emerged from the basic social contract:

My goal is for lay people and professionals to reach a common understanding about the appropriate ethical principles for medical professionals when interacting with lay people and for lay people when interacting with professionals. To me that requires a relationship of full, equal, and active participation leading to a covenantal bond specifying the appropriate role-specific moral duties for both professional and patient.

In my view neither lay people nor professionals should generate the principles. Rather the principles are required by reason, embedded in the laws of nature, or generated by the deity. Human beings only articulate principles. If the ethic is to be meaningful to lay people, then the lay people have to play a role in articulating the lists of role-specific obligations. They (lay people) have to learn that they have a legitimate, important role as active partners in establishing the contract (covenant) between the professional and the rest of us. The current AMA principles, as sound as they are, can be no more than a private agreement among AMA members unless the rest of us participate in drawing up the agreement (ibid).

This contract, for Veatch, is centered on decision-making and its goal is for the mutual establishment of this basic framework between doctor and patient. He argues that,

... the patient-physician relation ought to be one in which both parties are active moral agents articulating their expectations of the interaction, their moral frameworks, and their moral commitments. The result should be a partnership grounded in a complex contractual relation of mutual promising and commitment (Part 2, p. 3).

While the norms that govern the relationship do not come from within the profession nor from the relationship itself, Veatch did insist that these norms are deontological with an absolute lexical ordering of non-consequentialist principles over beneficence. "Consequences do not count morally until principles have been satisfied" (Part 2, p.6).

Ultimately, for Veatch, contract/covenant revolves around the interaction of autonomous moral agents for the pursuit of mutual self-interest, guided by the principles of the basic contract and the duties derived from it. While containing some plausible aspects of the therapeutic encounter and

perhaps incorporating some features of the traditional biblical covenant, it is not truly an understanding of covenant.

In the section entitled, THE PERSONAL PATIENT-PHYSICIAN CONTRACT, Veatch indicates that once the basic norms of the lay and professional roles are specified, there would be substantial room for discretion. He goes on to clarify this statement:

For example, if the professional norm were specified that because of the principle of autonomy no physician would withhold potentially meaningful information from a patient without his consent, it would remain for the individual patient and physician to agree between themselves whether the patient might waive that right to consent... physicians and patients could agree to a therapeutic deception by having the patient authorize withholding diagnostic information of a certain type...(they) would not be able to agree to any provisions that violated the basic social contract or the second contract between the lay population and the professional group (Part 2, p.31).

He goes on to cite the example that if the basic social contract contained a norm that prohibited killing of the innocent and the second contract prohibited physician killing for mercy then the individual patient and physician would not be able to agree to a mercy killing contract. Aside from any norms specified in either the first or second contract, the doctor and patient would be free to contract for whatever was mutually acceptable.

These statements are internally incoherent. On the previous page, he argued that the ASIC social contract would include such fundamental principles as beneficence, non-maleficence, autonomy, fidelity (or promise-keeping), veracity, avoiding killing, and justice. Clearly then, the principle to avoid killing is joined by the principle of truth-telling and of promise-keeping, which along with autonomy, are fundamental to informed consent. How is it that avoidance of killing cannot be negotiated while deliberate deception, which violates three other primary principles, can be mutually waived? The only rational difference that I can see is that euthanasia is illegal.

A patient limited and disadvantaged by the knowledge gap and constraints of illness upon her autonomy could not ethically be allowed (by mutual agreement at the patient's or physician's behest) to waive her right to truth telling and acquiesce to deception as he suggests. Even if that is truly what the patient desired, the physician has the duty, not to promote this acquiescence, but to promote the patient's ability and desire to participate in the discussion and decision-making process.

Even though Veatch frequently uses the terms contract and covenant interchangeably, it should not be considered as such. Unfortunately, the error Veatch made was to conflate the notions of contract and of covenant. These conceptions, as models for the therapeutic relation, are not only not synonymous, they are in many ways incommensurable. In addition to trust, mutuality and faithfulness Veatch's contractual model also crucially depends upon the specification of responsibilities and obligations and their legal enforcement.

Such a legal dimension to the doctor-patient relation may seem to be of necessity in many of the modern contexts of this relationship in which litigation is a constant threat and the profit motive sometimes rules. Much is sacrificed with regard to caring covenantal trust and I contend that the potential threats referenced above can be overcome without it being necessary to resort to contract.

Instead of this legalistic contractual model of patient and doctor relations in which self-interested contractors follow rules whose purpose is to protect those rights, I have proposed the caring covenantal model of the doctor/patient interrelationship, in which physicians are so involved in the lives of their patients that they go beyond rights and duties in caring for those in their care. In such a covenant of care, rights are recognized because they discipline the desire to help (averting paternalism), as well as block the temptation to exploit. They are not, however, constantly brought into play; in most relationships most of the time they lie unused and unnoticed in the background of caring interactions.

More importantly, the execution of a fair and meaningful contract is highly dependent upon the ability of both parties (but especially the patient) to autonomously comprehend the nature of his disorder, its potential consequences and the risks of the potential treatments (as well as potential benefits). When the patient is unable or unwilling to perform as a fully functional moral agent (as I have previously shown to be far too often the case), any contractual arrangement has little chance of promoting shared decision-making or being in the patient's best interest unless the physician goes significantly further than the "letter" of the contract and acts from an underlying disposition of respect for persons, caringly treating the patient with dignity and concern as well as promoting his autonomy.

Of course these physician duties and responsibilities are more accurately captured within the covenantal model than the contractual one.

The contractual model as proposed by Veatch fails to account for several features of the experience of illness that must, at least to some significant extent, contribute to the moral foundation of medicine. To experience illness is generally to be someone who needs assistance and who appeals for help. This appeal to health care providers to utilize their knowledge, time, energy and experience in the service of healing necessarily requires trust on the part of the patient and a willingness to place herself in the hands of others. In addition, therapeutic encounters are often initiated between doctors and patients meeting for the first time and are almost always marked by a clear asymmetry of power in favor of the physician because of the vulnerable state of the patient.

Such contractual agreements are fostered by a misdirected “respect” for “the principle of patient autonomy” (as has been discussed in the chapter on Beauchamp and Childress) rather than for the person whose autonomy should be fostered, but not respected. In assessing the promise of the covenant model, this chapter seeks to determine the degree to which it describes and inscribes the realities of the relation and its underlying moral attitude or disposition of respect. This relational orientation of caring respect is set by the need and appeal of a sick person for help, “without which the patient might die or suffer unnecessary pain or disability... It is grounded in the claim that comes from the vulnerability and suffering of a fellow human being” (Pellegrino, *For The Patient’s Good*, p. 32). Such an appeal typically involves a requirement of the physician to seek the patient’s good “even at some cost to the comfort, power, prestige or fiscal benefit of the physician” (ibid, p.31). Such requirements and expectations cannot be built into or presumed within the contractual model.

The physician who seeks to develop caring covenantal relationships with her patients, rather than to establish the terms of a contract, will know what it means to have respect for her patient as a person and such questions of how to deal with issues of patient autonomy like truth-telling, confidentiality, and paternalism become intuitive, natural and automatic. This perspective is applicable

to the wide range of physician-patient interactions that must be encompassed under the umbrella of ‘covenantal caring respect,’ in light of the wide range of clinical situations encountered in medical practice. The patient centered covenantal model is able to encompass patient encounters with non-autonomous patients. Children or adults who are unconscious, demented or psychiatrically impaired are treated with respect and accorded the dignity of personhood.

The covenant model captures and preserves these features of the inequality of the relationship: the vulnerability of one of the participants, the dynamic need of the patient, the responsiveness of the care-giver, the necessity of trust and the willingness to place the vulnerable patient’s good as the primary imperative. These factors argue strongly in favor of covenant rather than contract (at least as contractarianism is generally understood) as better suited to express the core ingredients and dynamics of this relationship. Covenant also better guards against the influences that often distort the relationship such as an excessive focus on patient autonomy and the resulting distancing of individualism.

May’s Argument for Covenantal Medicine

William F. May argued that the contract model was not only too restrictive as a moral description of the doctor-patient relationship, but “it was distorted as well because of its legalistic bent” (“Code, Covenant, Contract, or Philanthropy,” *Hastings Center Report* 5:29–38, 1972). May, citing Hume, concludes that contracts highlight a formal, business relationship and carry no natural obligation, but are rather “artificial contrivances for the convenience and advantage of society” (Hume, *A Treatise of Human Nature*, 1739, p. 525).

May presented the covenant model and argued it was at odds with the contract model at a deeply moral level (*The Physician’s Covenant*, Philadelphia: 1983, p.116). The fundamental problem with the contract model according to May is that 1) it cannot exhaustively predict or cover the needs of patients and 2) the kinds of services rendered by physicians in terms of empathy or compassion can

never be specified. “In other words, covenants cut deeper into personal identity” by calling upon human resources that defy description and prescription (Ibid, p.119). Contracts determine only what is required, not necessarily what is just, while a covenant “obliges the more powerful to accept some responsibility for the more vulnerable and powerless of the two parties” (Ibid, p.124). May suggests that the covenant is rooted in historical events. It is grounded in a specific historical exchange between partners leading to a promissory event. There is a mutuality, an exchange, in which both partners accept responsibility (Code, Covenant or Philanthropy).

Patients very often seek the care of physicians at the most vulnerable and needy moments of their lives. At these moments, patients are most dependent upon someone else to do what is best for them. Medicine is, at its core, a moral endeavor grounded in a covenant of trust. These seemingly intuitive concepts of the importance of trust in today’s medicine actually have little foundation in our medical heritage. In fact, a review of the early history of medicine is astonishingly devoid of medical ethics or consideration of physician duties to patients as “moral obligations,” beginning with the writing in the Hippocratic corpus.

The ethics grounding covenantal, patient-centered care places the service of the health-care provider within the full context of respect for patients as persons. The explicit duties to self and others emerging from Kant’s formula of humanity, which underpins covenantal ethics, specify that the goods and services given and received in patient centered care must be patient-responsive. This stands in opposition to the instrument of contract which presupposes that agreement is reached on the basis of self-interest. What I am getting at is the peculiar nature of this relationship. On the one hand the physician is paid for her services as in a contract, but so often she cares for her patient without a thought of remuneration and does not check to be sure the patient is insured or think for a second that if not, she would refuse him service. She generally gives much more of herself to the care and commitment to the patient than can be accounted for by her payment, alone. Covenantal ethics frequently requires doctors to be available to their covenantal partner, above and beyond the measure

of self-interest, and therefore covenantal ethical caring truly ethically qualifies the provider as a caregiver.

The covenant model avoids the idealist assumption that the physician's action is or ought to be wholly altruistic. On the other hand, it simultaneously rejects the contractualist assumption that the relationship is governed by self-interest in every exchange. Reference to the relation as covenantal may also be important not only in setting forth the proper context in which human health-care services are rendered, but also in prescribing the specific standards by which they are evaluated. In discussing his own use of contract language in contrast to May's use of covenant, Veatch writes in "The Case for Contract in Medical Ethics" (E.E. Shelp ed., *The Clinical Encounter*, pp.105-116):

There is almost nothing in May's essay to which I can take any exception. If there is any difference at all it would be in my concern that May... and all others who are nervous about contract language... overly spiritualize and romanticize the relationship making it as spineless as the buddy-buddy-relationship of the collegial model. I have consistently made clear that I oppose individualistic and legalistic explication of the contract metaphor. But I am also concerned about the squishy, apolitical, asocial romanticism of the collegial model.

In this passage, Veatch seems not to understand the covenant concept. It is neither apolitical nor asocial and it need not be squishy. There is in the covenantal conception a strong sense of specific obligations arising out of relationships that can be expressed both in terms of biblical laws and Kant's formula of humanity of the moral imperative. Joseph Allen identifies three common features of covenant relationships, whether considering the covenant relation into which all are born or specific covenant relationships. Covenants require respect for the dignity of persons, an obligation to be concerned for the needs of covenant partners and faithfulness (*Love and Conflict: A Covenant Model of Christian Ethics*, Nashville, 1984).

Medicine's response to this debate between ethicists (a theologian and a philosopher) was rather muted, ambivalent and not unexpected considering the embattled and defensive posture of medicine from the 1960's through the 1980's. The introduction of Medicare and Medicaid added fuel to the fire and the 'old-guard' physician establishment (not all physicians by any means, but many in positions of power) clung to the old, paternalistic (parent-child) model of practice. It was dying hard

and the torch of beneficence was raised in answer to the sword of autonomy wielded by patient advocates and ethicists and the unnecessary and irrational clash began. Some contend that it was in these tumultuous times that the contemporary discipline of medical ethics emerged as a voice on behalf of patients.

The problem with this advocacy of autonomy, however, resided in the unfortunate choice of an understanding and definition of autonomy as non-interference or liberty. This understanding is based on an incomplete and inadequate representation of how Mill, in *On Liberty*, defines freedom. This notion of autonomy, on the face of it, did seem to most directly counter the paternalistically disrespectful attitudes of physicians under the guise of beneficence (acting on behalf of the patient's well-being). The arrogance and presumptiveness of medicine had emerged from a long tradition of such attitudes in American medicine and, of course, could be traced all the way to Hippocrates, whose oath never mentions the patient's rights or concern for her wishes. The only one to whom the physician owed a debt of gratitude was his teacher to whom he pledged to care for and to educate his son in return. Patient care was at the complete discretion of the physician.

Maximal Care vs. Optimal Care

The contrast between this paternalistic model and the covenantal patient-centered model I am arguing for can be further unpacked by developing the distinction between "maximal care" and "optimal care." This dichotomy is between doing all that is humanly possible to treat and cure disease and doing all that is beneficial to optimizing the quality of life of the patient. The latter pays far more attention to human suffering and the former to physical death. Optimal care for the health of patients and their families is unceasing in its responsiveness to human suffering rather than to the relentless pursuit of maximizing length of life. Medical judgments should be guided by the needs of the patient and are discernible through the practical application of a physician's practical reason, guided by respect for persons. This analysis provides an account of physician identity and virtues capable of

resisting the seduction of a medical practice aimed at maximizing self-interest through market exchange and manipulation.

This approach to medical care does not dismiss the importance of medical proficiency and technical skill of doctors, but it does take issue with the current methodology of medical education. As William May stated, “The cumulative impact of the training of doctors filters out the personal, not merely the patient as person but the physician as person” (*The Physician’s Covenant*, p. 98). He continues:

The very structure of daily rounds and floor service reinforces for residents the importance of breaking ties with patients. Residents get acquainted with particular patients whose histories they have taken and whom they monitor daily. But the ritual of morning rounds and the institutional regimen of changing service assignments regularly put these incipient personal relations in a different perspective. Morning rounds give the young residents in the company of colleagues and the attending physician a ration of 3 to 5 minutes at the patient’s bedside. It helps distance everyone from the case. Further, movement from service to service, month after month, systematically prevents residents from staying the course with many of their patients... the institutional setup subliminally reminds young professionals that they must, above all, refine technical skills. The patient functions as locale for the disease like a farmhouse on a battleground that requires interest for the soldier only because of the enemy that may inhabit it.... As a young resident in internal medicine conceded, attention shifts from the care of patients to the treatment of disease and from the treatment of disease to the treatment of lab tests. The patient and the disease fade away as the young physician engages in interventions to bring lab values within acceptable limits... a task as far removed from patients per se as the interventions of the ships engineer or the car mechanic are from the passengers (ibid, p. 98-100).

The physician as healer must recognize that illness is something a person has. As Dr. Eric Casell has put it, “Disease... is something an organ has; illness is something a man has” (*The Healers Art*, 1979, p. 48).

The good physician looks at the whole patient, disrupted by illness and suffering, and attempts to assist the patient in reconnecting with his relationships and the world. This process of recovery includes regaining her self-control and self-confidence. Of course, in order for this to occur, the physician requires the patient’s cooperation and participation. Studies have shown that patients are less likely to accept some responsibility for their lives and health unless they are educated and share in the physician’s knowledge and understanding of their condition. This process of patient internalization

through the physician's efforts illustrates the physician's role in the covenantal patient-centered relationship of care as a teacher and advocate.

The description of the physician as bound to the relationship with her patient by a covenant as both healer and educator challenges doctors and medical educators to rethink and redefine their definition of "physician" as well as "healthcare" in general. Framing the relationship as a covenant expresses the view that the healer is committed to the total well-being of the sufferer and to the person of the patient. My point in making this distinction is that, without advocating for or condoning euthanasia, there are many situations of human suffering to which physicians must be present that are "worse than death."

I am arguing that patient-centered care, while bearing elements of contract, is about wholeness and the well-being of the person (about healing the entire human being) and is therefore beyond the scope of a contract, which by definition is restrictive. The healing and covenantal role of the physician extends beyond medications and interventional procedures and even beyond medical treatment generally to beneficently seek the well-being of patients as persons in their living and in their dying. It calls for providing comfort, for accompanying the dying and for not engaging in "useless technological assaults" upon the dying.

The nature of medical practice is a special kind of human activity and cannot be optimally pursued unless the physician has incorporated into her character the virtues of honesty, intellectual integrity, compassion, elimination of excessive self-interest and, importantly, humility. These traits mark physicians as dedicated to the care of patients rather than to their own self-interest and marks medicine as a moral profession. Medicine (and society) will always need the sort of doctor who keeps the patient-centered perspective and optimally balances it with a high commitment to principle and character. As we reflect upon medicine's ethical underpinning, we must never allow these principles to obscure the reality that caring respect places persons at the center of the moral arena.

Advantages of a Covenantal Model Over a Contractual Model

The advantages of a covenant model of the physician–patient relationship over a contract model begin in its fostering concepts such as ‘trust’ and ‘reciprocal respect and concern.’ I argue that these are essential elements of the patient-centered relationship and are consistent with the covenant, but not the contract, model of this relationship. The first obligation of medicine and its providers must be to serve the good of those persons who seek physicians’ help and trust them to provide it. Doctors, through caring and advocating for the patient, can affirm their own personal integrity and commitment and thereby honor their covenant of trust with their patients. In addition, the ‘demoralizing climate’ that currently threatens health care may be significantly lifted by the rejuvenation of an understanding of the doctor patient relation as a caring covenantal commitment of respect.

The most vital force sustaining any successful relationship is the element of trust. Trust is fundamental to the physician-patient relationship. The vulnerability of patients and their need for care force them to trust physicians. Patients generally view trust as an interactive process, requiring care, concern and compassion, with listening as a central focus. Trust can manifest at the interpersonal level, between an individual patient and a physician, built through repeated interactions and met expectations. This is intimately intertwined with trust at the societal level towards the medical profession, which has been negatively influenced broadly by the media and by waning social confidence in particular institutions. The level of trust in their physicians has been shown to correlate closely and independently with patients’ satisfaction with their physician and their adherence to treatment.

The doctor-patient relation has been compared to a marriage, where initial high hopes often obscure the possibility of disappointment and where subsequent unmet expectations can lead to a terrible loss of faith. This breakdown in trust has also prompted the suggestion of viewing that relationship purely as a contract, sustained by pre-set terms and agreements in order to ensure minimal standards of practice. Most of us would consider that suggestion an affront to the institution of

marriage and in a similar (though less confrontational) vein I consider that suggestion untenable in medicine as well.

Such a contractual approach is rather unfortunate and poses practical difficulties for the practitioner to truly benefit patients. Much of the concern regarding the weakening of the physician-patient relationship stems from the threat posed by rapid changes in the health care system to patients' trust in their physicians. Trust in any relationship takes time and repeated interactions to develop. For doctor-patient relationship, the brief and perfunctory consultations delivered by many profit-driven and quantity-driven medical practices fail to provide sufficient time for the development of a familiarity that strengthens this relationship.

May's Covenantal Promise

May describes the covenant model of the physician-patient relationship as a traditional covenantal promise of a faithful and reciprocal "exchange of gifts, labors, or services" that will "shape subsequent life for each partner." He writes that while "contracts are signed to be expediently discharged" and imply "do no more for your patients than what the contract calls for," covenants appreciate that "services may be required that exceed those anticipated in a contract or for which compensation may not be available in a given case" (Code, Covenant, Contract, Or Philanthropy, *Hastings* 1975; 5(6): 29-38). Most physicians give their time, energy and emotion freely to their patients at a level far exceeding that anticipated or compensated in their contracts with third party payers, Medicare and Medicaid.

The contract model of the physician-patient relationship, according to J.J. Ring, "ignores the moral nature of our profession" and its emphasis on trust, while the covenant model acknowledges these important attributes of our profession (The Patient-Physician Covenant, *JAMA* 1995; 274 (16): p.1265-6). The P-P relationship is more likely to be effective if grounded in the moral nature of respect for persons and based on bi-directional trust (within a covenant model of the physician-patient

relationship). According to Kyle Brothers, the physician has the responsibility to respond to the patient with commitment, empathy and creativity (Covenant And The Vulnerable Other. JAMA 2002; 288(9): p. 1133). Further, contract medicine encourages defensive medicine in the physician–patient relationship (May, Code, Covenant, Contract, Or Philanthropy). Arthur Frank, in *The Renewal of Generosity: Illness, Medicine and How to Live*, emphasizes the bi-directional nature of generosity and feels that it is an important attribute of the physician–patient relationship. “Contemporary health care often lacks generosity of spirit, even when treatment is most efficient. Too many patients are left unhappy with how they are treated, and too many medical professionals feel estranged from the calling that drew them to medicine.” He argues that “the current medical climate ‘demoralizes’ both physicians and patients, thus threatening their bi-directional generosity” (U of Chicago Press, 2004).

The model of the physician as contractor does have certain attractions and benefits. First, it represents a deliberate break with paternalistic models (such as priest or parent) for interpreting the role. At the heart of a contract is informed consent rather than blind trust. A contractual understanding of the therapeutic relationship encourages full respect for the patient as a person with dignity, who has not, through illness, forfeited his sovereignty as a human being. The notion of a contract includes an exchange of information on the basis of which an agreement is reached and a subsequent exchange of goods (money for services); it also allows for a specification of rights, duties, conditions, and qualifications limiting the agreement (May, *The Physician’s Covenant*, p 117). Finally, a contract does not rely on the inequality and superiority of philanthropy or the de-humanizing condescension of charity. It pre-supposes that people are primarily governed by self-interest. When two people enter into a contract, they do so because each sees it to his/her own advantage (May, “Code, Covenant, Contract, Or Philanthropy”).

Parties to a contract are better able to protect their self-interest in so far as they are informed about the goods bought and sold. The notion that contract medicine encourages increased knowledge on the part of the patient is all well and good. Nonetheless the physician’s knowledge so exceeds that

of her patients that the patient's lack of medical knowledge alone is not a satisfactory constraint on the physician's behavior. One must, at least in part, depend upon some 'internal' fiduciary and moral duties to serve as checks upon the behavior of providers of care.

There is nothing in the nature of contract that is even concerned with care for the person of the patient but rather emphasizes the contractual responsibility to inform the patient, respect his autonomous right to decision-making and to treat the disease of the patient with technical skill and expertise. This contract becomes the sole determinant of a physician's duty, undermining any relational, interpersonal bonding and trust.

It would be unfortunate, in my judgment, if the relationship between physician and patient were reduced to a commercial contract without something intangible, but significantly valuable, forfeited. First, the concept of contract reduces the element of giving in human relationships and significantly shifts the mindset away from caring and care giving. It suppresses the impetus to see or understand the patient as a whole person and in the end is destructive to the perceived need for respect for patients as persons. Contractualism allows doctors to treat patients as diseases provided they are successful at healing or curing them.

Consider, however, the predominance of chronic diseases that can be treated, but never cured. Diseases that require on-going care and place demands upon physicians require they become personally invested in the life and health of their patients. Treating chronic disease also requires understanding, empathy, commitment and trust. These are the situations in which patient-centered care flourishes. Contracts do not assure that any of these needs are met, nor is there an obligation to even acknowledge any responsibility, unless it is spelled out in the terms of the agreement.

May criticizes the contractualist approach to professional behavior for falling into the error of minimalism. It reduces physician behavior to a give and take: do no more for your patients than what the contract calls for; perform specified services for certain fees and no more. The commercial contract is useful in many of the areas of daily commerce. The existence of a legally enforceable agreement in

professional transactions may also be useful to protect the patient or client against the physician or lawyer whose services fall below a minimal standard (May, *The Physician's Covenant*, 119). It would be wrong, however, to reduce physician obligation to the specifics of a contract alone. It seems wrong for the duties and obligations of doctors to humanity to be contractualized. Medical practice cannot be reduced to human commerce.

Contract and covenant both include an exchange and an agreement between parties. But, in spirit, contract and covenant are quite different. Contracts are external; covenants are internal to the parties involved. Contracts are signed with the intention of being expeditiously carried out to the letter. Covenants have an implied promissory nature that engenders trust and grows relationships between persons. The development of relations of trust cannot be specified or guaranteed. Covenantal relationships nourish rather than limit human dignity, respect, responsibility and ultimately autonomy.

May, in *Theological Analyses Of The Clinical Encounter* (1994), argues that the idea of a covenant with God serves as a critical standard for all lesser covenants that people enter into. As the commitment to the patient in the therapeutic relation, it enjoins physicians to never turn away from the stranger and the needy. The medical covenant emphasizes moral theory grounded in both obligations and virtues. In this relationship emphasis is placed upon the physician as moral agent, the agent's action and the result of that action. Covenantal fidelity by the physician defines the ruling principle as respect for persons. This can be extended beyond the primary person-centered relationship of doctor and patient and Ramsey rigorously applies this principle to issues as far-reaching as abortion, organ transplantation, genetic engineering, in-vitro fertilization and all forms of high-risk therapy.

Practicing medicine is identified as a life commitment to a common good that is centered on the respect for humanity and its dignity in the form of persons each deserving the care-giver's utmost efforts to serve and to go the extra mile even if her relationship with these persons is more metaphysically symbolic than empirically real. This somewhat paradoxical assertion indicates that, in addition to being covenantally committed to patients that they know (and perhaps know well),

physicians are also (and equally) committed to the patient who is an empirical and moral stranger in need of their care. Such medical care is delivered hundreds of thousands of times a day in Emergency Departments, Walk-in Clinics, ICU transfers from other hospitals by helicopter and patients brought by ambulance or helicopter for life-saving organ transplantation.

Each of these situations has in common the fact that this physician is meeting (or encountering in the case of unconsciousness) this patient for the very first time, with little, if any, time to establish much more than an introduction and certainly not time to establish a proper patient-doctor relationship. Nonetheless, physicians who are dedicated to these areas of medical care, care just as deeply for these “unknown persons” as they would if they were neighbors, long standing patients or friends. Non-medical persons, in attempting to grasp and understand (believe) that this kind of commitment is a daily occurrence in the lives of these doctors, are met with incredulity. Yet it is all too true. Such behavior does not qualify as heroism. Such actions are not ones of supererogation. These doctors and countless other physicians in many fields of medical practice do exhibit what I contend qualifies as “good samaritanism.” Such actions clearly go above and beyond the requirements of contract.

Most medical practitioners have forgone family gatherings and missed or been called away from holidays, birthdays and anniversaries to meet the needs of a fellow human being in distress and for whom they have received “the call.” Those who wish to criticize the loss of this human element in the minds and hearts of today’s physicians and argue that they are now driven by greed do not have a large enough “sample size.” The only other humanist calling that I would place in this category is that of fireman. There are striking similarities, for both professions are constantly putting out fires, especially after hours, in the middle of the night or on weekends and therefore doing so with a skeleton crew.

It is this profound sense of, and commitment to, caring respect that practicing doctors have for humanity that suggests a special moral status of “being called.” This “covenant with suffering humanity” is unlike the *explicit* “social contract” often referred to by moral philosophers when

justifying the moral authority of governments. Cruess and Cruess propose that the notion of *implicit* covenant is a useful device for understanding the moral obligations inherent in the practice of medicine. (Expectations And Obligations: Professionalism And Medicine's Social Contract With Society. Perspectives in Biol Med. 2008; 51:579–598).

Such moral duties begin with the assertion that physicians have a special moral obligation (*qua* physician) to refrain from acting out of self-interest. Beyond the psychological appeal of a caring physician, doctors ought to have caring concern for their patients as persons in addition to having concern for their well-being in order to be trustworthy. Caring is a preventative against the ethical danger of making clinical judgments that reflect self-interest rather than patient interest and also protects against the moral hazard of finding good excuses rather than doing what one should. “Patients need to believe that their doctors are acting from care rather than selfishness” (Rosamund Rhodes, 1995).

Physicians must recognize that the particular vulnerabilities of patients that accompany illness are unlike those encountered in any other personal or professional interaction (with the exception of clergy). These vulnerabilities demand a special set of moral duties for medicine. This implicit covenant and these stringent moral duties for medicine are different and special by the degree of accountability and responsibility rather than different in kind.

After all, we also have societal expectations of factory workers and gas station attendants. Does their implicit covenant to work in factories and at gas stations imply a moral duty for them to refrain, for instance, from striking? Few would take this implausible position. If medicine's implicit agreement or covenant has such special moral implications (that going on strike would be tantamount to patient abandonment), we need no further evidence that this differentiation is valid.

Unlike the contractual model, covenantal ethics places the services of the physician in the realm of personal commitment rather than contractual agreement. The contract model has a tendency to see the doctor-patient exchange simply as a commercial exchange of services for goods. Covenantal

ethics, unlike a contract, often requires a doctor to be available to the patient over and above the measure of self-interest. Therefore the covenant has a significant element of caring and concern in it. The physician's commitment is responsive to and is guided by the needs of the patient. Sacrifices are clearly there on the part of the physician, but it is thought of as an opportunity to serve, rather than a sacrifice. Caring service to others in need actualizes Kantian respect.

The contractual model of the physician-patient relationship does serious damage to the likelihood that this notion of a voluntary "opportunity to serve" would be embraced by the physician in the way that covenant specifies. The kind of minimalism encouraged by a contractualist understanding of the 'professional' relationship produces a physician attitude toward one's legally and externally prescribed duty that is grudging, calculating (of one's own self-interests) and lacking in compassion, empathy and spontaneity. This 'arm's length model' dis-incentivizes physician humanism, which is then too quickly exhausted to go the extra mile with her patients along the road of their distress.

The Contractual Model and 'Defensive Medicine'

"Contract medicine not only encourages minimalism, it also provokes a peculiar kind of maximalism, the name for which is 'defensive medicine'" (*The Physician's Covenant*, 122).

Particularly, under the pressure (or perceived threat) of malpractice suits doctors are tempted to order too many examinations and procedures for self-protection and this mind-set is simultaneously self-enriching. This is due to the all too common situation in which being 'overly cautious' actually generates more physician income.

Contractualism simultaneously tempts the physician to do both too little and too much for the patient. The doctor is tempted to extend herself only to the limit of what is specified in the contract. At the same time, however, she is also tempted to excessively order procedures that are merely useful in protecting herself as the contractor against litigation. She may order them even though the procedures are not fully indicated by the condition of the patient. The link between these apparently contradictory

strategies of too little and too much is that the emphasis in contractual decisions is grounded in self-interest.

Two additional objections to contractualism can be briefly summarized. A self-regulating mechanism in the traditional contractual relationship is the freedom and opportunity to shop for both price and quality among various vendors of services. This freedom of choice would have to be greatly expanded for the patient by an increased number of physicians in a given locale providing similar services and who were essentially “in competition” for patients. The crisis circumstances under which medical services are often needed and delivered, however, do not always provide the consumer with the kind of leisure or calm required for discretionary judgment. Thus normal marketplace controls cannot be fully relied upon to protect the consumer in dealings with the physician.

For the second objection, medical ethics should not be reduced to the contractual relationship alone. Contract fails to hold the more powerful physician to a “higher” standard. Normally conceived, ethics establishes certain rights and duties that transcend the particulars of a given agreement. The justice of any specific contract may then be measured by these standards. If, however, such rights and duties adhere only to the letter of the contract, then a patient might legitimately be persuaded to waive his rights. The contract would solely determine what is required and permissible. An ethical principle should not be able to be waived (except to give way to a higher ethical principle). Medical ethics should not be so defined as to permit a physician to persuade a patient to waive rights that transcend the particulars of their agreement (*ibid*, p. 124).

Covenantal Commitment and Injustice to the Obligations Owed to Others

What limits ought to be placed on the demands of an excessively dependent patient? Another parallel question is, at what point does the keeping of one's covenant to a particular patient produce an injustice to the obligations owed to others? These questions help us avoid deluding ourselves about the

power of “covenants” and sentimentally retire to the comfort of this ethical notion. Some objective reference point is required by which covenants and contracts are both justified and measured.

In both the contractual model and the covenantal model the patient is asked to become a more active participant, both in the prevention and the healing process of treating the patient’s disease. She must bring to the partnership a will to life and a will to health. Patients thus engaged in such a covenant are more likely to be personally committed to the relationship and I argue are more likely willing to be counted on to follow physician advice, faithfully take prescriptions and so forth. The trust a physician can place in her patient at hand, frees her up to attend to the needs of those countless others to whom she is also covenantally interrelated. Can the same be even hoped for in a contractual arrangement (unless explicitly stated in the contract)? It seems to me unlikely that there could be enough personal “buy-in” by patients, even if spelled out in bold upper case letters.

Another advantage of the concept of covenant is that it is not so restrictively personal a term as parent or friend. It reminds the physician, as well as the community, that it is not good enough for the individual doctor to be a good friend or parent to the patient. It is also important for institutions such as the hospital, the clinic or the professional group to keep covenant with those who seek their assistance and sanctuary. The concept therefore permits a certain broadening of accountability beyond personal agency.

Simultaneously, the notion of covenant permits setting medical/moral responsibility of physicians for health-care within social limits. The covenant concerning health should be situated within a larger set of covenantal obligations that both the doctor and patient have towards other institutions and priorities within the society at large. Conversely, the traditional doctor-patient relationship as parent or friend tends to establish an exclusivity of relationship that obscures those larger responsibilities.

Paul Ramsey and *The Patient as Person*

Paul Ramsey published his 1970 book, *The Patient as Person* prior to the appointment of the National Commission or the publication of The Belmont Report. *The Patient as Person*, based on Ramsey's Lyman Beecher Lectures on Medical Ethics at Yale University in 1969, contains seven chapters on some of the issues arising from new options made possible by medical progress: the meaning of consent in human experimentation; the confusion regarding the meaning of death; the ethical limits upon caring for the dying in the context of increasing technical ability to save life; the giving and taking of vital organs; the distinction between heart transplantation as an experimental and a therapeutic treatment; and the problem of choosing patients to receive scarce and vital resources.

Ramsey's work has implications for many other collateral problems that can be addressed by the covenantal model in biomedical ethics. The key ingredients in the notion of covenant for him are promises and fidelity to promises as well as to truth-telling. This book is an extended reflection upon what respect means in the concrete situations medicine confronts. Ramsey provided an account of "respect" that bridges the historical gap with regard to respect, duty and human dignity in medicine between Kant and the 20th Century. In fact, his ideas are very reminiscent of Kant's and Ramsey was deeply informed by Kantian sensibilities.

According to Stanley Hauerwas, Ramsey knew that the term "person" would evoke Kant's notion that persons are to be respected and he made clear very early on that respect connotes primarily protection ("How Christian Ethics Became Medical Ethics: The Case of Paul Ramsey; *Wilderness Wanderings*, 1997, 124-40). Paul Ramsey and his landmark book are considered by many to mark the official beginning of the field of bioethics. Ramsey, without ever articulating it as a principle or referring to it as respect for persons, provides us with a substantive account of "respect," before it "re-emerged" in contemporary medical ethics from its Kantian "moth-balls."

Ramsey rooted his understanding of respect in what he believed to be the fundamental nature of human relationality, namely covenant. Inalienably relational from the first moment of existence, humans for Ramsey come into being and are sustained within networks of covenants. Ramsey was a theologian and utilizes the Hebrew term *hesed* and the Christian term *agape* rather than respect, though he viewed them as interchangeable.

In the Hebrew Scriptures, *hesed* refers to a sort of love that has been promised and is owed—covenant love—as in Hosea 1:1. *Hesed* does not suggest some kind of generic love of everyone. Covenantal love is given within the context of a relationship where it is already promised and where the recipient is commanded to respond in kind. Covenant love is neither optional nor unconditional; it is obligatory. *Hesed* is compelled or commanded and *hesed* translated as “love” does not refer primarily to feelings but to decisions of the will.

Agape is said to be a love that God has for humankind in general. The term differs from *hesed* in that it does not refer to a love already promised to a specific group of people. *Agape* is also used for love shared and expressed between human beings. *Agape* is not just a covenant love owed to a particular person or group with whom one is in a committed relationship. *Agape* often refers to a more unconditional, even self-sacrificial love. It goes well beyond “love your neighbor as yourself.” It is often bestowed on the unloved and the unlovely. It is an undeserved and unmerited benefit or favor bestowed on someone or upon humanity.

Though in less theological terms, Kant equally spoke of the distinction between God’s holy will and humanity’s good will. Covenant in Ramsey’s conception promises fidelity, care, presence, and sustenance. His conception of the physician-patient relationship also acknowledges the inherent inequalities between physician and patient that amplify the level and moral commitment of physicians to their patients.

Kant recognized that all human beings were vastly unequal to God’s holy will. In the *Groundwork*, he argued that it was this imperfection of the human will that generated the need for

earthly rational creatures to recognize and embrace their need for these duties and obligations, guided by a moral imperative, in order to rationally actualize their freedom from the causal influences of their human nature.

Covenant grounds what Ramsey believed one person owes another. He used a wide array of secular and theological terms to describe the considerations shaping our working notion of person-to-person relationships and in the following quote, it is clear that Ramsey believed that a whole host of related, but distinguishable, terms are needed to capture the combination of attitudes and obligations encompassed by covenant:

The practice of medicine is one such covenant. *Justice, fairness, righteousness, faithfulness, canons of loyalty, the sanctity of life, hesed, agape and charity* are some of the names given to the moral quality of attitude and of action owed to all men by any man who steps into covenant with another... (1970, p.iii).

These italicized terms function, as Ramsey's analyses unfold, as specifications of the notion of respect. He uses these terms in places where one might expect to find respect to be the term of choice. An example of the latter would be his discussion of informed consent in the research situation.

To conceive medical ethics in covenantal terms places the person as patient at the center of medicine's moral life. Above all else, covenant defines the moral life as relational. Moral action (such as respecting, caring or giving) is best conceived as responsive to the needs of either one's self or of others. In this sense, covenant appropriately describes the doctor-patient relation. Both Ramsey and May drew upon this model in developing their notion of the commitment and promise at the center of the interrelationship of physician and patient.

Ramsey has noted that the moral commitment of the physician is not to treat diseases, or populations, or the human race, but the immediate patient before him or her (Ramsey, 36, 59). The patient as person, however, is situated in a social environment subsumed under a broadly understood moral community of all of humanity. Ramsey uses the notion of person to protect the individual patient against the temptation of physician researchers, especially in experimental medicine, to use one patient for the good of another or society.

Without the presumption of the inviolability of the “person,” Ramsey thinks that we would have no basis for “informed consent” as the controlling criterion for medical therapy and experimentation. Moreover, it is only on this basis that doctors rightly see that their task is not to cure diseases, but rather to cure the person who happens to be subject to a disease. Thus, the notion of “person” functions for Ramsey as a Kantian or deontological check on what he suspects is the utilitarian bias of modern medicine.

According to Ramsey, the major issue of medical ethics is how to reconcile the welfare of the individual with the welfare of humankind when both must be served. Ramsey argues that it is necessary to emphasize the personhood of the patient in order to remind doctors or experimenters that their first responsibility is to their immediate patient, not humankind or even the patient’s family. Thus, Ramsey’s emphasis on “person” is an attempt to provide the basis for what he takes to be the central ethical commitment of medicine, namely, that no one will be used as a means for the good of another. Medicine can serve humankind only as it does so through serving the individual patient.

Ramsey’s substantive account of respect for persons intentionally included individuals (patients) with compromised or non-existent autonomy under the “big-tent” of personhood. He made clear very early on in his book that respect connotes primarily protection. The term’s first appearance in his text noted: “We should ask, what are the moral claims upon us in crucial medical situations and human relations in which some decision must be made about how to show respect for, protect, preserve, and honor the life of a fellow man?” (1970, p. xiii) Again and again, Ramsey linked respect with protection, service and care (pp. 168, 191,193).

In a similar vein, Edmund Pellegrino (a physician and ethicist) argued persuasively that medicine is itself a moral community of healers and care-givers along with the extensive support staff necessary to carry out the mammoth task of delivering modern medical care. Individual patients, upon entry into the medical system, become members of this moral community as well. Consequently, the

appropriate starting place may be to ask what kind(s) of community(ies) is/are necessary to sustain the long-term care of the ill.

For Ramsey, respect is a duty, the fulfillment of which demands multiple interrelated modes of responsiveness to the unique, irreducible worth of the person, a worth affirmed not only in honoring the individual and deferring to his wishes, but also in tending to his needs and caring for him. His understanding of respect can be derived from the sorts of actions he enjoins and more importantly what he believes violates the relationship between persons. Ramsey drew an even clearer line than Belmont on the question of nontherapeutic research on children.

Nontherapeutic research on a human being who cannot consent to take a risk for others is not only to act disrespectfully—it is to violate the duty to be loyal, faithful, and loving. Likewise, for physicians to abandon the dying is to violate their covenant with the patient as well as the categorical imperative (1970, p. 153). Although theologically grounded, respect, Ramsey continued, “means to treat human life with ‘holy awe.’” This robust account of respect reflects the expressions we read in Kant, both regarding the moral law itself and the dignity of humanity, with value beyond price. The most elegant statement regarding his account of respect Ramsey drew from Karl Barth:

Respect is man’s astonishment, humility and awe at a fact in which he meets something superior—majesty, dignity, holiness a mystery which compels him to withdraw and keep his distance, to handle it modestly, circumspectly and carefully... he is faced by a majestic, dignified, and holy fact. In human life itself, he meets something superior...(1969, p.106).

Ramsey sought (as I do) to include individual patients with compromised or non-existent autonomy under the umbrella of personhood.

The sanctity of this relationship, when properly grasped and executed by caring doctors, results in two key benefits to patients. Not only does the covenantal model for the therapeutic relationship actualize the proper level of respect for those patients with whom the doctor has a long-standing relationship, but it also applies with equal moral force in the treatment and caring for a previously unknown patient. Covenantal caring can be instituted by the physician from the very first encounter she has with a new patient.

This is increasingly important as medicine has moved out of the domain of the familiar and loved family physician, into the arena of highly specialized, but unknown doctors, perhaps hundreds of miles from the patients home. Such physicians, upon accepting the patient in transfer or by referral, must step in and immediately engender that same level of trust by the patient that he has in his known and trusted family doctor. This trust is essential if this “specialist” is to establish the willingness of these patients to “turn over” their care to a stranger, often in an unfamiliar and seemingly hostile environment, no matter how well-respected or highly recommended she comes.

An example of this scenario would be a tertiary care (major medical center) physician’s discussion of informed consent in the research situation. The patient has been referred for potential life-saving therapy, unavailable except through a research protocol. This doctor may clearly acknowledge that the moral requirement of informed consent is “expressive of the respect for the man who is his (her) possible subject in medical investigations” (1970, p.8). Ramsey describes this physician duty, by virtue of his character and commitment to the tenets of medicine, as also alternatively understanding the meaning of informed consent “as a canon of loyalty expressive of the faithfulness-claims of persons in medical care and investigation” (1970, p.10).

In fact, if the contemporary understanding of informed-consent, as understood by this ‘enlightened’ contemporary physician, were informed by Ramsey’s conception of it (as describing a thick and robust understanding of the human covenantal relationship in medical care), it would continue to carry a decidedly moral and Kantian implication. Grounded in this way, the doctrine of informed consent might not have devolved into a legalistic one.

The willingness to be present with the ill is no special or extraordinary activity, but a form of the human obligation to be present to one another in and out of pain. Moreover, it is from Kant’s perspective rational beings should be creatures who have learned how to be present with those in pain without that pain driving them further apart. In a truly Kantian world, the covenant between doctors and patients should be no different than that in all human relationships.

Transcending the ‘more apparent than real’ pluralisms in our society and our world is theoretically possible and a worthy goal for a just society. Unlike the rest of society, which is able to agree to disagree, to respect liberty as an arms length *modus vivendi* and to exist (and even thrive) in the face of moral disagreement are not options for medicine. Medicine requires a univocal commitment to respect all patients as persons and to place the patient first, above any personal self-interest. This is required at all levels, not just in the patient-centered, covenantal relationship, but also at the level of administrators, hospitals, insurance companies and state and federal regulators. This is not to argue that it has been achieved, only that it is required.

Covenantal Fidelity, Truth-telling and Performative Speech

In his seminar, Philosophy of Language, Vanderbilt professor Jose Medina insightfully clarified the philosopher J. I. Austin’s important distinction between two kinds of speech: ‘descriptive’ and ‘performative’ utterances. In ordinary declarative or descriptive sentences, one describes a given item within the world. (It is raining. The tumor is malignant. The crisis is past.) In performative utterances, one does not merely describe a world, but in effect, one alters the world by introducing an ingredient that would not be there apart from the utterance. Promises are such performative utterances. (I, John, take thee, Mary. We will defend your country in case of attack. I will not abandon you.) To make or to go back on a promise is a very solemn matter precisely because a promise is world-altering and promises kept are trust-building.

In the field of medical ethics, the question of truth-telling has tended to be discussed entirely as a question of descriptive speech. Should the doctor, as technician, tell the patient he has a malignancy or not? If not, may she lie or must she merely withhold the truth? Viewed from this perspective, the question is a matter of rights (patients have a right to the truth) and is juridical (I may be legally punished for failing to honor this patient right).

The distinction between descriptive and performative speech expands the question of the truth in medical practice. The doctor, after all, not only tells descriptive truths, she also makes or implies promises. Promises are performative utterances and as such one is not merely describing a relationship, but one is committing to certain very specific behaviors. *I will defend you. I will take care of and care for you. Despite the fact that I cannot cure you, I will not abandon you.* In short, the moral question for the doctor is not simply a question of telling truths, but of being true to her promises to respect you as a person and honor the covenant that exists between her and you.

In medical ethics, the question of truth telling has tended to be discussed entirely as a matter of descriptive speech, when in reality it too is performative. It is not nearly enough to tell the truth in so far as telling a patient that he has a diagnosis of malignancy. The total situation in this covenantal relationship includes the descriptive telling of what the problem is and what the potential treatment options are, but it also includes the performative requirement of committing oneself to treating his condition and not abandoning him even if he cannot be cured. The moral question for the doctor is far more than telling the truth for it is also being true to her promises. The fidelity of the physician will not eliminate the disease, but it affects the human context in which the disease runs its course. What the doctor has to offer his patient is not simply proficiency but fidelity. Perhaps more patients could accept the descriptive truth if they experienced the performative truth. Perhaps also they would be more inclined to believe in the doctor's performative utterances if they were not handed false diagnoses or false promises. "This is why a cautiously wise medieval physician once advised his colleagues: Promise only fidelity!" (Ramsey, p.143)

Covenantal fidelity to the patient remains unrealized if it is not coupled with medical proficiency. While it is important for human beings to be present to one another, it is not alone sufficient and in crisis, the ill person needs not simply presence, but clinical skill. The patient requires not only personal concern, but also highly disciplined medical services targeted to the specific illness of the patient. Covenant does not completely and inclusively satisfy the needs for a physician-patient

model in that, in circumstances of a physician's failure to live up to her professed duty, there remains a legal recourse to seek redress for such failure outside of the internal disciplinary regulation of medicine. One ought not to be dependent entirely upon disciplinary measures undertaken within a covenantal profession.

Because the contractual model reduces medical ethics to contract alone, it incurs the danger of minimalism (as previously discussed). Patients, on the other hand, legally have recourse against those physicians who fail to meet minimum standards. There ought to be appeal to the law in cases of malpractice and for breach of contract explicit or implicit within the covenantal model as well. I am arguing, however, that the instrument of contract and other avenues of legal redress can be sustained only by a physician's personal sense of obligation to the patient that involves a covenantal orientation. This is primarily because there are too many possibilities for breach of contract, under the contractual model, that may easily go undetected.

In the case of an injustice a legal appeal cannot be sustained without assistance and testimony from physicians who take their obligations to patients seriously. If, in such cases, fellow physicians simply band together and protect their colleague like an endangered species, the patient with just cause is not likely to get far. Thus the instrument of contract and other avenues of legal redress can be sustained only by a moral sense of obligation to the patient as a person that is encompassed by the concept of respect. Needless to say, it would be better for all concerned if discipline internal to medicine and continuing education were so vigorously pursued that it cut down drastically the number of cases that needed to reach the courts.

Covenantal fidelity includes the obligation to become technically proficient (and to remain so through continuing education); it reinforces the legal duty to meet the minimum terms of contract, but it also requires much more. The moral feelings of empathy and caring concern are grounded in the 'respect' that caregivers hold for patients as persons (irrespective of patient functional autonomy or moral agency). Such relationships cannot be based upon contracts but are rather based upon trust. In

short, the contract model is hardly enough to describe the paradigm of trust between doctor and patient, considering its limited applicability, but, interestingly, “it is enough to govern managed care” (Jacobson 2002).

Medicine, however, is obviously more than a business with self-interests protected by contract, for beneficence remains as a needed principle for the clinical encounter, especially in situations where the patient lacks the capacity for moral agency and needs to have his well-being protected. Here the covenantal character of medicine is prominently displayed. We normally think of such responsibility as exclusively serving the patient’s interests, that is, doctors act in accordance with the ends of medicine to relieve suffering and effect cures and this is broadly regarded as a good. Because the values of the physician do not always coincide with those of the patient, there remains the possibility for disagreement regarding the solutions offered. Whether they reflect the best options in a particular case in the setting of the covenantal model has been a continuing debate.

Patient autonomy is used to trump physician values in determining critical choices when conflict arises. So in a simple way we think of physician responsibility in terms of service to the patient, but the inequality of that relationship is balanced by a counter principle of patient independence and free choice. Beneficence is limited by patient autonomy in the covenant model; while in the contract model, beneficence is absent.

The contract model is not dependent upon trust nor does it promote trust. It is not about whom one trusts but merely about what is entrusted. Because contracts are part of a legal system that is designed to define services and limit liabilities, they are, in this way, a substitute for trust. Contracts elicit promises that reflect no human kindness (Hume 1739); they show the limits of trust, not its full character.

Trust, in more intimate settings such as covenantal relationships, is implicit and often remains unarticulated. Trust also, in fact, must adapt to social challenges and reflect our deepest moral obligation toward another. In this way, medicine becomes an exemplar of trust. When trust fails or is

denied, the doctor-patient relationship loses its moral bearings and resorts to a contract that hardly suffices to describe the trust that must ground the healing relationship.

The model of the physician patient relationship as a covenant, apart from all other proposed models, insists that physicians must teach their patients. The contract model, for instance, clearly exhibits agnosticism towards the physician's teaching function. Paternalist models emphasize compassionate care and benevolent decision-making rather than the time-consuming and often frustrating requirement for candid instruction.

May observed that the milieu in which medical education takes place does not promote a high regard for patients:

The location of many teaching hospitals and residency training programs in the inner city tends further to convince young professionals that preventive medicine and the teaching it requires are activities of low yield. Residents complain that patients often come in only when their diseases flare... destructive habits so grip the patient as to make rehabilitation and more stable chronic care difficult to sustain. After treatment, patients go back into the streets and fall into the same injurious habits again. They forget appointments and they do not comply with a regimen. Patients will say, "I don't know what medicines I take. It is in the chart. Read the chart." But the resident knows that the chart only records what the physician prescribed, not what the patient is taking, if anything. Further, patients fear the truth or fail to assimilate it, or accept it but selectively. Some pounce on the bad news and panic; others dissolve the bad news in a blurry confusion and ignore the importance of compliance...thus, early in their education physicians come to expect very little from patients...Cynicism, despair and sometimes resentment infect the exhausted resident. And yet – even parentalism offers some moral warrant for teaching one's patients. The parent, after all, is committed to the being and well-being of the child, and the good parent recognizes education as an important ingredient in the child's flourishing. The main thrust of the image, however, condescends too much to encourage persistent teaching. (*The Physician's Covenant*, p. 146).

To the extent that medical practitioners view themselves as only contractors dispensing medical services, they will also downplay the role of teaching among their duties to the patient. "Contracted for and paid on a piecework basis, whether by the consumer personally or by third-party payment systems, the doctor offers discrete, itemizable services," rather than taking responsibility for the patients improvement in self-care and health maintenance (ibid, p.146).

Teaching takes time; it reduces the number of patients the physician can see; it complicates the question of patient management and exposes the physician to the possibility of making personal as well as technical errors. Both the sub-specialist and the family doctor can drop back from teaching the

patient – the sub-specialist offering encoded information to the attending physician and the attending family physician sometimes renege on the task by defining himself or herself chiefly as the orchestrator of technical services. And yet, the contractualist model does retain a fragment of the teaching responsibility, to the degree that the seller of services accepts responsibility to inform the buyer about the services and the product offered for sale. This sub-optimal relationship has quickly devolved into one that is clearly pathologic. The motivations and the goals, on both sides of the contract, have become so distorted that all one can conclude is that today's medicine is in an awful mess.

The economics of medicine and the structure of medical education reinforce the propensity of doctors to neglect patient teaching. The current third-party payer system in America, including Medicare, remunerates physicians on the basis of relative value units (RVU's) that are assigned to various clinical services and procedures. This discrete breakdown of physician payment does not foster and promote either relationship building or patient education. RVU's are not assigned to either of these physician activities. The failure of payers to recognize or attribute value to these activities leads physicians, functioning under the contract model, to allocate as little of their time to these pursuits as is necessary to obtain informed consent.

Our scientifically and technologically advanced medical knowledge points to an understanding of human disease as a process, rather than episodic. For example, heart attacks were once considered sudden random and unpredictable events. Our modern understanding of the progressive nature of coronary atherosclerosis and the many factors that contribute to (or might retard) this progression occur long before symptoms of cardiac disease develop. Understanding the progressive nature of this disorder and the most relevant and reversible risk factors makes a powerful argument of the need for an interpersonal and collaborative relationship as I have been developing. Within a covenant of trust, the doctor must function as her patient's advocate by collecting the necessary data (such as blood pressure, blood sugar, cholesterol level, family and tobacco history and so forth) and equally as a

teacher, sharing this information and its meaning to the patient in terms of cardiac risk. This shared information must then be followed by an understandable regimen of medications, as well as engaging her patient to buy into the concept of reversible risk factors and become self-motivated to begin behavioral modification (exercise, diet, blood pressure monitoring, smoking cessation and so forth). Only through engaging their patients in a relational and collaborative manner can physicians, as educators as well as care-givers, truly foster and promote functional autonomy and thereby fully respect their patients as persons.

Conclusion

The distinction I have drawn between Covenant and Contract has been argued by some (notably Veatch) to be more symbolic than real. The reference to these models as ‘metaphors’ for the doctor-patient relation might also be cited as providing evidence that such notions are more attitudinal or dispositional than substantive. I have argued that these differences are not only substantive and real, but squarely address an ever-increasing challenge faced by currently practicing and young practitioners-to-be to remain true to the commitments they have made to their patients, to their moral community and to themselves.

The rapidity of the sweeping changes in medicine, as a science, are being addressed with changing curricula in medical schools and innovations in training residents and fellows in the latest diagnostic and therapeutic procedures. The changes in the modes of delivery of healthcare and the impact of governmental, institutional and societal demands upon physicians entering practice are not being adequately addressed.

Traditional attitudes and dispositions continue to be passed on through the same old “hidden curriculum” that has pervaded institutions of higher medical education since I was a medical student 40 years ago. Accelerating changes in the way medicine is and will have to be practiced are not being recognized, communicated or reckoned with by academic medicine to the detriment of doctors in

training. New ways of educating trainees and young physicians about how they should think about, understand, regard and behave toward their patients are required for them to be equipped to handle the plethora of obstacles being erected to keep them from developing the kind of covenantal relationships I have been writing about.

It is crucial that the model relationship for medicine and medical education bears no resemblance to an arms-length contract grounded in self-interest which undermines the goal of restoring patients' trust and promoting mutual respect. The focus of a physician-patient relationship model should not be on how much authority either party should have in the relationship; rather, the focus should be on how physicians can cultivate a relationship best able to achieve the health-related goal most appropriate to that particular patient, while ensuring that the values and interests of the patient and the personal and ethical integrity of the physician are respected.

Physicians (and medicine generally) need to adopt the covenantal relationship of trust as well as respect for persons as the grounding principle of the ethics of medicine. Care-based, patient-centered relationships can best actualize this respect. The efforts of medical practitioners to enter into covenants with their patients must also be supported by the continuing societal commitment to the value of the doctor patient relationship as central to providing optimal medical care within the broader scope of socially responsible health care delivery. Only through the prism of this reciprocal trust, obligation and caring, can the continued recognition of the dignity of humanity in medicine remain inviolate.

CHAPTER 6

CARING, RESPECT AND CARING-RESPECT: THE SYNTHESIS OF THE UNIVERSAL AND PARTICULAR ASPECTS OF MEDICINE

Caring epitomizes the particularization of the foundational conception of respect in medicine and characterizes, in practical, comprehensible and actualizable terms, the commitment of physicians to individual patients as persons. This conception of medical practice also reflects an understanding that the medical responsibility of doctors is directed by the unique life situation of each person for whom they provide care. It is only with the moral disposition of caring-respect that physicians can come to understand that their task is not merely to cure disease, but rather to care for and cure the person who is afflicted by and suffering from illness. The moral centrality of persons serves as a check on the contemporary utilitarian bias in modern medicine that is oriented toward assessing the overall quality of medical care based upon epidemiologic data on the health of our society, rather than upon the health and well-being of particular persons.

In arguing for respect for persons as the ground of the *prima facie*, contingent moral principles in medicine, I remain aware that critics continue to view respect as too general and abstract to be practically (clinically) useful. I am also concerned that multiple competing understandings of respect pose a challenge to presenting moral respect for patients as a commitment made by individual practitioners to each particular individual who is undergoing medical care. Respect is an integral aspect of the ethics of medicine, yet it has often been over-looked or dismissed in medical ethical writing and discourse, being judged as obligating physicians to vague and ill defined entailments in the setting of patient care where they must provide the kind of moral direction I am arguing for.

Hence I have built a case for redefining respect in terms of caring, particularizing it to specific clinical situations in order to empower physicians to access their ‘moral feelings’ and apply caring-respect to do the moral work I have been asking respect for persons to do.

From the outset I have been relating concepts of care, caring and caringness to respect because caring humanizes it in terms more readily translated into physician duty and action. In this process I have encountered feminist and ethics of care theories with viewpoints that are, in some measure, antithetical to mine. This arises primarily in their overt dismissal of Kant's ethics and moral duties as an ethics of male dominance, rugged individualism and chauvinism.

This feminist backlash rejects society's historical normative grounding in justice and freedom because it supports continued male domination. The feminist ethics's emphasis upon relationships of caring were first articulated by psychologist Carol Gilligan in her 1982 book, *In a Different Voice* in which she argues that, "The relational bias in women's thinking that has, in the past, been seen to compromise their moral judgment and impede their development now begins to emerge in a new developmental light. Instead of being seen as a developmental deficiency, this bias appears to reflect a different social and moral understanding."

Care ethics proponents have rightfully complained that attempting to apply principles directly to medical cases had already excluded what Gilligan has called the 'dimension of care.' An extension of Gilligan's position to medical ethics challenged the assumption, tacitly held by most mainstream medical ethical theories, that the norm of justice provides an adequate framework for representing both the moral dimensions of health care and the moral competencies of health care providers.

After conducting interviews with female university students and studying the work on moral development of fellow psychologist Lawrence Kohlberg done exclusively with male subjects, Gilligan arrived at these conclusions:

The moral imperative that emerges repeatedly in interviews with women is an injunction to care, a responsibility to discern and alleviate the 'real and recognizable trouble' of this world. For men, the moral imperative appears rather as an injunction to respect the rights of others and thus to protect from interference the rights to life and self-fulfillment. Women's insistence on care is at first self-critical rather than self-protective, while men initially conceive obligation to others negatively in terms of noninterference. Development for both sexes would therefore seem to entail an integration of rights and responsibilities through the discovery of the complementarity of these disparate views.

I have previously voiced my objection to the principlist assumption that the norm of justice provides an adequate framework for representing the moral dimensions and to the principled-approach of directly applying principles in a top-down fashion to medical cases in my critique of Beauchamp and Childress in Chapter 4. Their approach has resulted in a rights-based model of healthcare and an understanding of autonomy as non-interference.

In evaluating the feminist ethics of care literature I sought points of confluence with my conception of respect. I also explored whether care ethicists would be more receptive to a notion of caring respect than they had been to caring justice. One striking difference I observed in the methodology of care ethicists from mainline contemporary bioethics was that, rather than addressing care ethics to the principled resolution of moral quandaries, the perspective of care highlighted the rudimentary moral skills (caring skills such as kindness, sensitivity, attentiveness, tact, honesty, patience, reliability, etc.) that guide us in our relationships with particular patients. Care ethicists share the following beliefs of the theory as basic:

Persons are understood to have varying degrees of dependence and interdependence on one another. This is in contrast to deontological and consequentialist theories that tend to view persons as having independent interests and interactions.

Those particularly vulnerable to one's choices and their outcomes deserve extra consideration to be measured according to their vulnerability to one's choices.

It is necessary to attend to contextual details of situations in order to safeguard and promote the actual specific interests of those involved.

(Ethics Of Care, 2015, December 13; In Wikipedia, The Free Encyclopedia)

None of these basic tenets conflict with my representation of respect for persons in this project. In fact, from this cursory appraisal of the commitments of care ethicists, in relating respect for persons to medicine and care-giving, my theory of respect for patients in medicine might already be claimed to be an ethics of care. Encouraged by this assessment, I moved forward with the incorporation of care as a more central commitment of my development of a practical, but morally sound, ethics for medicine.

I am thus presenting a synthesized perspective of caring-respect for persons as a natural bridge between the particularity of care and the universality of respect which grounds not only the contingent

principle of justice but all other *prima facie*, mid-level moral principles in medicine. I have found numerous points of confluence and have (I believe) resolved some of the vagaries of the application of respect for persons to concrete individuals and situations by adopting many of the commitments of care theory.

In so doing, however, I also found much in care theory that I take issue with and in this chapter offer a critique and suggestions for its improvement and a grounding of it as a complete moral theory by incorporating respect for persons as a core principle. I am heartened by the number of recent care ethicists who are re-evaluating its relationship to Kantian ethics.

I have supplanted the failed effort at integrating care with impartiality by care ethicists such as Lawrence Blum with the conjunction of care and respect for persons and universalizability. I argue that neither the impartiality of justice nor the partiality of care are foundational principles, either individually or in combination, unless grounded in respect for persons.

The synthetic conception of caring-respect for persons that I have proposed views caring for a person as an important way of showing respect for both her inviolable value in the universal and for her individual value and vulnerability in her particular life circumstances. Unlike the typical understanding of caring in the ethic of care, this is a kind of respect we owe to all persons, not just to our loved ones and friends. Caring-respect recognizes and values the human reality that relationships of caring often involve emotional connections as well as duties of respect. The synthesis of caring and respect broadens morality to encompass not only inner motives but also outward acts, including emotion-expressing acts. A morality of caring-respect is not inclined to draw a sharp distinction between act and motive and allows for a standard of evaluation of actions independent of the evaluation of particular agents.

The core reason for the reformulation of universalist ethics (grounded in respect for persons) to encompass caring rests upon my perceived need for an expansion of the “moral point of view” in medicine. The goal of this endeavor is to broaden our thinking in clinical practice to include greater

emphasis on the anticipated communication with patients with whom we know (as doctors) that we must finally come to some agreement. This means that the ethics of medicine needs to incorporate the ability to practice conversational or communicative ethics, which is fostered by an enhanced inter-connection of caring.

In Kantian ethics, after all, the universalizability procedure of the categorical imperative itself incorporates the willingness to reason from the other's point of view. The universalism of Kant is specified first by his commitment to the equal worth and dignity of every human being in virtue of his or her humanity. The dignity of others as moral individuals is manifest in the respect we must show for their needs, interests, and points of view in our moral deliberations. Moral respect leads us to take the standpoint of the other into consideration. This requires that we accept inter-subjective norms and rules of action governed by respect for all persons, independently of their ability or willingness to reciprocate (Benhabib, 1992). In fact, it is precisely in situations of moral disagreement, or in deliberations in which one or more of those participating in the dialogue is morally perplexed or encounters an unexpected or unfamiliar perspective, that we are motivated to search for moral knowledge in the hope of getting the conclusion of our moral deliberation 'right.'

This scenario is directly encountered frequently in contemporary practice, for it is not uncommon for the physician and patient to be approaching the clinical dilemma from very different frames of reference. For Kant, perplexity bridges the ordinary with the philosophical and remains an important force in thinking critically about objectivity and truth in moral matters (Deligiorgi,K., 2012, *The Scope of Autonomy*, Oxford).

For Kant, the way of validating the correctness and objectivity of our point of view is via the test of universalizability. Kant provided us the resources to consider a notion or an action to be morally objective and, at least in a moral sense, right or wrong, prior to and independent of our choices. Universalizability in Kant's moral theory specifies acceptable forms for the justification of moral principles, judgments and maxims. Kant's first formulation of the categorical imperative offers a

procedural test for universalizing our contingent principles of action. Kant's intention is to specify a model of individual and collective deliberation that imposes constraints upon the kinds of justification leading to certain conclusions rather than specifying the moral domain (including the right and the good).

To be clear, however, the test does not directly confirm for us what is right, for its main function is negative, that is, to determine for us if something is morally permissible or impermissible. Permissibility does not equate with 'right;' it does establish that the first hurdle moral rightness must satisfy has been cleared. If, on the other hand, a contemplated maxim of action fails the test, it is impermissible and morally wrong.

One way to get to the morally right is to examine the opposite of what was just determined to be wrong. We can come even closer to determining moral rightness if we combine this procedure with the positive duties of the formula of humanity through enacting the specified and entailed imperfect duties of respect in the given situation. If the considered choice or action treats all affected persons as ends and not mere means, then any other factors that determine rightness are the particularities of the given context and persons involved and becomes a subjective choice.

Another way of stating this is that universalizability and respecting patients as ends does not dictate specific outcomes; these two formulations constrain the kinds of justification we can use for our actions, judgments, and principles. The procedure of universalizability can also be applied to test the validity of moral judgments, principles, and maxims. Questions of care are moral issues and can also be dealt with from within a universalist standpoint. Such a universalism supplies the constraints within which the morality of care must operate.

The principled vs. the caring orientations to moral understanding in the literature of medical ethics has come to be called the 'justice-care debate.' In my view, the juxtaposition of caring with justice (or partiality with impartiality) produces an unnecessary dichotomy of moral points of view. This dichotomy is much like that of autonomy and beneficence that I have shown to be illusory

provided these competing principles each find their grounding under the foundational conception of respect for persons.

In discussing the ethic of care developed by Gilligan and especially Nel Noddings, I address their misunderstanding of Kant. This proves to not only support my argument for Kantian respect, but also shows how Kant's ethics can actually be understood as the precursor to an ethics of care and caring-respect, rather than the nemesis that these early care theorists represented him to be. In recent years, a number of feminist ethics of care proponents have also gravitated to the renewed interpretation of Kant's ethical theory brought to light by Allen Wood (along with many others) that I have presented in previous chapters and applied to medicine.

The moral standpoint of care that Gilligan espouses arises out of the special nature of the relationships we have with other individuals. This moral standpoint is quite compatible with a physician's moral standpoint in relation to her patient. In medicine, it is this special relationship of covenant that establishes the moral obligation of the physician to provide care and assistance to her patient. This moral obligation is not able to be adequately understood as one grounded in justice and even less accurately as governed by impartiality. From a Kantian point of view, this obligation of physicians would be better construed as one of benevolence. According to Seyla Benhabib,

It has been frequently maintained with respect to Gilligan's work that the ethic of care and responsibility covers the same domain that Kant classified as 'positive duties' of benevolence or altruism. The domain of the moral, it is maintained, is distinct from supererogation or altruism although such acts may crown a virtuous character ("The Debate Over Women and Moral Theory Revisited," ed. Meehan, J., *Feminists Read Habermas*, 1992).

The analysis of caring, through the lens of the care ethicist, will help clarify and solidify my conception of caring-respect as the moral foundation of medicine and dispel the idea that justice and impartiality can provide adequate normative grounding for medicine. In doing so, we shall see that the debate between Lawrence Kohlberg and Carol Gilligan (which ultimately led Gilligan to assert "Care was the principle that tempered Justice" (1987, p. 24)) was misguided.

A debate between justice and care theorists to establish the grounding of a proper understanding of morality in medicine misses the mark on at least two counts. First, justice provides us with, at best, an incomplete articulation of respect for persons and, at worst, a shift in the moral orientation of medicine away from universal respect and the value of persons and toward a concern for juridical rights and obligations that find their general ground in impartiality and find their particular application in fairness. Justice theories of morality generally regard the domain of morality in terms of the widest public sphere and in this general form it is the impartiality of justice that receives the greatest emphasis. In so doing, these theories fail to adequately represent the moral bases of particular relationships of care whose survival depends on more interpersonal principles than impartiality and mutual non-interference.

These relationships are often asymmetrical helping relationships such as those between doctors or nurses and patients and between medical educators and students as well as affiliations of intimacy and mutual support such as friendship and family relationships (parent/child). The care perspective, according to Annette Baier, finds moral relevance in forms of human relating and responsiveness that arise between human beings who are seen by each other as precisely the particular unique individuals they are, rather than as abstractly conceived rights bearers. As a result, the care perspective allows for partiality as a legitimate moral point of view. In addition, because the care perspective is attentive to real individuals rather than simply to individuals abstractly conceived, caring (and I submit caring-respect) acknowledges the moral significance of the real differences and inequalities that distinguish particular persons (Baier, "The need for more than justice," *Can J of Phil*, 1987;13 Suppl:41-56).

Within the covenant of trust, physicians must demonstrate the willingness to reason from the patient's point of view and the readiness to seek understanding with the patient to reach some reasonable agreement in an open-ended moral conversation. One consequence of reformulating respect for persons as caring-respect is that the universalizability principle must be viewed not only as generalized (to all persons), but must also be particularized to the concrete person of the patient. The

standpoint of the concrete patient requires physicians to view every moral patient as a unique individual with a certain life history, disposition and endowment as well as needs and limitations.

Caring-respect can be thought of along the model of a continuum. The universal commitment of respect that considers every human individual as worthy of respect and possessing dignity represents one end of the continuum. At the other end stands the patient, who imposes upon us the duty to care personally for him in his concrete particularity. At this end of the continuum, the ethical relationship with the patient is not unlike all of those ethical relationships in which we, as social creatures, are already immersed. To be a family member, a parent, a spouse, a sister or a brother means to know how to reason from the standpoint of the concrete other. To participate in such ethical relationships means that we, as individuals, know what is expected of us in virtue of the kind of social bonds that tie us to these others. We therefore, as physicians, already have an understanding and much practice in the kind of conversational ethical relationship of care that is demanded of us by the patient, within the covenantal relationship.

The contemporary distinction that is typically drawn between the universality of an ethic of respect and the particularity of the ethic of care seems to require that physicians (and ethicists) must divisively choose between the relative strength of their commitments to particular individual persons as patients and their universal commitment to respect for all persons in need of medical care and set their priorities accordingly. I propose that through the union of respect and care, we find resources for a more integrative approach to moral theory and moral life that transcend this presumed dichotomy in medicine, proves it false and expands the moral domain.

Caring: The Particularization of the Universal Concept of Respect

Caring, then, is an important component of respect and is the particularization of the more universal notion of respect. We need to place greater emphasis upon the meaning of “care” in health care. It isn’t merely the bringing to bear of one’s skill and scientific expertise upon the illness or

disease of another; it often also entails an emotional bond between care-giver and recipient and always entails a moral element of respect for persons. Caring-respect, as I am referring to this aspect of medical care, entails the duties and obligations to particular patients that respect for persons entails universally to all patients. The important difference is precisely that of standpoint. Caring, as I propose it, orients the focus of respect for the patient upon the specific context and is particularized to the given situation. It pertains to actual, practical, personal, relational and moral concerns for the person who is the patient and these concerns are not and cannot be conceived to be impartial.

The covenant model of the physician-patient relationship captures this caring relation of trust as a commitment to the whole person rather than to the eradication of disease or the treatment of organs. Respect as caring situates the physician – within the covenantal relationship – in position to provide her expert opinion and guidance with an attitude of caring and a respectful concern for meeting the patient's needs and informing him fully.

Patients often consciously choose to follow the recommended treatment pathway of their doctor, having developed trust in the caring relationship built through her respectful communication and demonstrated clinical acumen. There is nothing standing in the way of a patient – freely and without coercion or manipulation – choosing to accept and follow the doctor's recommendation. This is how a healthy, mutually validating, therapeutic relationship of care should function and in no way disrespects the person of the patient nor denigrates his autonomy.

Patient autonomy so achieved, then, does not consist in total independence from the sentiments, judgments, and actions of the physician, but in an ability to distinguish those areas in which one ought to be independent and those where one ought to acknowledge dependence. To be in this way autonomous in one's relationship with one's doctor is a necessary condition for achieving many of those key goods without which this relationship would no longer have point and purpose.

Regardless of a patient's functional level of autonomy, there is an irreducible dependence of the patient upon the medical care and caring concern of his doctor. This dependency is natural to the

roles of doctor and patient within the covenantal relationship. Caring respect is uniquely suited to embrace the conceptual notions of autonomy and beneficence as perfectly compatible mid-level contingent principles. Taking actual patient-physician relationships as its starting point, a care-oriented medical ethic has a broader scope that necessarily includes those forms of human attachment and responsiveness (such as compassion, concern and sensitivity) and encompasses the breadth of human feelings and emotion.

The 'Idea' of respect for persons grounds and validates a plethora of secondary principles and is able to provide justification for the particular judgments required in medical relationships. Such judgments cannot take place in isolation because they are inextricably relational. The formulation of these principles emerges from asking the question, as posed by Alisdair MacIntyre in *The Tanner Lectures on Human Values*, "By what principles are we, as actually or potentially rational persons, bound in our relationships?" (Truthfulness, Lies, and Moral Philosophers: What Can We Learn from Mill and Kant? Princeton, April 6, 1994). This dissertation argues for those principles that emerge from and find their ground in respect for persons and satisfy the test of universalizability when applied to specific case situations.

Respect and caring are notions inherent in the very nature of our rational being. The mistake is often made of distinguishing Kantian respect as rational and thus as something cold, distant, clinical, calculating and univocal. Caring, contrarily, is often mistakenly characterized as based in feelings and emotions and arising "pre-cognitively" from our deepest self (the Heideggerian "deep caring"). I argue that caring is "felt," but it is, in the context of medicine, a rational and moral feeling and is the motivating factor in getting us from rational reflection to action. Caring functions to integrate our life with others and gives our lives relational and inter-personal meaning. Caring-respect involves the affective, cognitive and conative faculties of caregivers, which dispels the view of caring as arising merely from feelings of empathy and irrational emotion. This is not to denigrate emotion, but it must be understood as informing and being regulated by reason.

It is very clear that Kant does not regard feelings as morally irrelevant. He states his view quite explicitly: “Natural inclinations, considered in themselves, are good, that is, not a matter of reproach, and it is not only futile to want to extirpate them but to do so would also be harmful and blameworthy” (*Rel* 5:58). He also thinks we should actively cultivate our moral emotions: “it is a duty to sympathize actively in the fate of others.” To accomplish this it is also a duty to “cultivate compassionate . . . feelings in us” (*MoM*, 6: 457). So not only is it untrue that Kant thinks we must detach ourselves from emotions in order to free up reason for moral calculation, it is also untrue that he attributes no moral significance to them (Guyer P. (2000) *Kant on Freedom, Law and Happiness*. Cambridge).

It has been objected by some proponents of care ethics that Kant’s characterization of ‘active sympathy’ as a duty fails to capture the reality of caring as a natural impulse. They argue that caring is something that proceeds from emotion, not something one should have to make oneself do, even if it is also something that can be cultivated. What they overlook, however, is that either one feels sympathy, or one doesn’t. If you don’t, how can the ethics of care make any moral demand on you? The problem care theorists run up against is that an ethic that appeals only to people with a certain frame of mind and which recommends what they are naturally inclined to do without prompting cannot be universalized as an ethical theory.

Unfortunately, it seems that from its inception, the ethics of care theorists have focused at least as much upon what care is not, as upon a coherent ethical notion of what it is. My point is that it is not clear what care entails and how it obligates physicians and nurses, as persons, committed to providing healthcare to their patients. This is primarily hampered by the over-emphasis of ethics of care theorists upon the emotional attachment of relationships and consequently its limitation to the particular situations in which an emotional bond of caring provides both the motivation and the orientation of the duties and obligations it entails. Some care ethicists have gone so far as to besmirch caring actions motivated by duty or obligation as not truly caring and unworthy of inclusion within ethics of care theory.

It is confounding to me how an ethicist who would urge us to accept the ethics of care could do so without suggesting that we *ought* to care, and that we *ought* to cultivate the appropriate sentiments if we have no natural tendency in that direction? In fact it seems incongruous that a care ethicist would not hold caring to be a duty (or better a virtue that is also a duty). Nel Noddings, for example, cannot avoid this idea (and in practice neither can anyone else). She refers to caring as the ‘first and unending obligation.’ The difference is that for Kant it is explicitly part of his ethical theory, whereas for the care ethicists it slips out accidentally, or as something they only reluctantly concede. This is the one of many opportunities for care ethicists to improve their position by adopting at least some of Kant’s ideas.

Another of the major shortcomings of an ethics of care is well articulated by Lawrence Blum,

Care issues are genuinely moral, yet the care perspective does not amount to a moral theory with a distinct account of a moral point of view. Considerations of a universalist morality effectively sets the constraints within which concerns of care should be allowed to operate and they trump them if necessary (1988 Gilligan and Kohlberg: Implications for Moral Theory in *Ethics* Vol. 98, 3).

Here, Blum cries out for a more thorough articulation of what care ethics entails. He hopes to conjoin the ethics of care with a universalist morality to set the constraints and override aspects of care theory such as the overemphasis upon the emotional attachment of relationships. Caring-respect for persons is just such a universalist theory and should fit well with the numerous aspects of the care perspective with regard to the particularity of the concrete “other” that are morally laudable.

Reason and emotion both have an essential role in Kantian ethics. It is difficult to make the same claim for the ethics of care, as most writers on caring treat reason with suspicion or else say very little about it. This is another significant shortcoming of contemporary care ethics. Patricia Benner, a nursing ethicist who wrote of the stages of clinical competence in nursing, is a case in point. She claims to distrust anything that appeals to ‘rationality’ and her account of skilled professional practice is characterized by its lack of dependence upon ‘explicit cognitive activity.’ “Expertise is habit or intuition born of experience. Conscious analysis is reserved only for new and unfamiliar situations” (Benner P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*). I

would submit that in 2015, no knowledgeable professor of nursing, or medical ethicist of any stripe could make such an assertion with a straight face and most would take offense that it denigrates the scientific knowledge nurses must acquire before being awarded their R.N.

The problem is that one person's intuition is another person's prejudice. Reason's job is to 'vet' intuition, habit and experience and check that they are not simply camouflage for whim, fancy or any other form of parochialism, chauvinism or preconception. Kant's linking of reason and autonomy will not go away, and care ethicists' distrust of this connection deprives them of a valuable resource: skepticism. Koehn is particularly sharp about the care ethic's lack of self-suspicion:

Given the well-known phenomena of bad faith and projection, the ethic should have some feature or factor capable of engendering self-suspicion in the caregiver regarding her own motives. There is no warning regarding pride and hubris in this ethic which bases itself upon only the subjective desires, whims, and needs of the cared-for and caregiver (1998, *Rethinking Feminist Ethics: Care, Trust and Empathy*. Routledge, London. pp 40–41).

It is precisely these subjective whims and desires for which Kantian self-determination (critical thinking for oneself) provides the corrective. Kant's is an ethics of care with a substantial portion of distrustful rationality.

Relational Caring can be Universalized Through Respect

The ethics of care concerns a personal commitment to treat a person with integrity based on a certain understanding of one's relationship to the other and is often grounded in personal affection or familial love. I argue, however, that care and caring are too important to be left to the vicissitudes of family affiliation and friendship. Since natural bonds of affection do not, in themselves, suffice to meet medicine's stringent demands, healthcare providers must cultivate caring relationships in a systematic way. That structure for systematic care in medicine is the covenantal relationship, within which the practice of caring-respect, nurturing and trust-building results in an ideal environment for caring.

The notion of caring-respect as a "universal principle" can be embraced without proposing a principle that contrasts with a morality of personal care. Lawrence Blum, a notable proponent of care,

concedes that in acting from love, care, and compassion, moral agents are also acting from some kind of ‘principle.’ This point calls attention to the important recognition that an ethics of care, if it is to be a moral theory at all, is meant to be a morality for all. Proponents of care ethics do not offer care as a relativistic moral standpoint that one could choose either to respect and embrace or not, without any moral consequences. It cannot be understood as applying to some but not others, of being subjectively dependent upon the desires of the agent, or of being confined to a particular group.

Caring-respect, then, by embracing love, care, and compassion, becomes a principle that also encompasses an emotional response and therefore must acknowledge that moral action – according to this principle – requires caring for particular persons in a way that cannot be exhaustively codified by the universal principle of respect. This natural tension between the universal and the particular reflects the realities and complexities of human interrelations.

At the same time, however, respectful caring can be thought of as a universal principle that is not wedded to pure rationalism, impartiality, or to the commitment of adherence to universal principles alone. It allows for other moral capacities – involving the perception and sensitivity to particulars as well as care and concern for individual persons – to be equally contributory to the moral life that is captured in the notion of caring-respect.

While it is true that many acts of caring are in fact obligatory, I may do something beneficial for a patient that is outside the territory of obligation altogether. In other words, it is quite possible to do something for another in acting from the universal notion of care that is morally good but is not required. Such acts of caring, though not supererogatory are nonetheless morally meritorious. This viewpoint allows for caring and caring-respect to embrace a much wider set of actions and represents a more significant part of a typical human life.

In order for respect for persons to be a yardstick against which both rules and virtues can be measured, it must be given the utmost priority in determining the ethical/unethical nature of a given proposed action. Kant described two “wide” duties of respect for persons as the duty to promote the

“happiness” of others and the “moral perfection” of ourselves. Caring is both concerned with the needs of others and committed to working on one’s self-improvement. Happiness is not something we can intentionally set as a determinate end for ourselves (though as Kant made clear, we are all naturally inclined to pursue it). Similarly the actualization of the functional autonomy of others can be promoted, but is not within our direct control to effect.

Caring for other persons is best understood as a structured compound of a rationally reflective attitude or orientation toward others (whether collectively or individually) and various less complex emotions, predispositions, and desires, unfolding over time in response to relevant particular circumstances. By virtue of her steadfast attunement to these complex particularities of her patients, the caring physician imbues the patient with importance.

As Milton Mayeroff indicates in *On Caring* (1972), “Caring is helping another grow and actualize herself.” In the case of medicine, it is to achieve the highest level of functional autonomy possible. He continues, “It is a process, a way of relating to someone that involves development, in the same way that friendship can only emerge in time through mutual trust and a deepening of the relationship” (1972, p.1). He then asserts that, “To care for the other, I must see the other as it is and not as I would like it to be or feel it must be” (1972, p.2).

Thus, the caring physician will identify with the interests of the patient while at the same time recognizing the limits of that identification. Mayeroff observes: “I experience what I care for...as an extension of myself and at the same time as something separate from me that I can respect in its own right” (1972, p.3). This is how the connection between caring, caring for and caring about blend into actualizing caring-respect. These feelings and attitudes cannot cross the line from being about the patient (or the one cared for) to being about myself, as physician (satisfying my own interests or needs).

Caring involves the apprehension of our internalized moral values and the act of relating them to the actual human experience of patients. The awareness of the needs of others is sensitized by this

attitude of caring-respect and is invaluable in recognizing distress and vulnerability in the patient whenever present. Caring can become manifest as altruistic feelings such as sympathy, compassion and concern. These experiences motivate action aimed at bringing about the good of the patient.

The doctor's desire and agency to promote the good of the patient, arising from caring, converges with the moral demands of respect and the rational demands of clinical practice. Thus caring can be understood as the functional enacting of one's duty to respect the patient and assist in repairing and rebuilding the damage to the patient's functional autonomy caused by illness, just as the technical and intellectual application of clinical skills aims to repair and heal his bodily ills.

I conceive of caring in medicine as arising from the commitment of physicians to confront the often tragic experience of illness, suffering and pain in their patients, without ever losing sight of the duties of 'respect for persons.' As a moral concept, caring-respect entails a commitment toward patients that goes well beyond the treatment of physical impairment. Caring involves duties that take on a moral character and, so conceived, serves as a principle of moral guidance and moral motivation sufficient to successfully confront the adversity of medical practice while maintaining respect for both self (as physician) and others (as patients). Rational reflection must be done with care of the patient in mind, for it requires the sort of thinking from which a judgment for a particular caring action is drawn. Calling it 'moral' might seem to restrict its usage in medicine to morally relevant discourse, but I contend that all medically relevant discourse is value-laden with significant moral implications.

Caring is both a moral and non-moral disposition that specifies, on a personal level, what the functions of truthfulness, trustworthiness, and integrity are in the cooperative inquiry within the physician-patient relationship. At the same time, respect establishes the relevance of these virtues, required for beginning such inquiry into the moral life in general. As a guiding ethic of medicine, caring-respect must occur without exception in all interactions with patients. The virtues, many of which will again be highlighted in this chapter, serve as action-oriented guides that are ends-oriented (consequentialist) and morally grounded in caring-respect for persons as ends in themselves. Certain

things are basic to human nature and the human condition – notably care and what is necessary for care.

While it is useful to establish respect for persons as the foundational principle of medicine and to derive guidelines from principles for typical situations in medicine, we must remember that principles and guidelines are merely signposts or reminders. They help us take into account what must be considered in the pursuit of the practice of a moral medicine. They in no way, however, relieve us of the burden of careful judgment that sometimes forces us to deliberate outside the box of general truths in order to fulfill the special (particular) demands of care. This kind of thinking accepts and makes room for intuitions, emotions and feelings as we call upon all of our faculties to determine the right and best course of action and keep the patient and his wishes at the center of this deliberation.

To care for someone involves significantly more than recognizing him as a patient having a disease or injury that it is our duty to diagnose and treat. Caring involves treating him in a way that his welfare is of direct concern to us. This does not, however, entail that there necessarily is an end that we wish to bring about. There are situations in medicine that involve such an end, and the caring relation of medicine might be thought to aim at helping persons become well. The practice of medicine, however, is often not engaged with this but rather with helping someone come to terms with the kind of illness and prognosis that he has. In this latter case the “end” is not some kind of state, since this requires dealing with the illness in a long term way, i.e. accepting situations that cannot be changed and learning to live differently. In this case, the role of caring-respect shown by the physician is rather to assist and guide the patient toward an alteration of his focus and expectations.

In *Kant's Ethical Thought* (p. 398), Allen Wood notes that Kant makes a similar point regarding the combining of respect and love in the setting of friendship in the Doctrine of Elements (*DV* 6.1, note 23). Kant is speaking of philanthropic love for human beings that must be grounded on respect for them and is possible only on the basis of respect (*ED* 8:337). This harmonious relationship understands the relation of love and respect as moral feelings. It is in the setting of ‘friendship’ that

such love can be conceived as being for an individual, rather than love for rational nature according to Wood.

This is an important insight – respect for persons is not fully captured in respect for rational nature or even for humanity and must include respect for the individual, in all of his concrete particularity. I see no significant difference in the notion of philanthropic love, *agape* and caring, each of which represents awe-inspired respect for the unity of this whole, embodied, particular person. I believe Kant would have no hesitation in extending his meaning of friendship to any relationship of caring, particularly the doctor-patient relation closely bound by covenantal trust.

Noddings' Critique of Kant's Ethics

Nel Noddings is a powerful figure in feminist ethics and has played an important role in defining care ethics. She claims that care ethics operates in complete opposition to Kant's ethics and her version of feminist care ethics professes to be incompatible with Kant's ethics. Noddings insists that "care ethics...rejects...Kantian principle-based ethics" (*Caring: A Feminine Approach to Ethics and Moral Education*, Berkeley: U of Cal Press, 1984). John Paley confirms that, "the ethics of care has usually been regarded as anti-Kantian" ("Virtues of autonomy: the Kantian ethics of care," *Nursing Philosophy* 3, 2002: 133-43).

In spite of this, some Kant interpreters have claimed that there is no significant division between Kant's ethics and care ethics. Marcia Baron argues, "Kant's ethics doesn't require detachment from other persons and from one's own projects except in a way that is not objectionable and is congenial to feminism" ("Kantian Ethics and Claims of Detachment" in *Feminist Interpretations of Immanuel Kant*, ed. R. Schott; PSU Press, 1997, 147-70). Paley makes an even stronger claim that due to what Kant says about interdependence, context, teleology, and emotion, he "can be regarded as a care ethicist" (2002).

Noddings' criticism begins with the argument that Kant's ethics, unlike care ethics, is not relational and fails to recognize the ways our actions affect others and the way people interact interpersonally and socially. A relational ethic is one that includes and is attuned to not only moral agents but to those who are recipients of their actions and to the conditions under which they interact. Her claim here refers to relationships of dependence, such as Parent-Child. In medicine, this could be understood as applying to the provision of medical care to children and to patients with severe dementia or a persistent vegetative state. She characterizes Kant's "autonomous self" as independent and individualistic and unconcerned with relationships of dependency and care. Noddings denies that there are relational aspects of Kant's account of moral duties and virtues. She and Kant, however, both maintain that we have moral obligations to act in ways that are philanthropic and hospitable, as noted by Allen Wood above. Kant actually offers a view of our moral obligations that is identical to that detailed in Nodding's care ethics. I have repeatedly detailed, throughout this dissertation the relational and interpersonal aspect of Kant's ethics and I will not belabor the point.

Noddings also accuses Kant of failing to see that we bear some responsibility for the moral growth and perfection of others (*Educating Moral People*, New York: Teachers College Press, 2002). She is correct that Kant felt we have a duty to further our own perfection, but our duty to others is to promote their happiness, not their perfection (6:385). Kant only meant that we could not have an obligation to do something that was beyond our control and the growth and development of persons is ultimately up to the individual himself.

In order to claim that physicians have a (Kantian) duty to promote the perfection of others, we need to show that there are duties explicit in the formula of humanity to help develop patients' natural and moral capacities. A partial account can be found in the doctrine of method sections from the *Critique of Practical Reason* and the *Metaphysics of Morals*. In the *Critique of Practical Reason*, Kant states that to bring an uncultivated mind toward the morally good requires some "preparatory guidance" (5:152). This corresponds with the physician duty to educate and foster patients' ability to understand

their medical condition and to be in the best possible condition for determining their own goals of treatment. Kant clearly delineates, in our imperfect duties, the requirement to promote and facilitate others' ends and this applies to physicians insofar as their actions and examples may enable or hinder patients' efforts at improvement of their functional autonomy and decision-making ability.

In the moral education of others, we are facilitating the same kind of self-growth in others that we must promote in ourselves to satisfy our duty to further our own perfection. Insofar as we have a duty or responsibility to morally educate young people, we have in effect a duty to promote their perfection. Although Kant's explicit list of duties does not include the duty to further others' perfection, there is an unstated, but nevertheless thoroughly explained and justified, duty to promote others' perfection. Contrary to the critique of Noddings,' Kant recognizes our responsibilities to advance the moral development and perfection of others.

Kant's veil of philanthropy in our dealing with others correlates to the "act of confirmation" of Noddings. Kant and Noddings both begin from an ethical position of respect for others and derive a moral duty that others' faults and mistakes ought to be viewed charitably. Noddings and Kant both recognize that an important effect of treating the misjudgments of others charitably is preserving the ability of others to improve. Insofar as Noddings' ethic is relational in describing the nature and the effects of our obligation to act in confirming ways, Kant's ethic is similarly relational in requiring us to apply the veil of philanthropy and thereby facilitate others' moral growth.

This moral duty to treat misjudgments charitably is directly applicable to the manner in which physicians ought to regard and deal with the "errors in judgment" of patients. If a doctor offers a generous or charitable interpretation of a patient's act or judgment, by supposing that there is some truth or some good present in it, she preserves the patient's self-esteem. In so doing, the physician keeps open the lines of communication, maintains the patient's trust and respect, and renders the patient more receptive to further education, discussion and persuasion toward a more informed point of view. Throwing the veil of philanthropy over others' mistakes means assuming the best of others

and being cautious in our acts of reproach or criticism. It also means not giving up on patients who fall short of physicians' expectations. In short, it calls for the recognition of the fallibility and vulnerability of the patients under their care.

Caring-Respect and the Virtues of Caring

My conception of caring-respect owes much to Robin Dillon's (1992) work emphasizing that respect involves elements of care. The practice of caring respect in medical care involves not only holding an attitude of caring respect, but also providing treatment in a caring way. Caring respect means treating others in ways that do not demean them, either in their own eyes or in the eyes of others, and acknowledges their worthiness of respect. Consequently, there are virtues of caring and one cannot successfully achieve the aims of caring without practicing them consistently and with regularity.

These virtues of caring-respect arise from the recognition that others are worthy of attention and responsiveness and are capable of understanding and expressing their needs. Caring-respect entails more than dispositional virtues as Julie White has shown (White, 2000 *Democracy, justice, and the welfare state*, Penn State U Press). She attests that social service programs that fail to treat their clients with respect tend to breed resentment and mistrust and ultimately are less effective than programs that treat their clients as knowledgeable and capable persons.

There are a number of virtues that overlap with my notions of caring and of respect. This is not surprising considering that I am attempting to fuse these two notions into the singular principle of caring-respect. It is interesting to revisit some of the virtues and dispositions attributed to respect in Chapter 2 and examine the subtle differences in their expression when understood through the lens of caring.

The first virtue of caring I will address is attentiveness. Lawrence Blum identifies this quality as "moral perception" and describes it as a sensitivity to certain situations that elicit the call for a

moral response (1994. *Moral perception and particularity*. Cambridge, pp 30-61). The caring person recognizes when another person needs assistance and is quick to respond. Attentiveness of this nature entails some measure of empathy and a capacity to discern the need that another person might have. Blum indicates that if a person does not have empathy for another, she may, nonetheless, meet his most obvious needs, but overlook other underlying ones (ibid, 34-36). Joan Tronto contends that the caring of one who lacks attentiveness will be limited or ineffective and will often fail to even notice when others are in need (*Moral boundaries: A political argument for an ethic of care*. New York: Routledge1993, 127).

Responsiveness is the virtue of engaging others in dialogue to understand the specific nature of their needs and to assess their responses to our care. The physician who fails to engage the patient interactively prior to providing care for him will be less effective than the caring physician who is open and responsive.

Caring-respect also encompasses the virtue of presence; this involves the doctor's use of herself to convey a deep sense of availability to the patient. Presence, however, is conditional on circumstances and the situational context and can only exist in the context of the social structure of a continuing relationship to the patient, such as that actualized in the medical covenant. Presence cannot be required as an unconditional duty, for there are myriad reasons why a physician may face greater needs for her time and services elsewhere. By virtue of her steadfast emotional attunement to the ebb and flow of the fortunes of her patient, however, even in the absence of physical presence, the caring physician can still imbue the patient with "importance."

Caring-respect embraces more than an obligatory duty. The duty of caring-respect is engendered within the physician care-giver from her empathic recognition of the suffering patient. Seeing this suffering person clearly and not at all unlike herself, the doctor is 'called' into duty. Clear points of personal identification, however, are not necessary or crucial for the doctor's recognition of respect and the moral feeling of universal empathy for all suffering humanity.

Caring for the patient as ‘stranger’ is an increasingly common situation in today’s medical practice and requires a skill set that is grounded in universal respect for humanity. The physician’s character and virtuousness are put to the test in encountering patients with whom she finds no immediate common ground. In such settings, Kant’s understanding of respect as universal gains particular value and traction and offers a clear advantage over care based theories wedded to personal relationships of affection or emotional attachment.

Ethics of Care theorists often also emphasize affection or emotional attachment as another candidate for a virtue of caring. Both Gilligan and Noddings grounded their original accounts of caring in affection, and other care theorists have incorporated this element into their theories. The logic for including affection among the virtues of caring is the belief that individuals who feel emotionally attached to those they provide care for will better attend to their needs.

There is no reason, however, for supposing that emotional attachment is always necessary or even desirable for achieving good care or enacting caring-respect. An attentive, responsive and respectful nurse will provide good care to a patient regardless of whether or not she feels attachment to him. Since affection is not requisite to all forms of good care, I would not consider it one of the central virtues of caring-respect. Diemut Bubeck argues that “care does not require the existence of an emotional bond between carer and cared-for” (*Care, gender, and justice*. Oxford: 1995, 134).

Many people do care for others out of affection, love, empathy, or recognition that their own well-being is tied up in the other’s well-being. Caring in this manner plays an important role and these feelings that motivate this form of caring might also be incorporated in certain instances that actualize caring-respect. The distinction I am making between caring and caring-respect, however, is that the latter represents an independent moral duty to care for and about others apart from these feelings of affection. A duty, for example, to respect and care for total strangers toward whom we feel no affection can be explained and rationally defended in terms of caring-respect, grounded in respect for persons and Kant’s formula of humanity.

Obligations of Care and of Respect: Dillon and Kant on Caring Respect

One complaint that has been raised against the notion of a principle of respect for persons is that such a principle “ought to tell us precisely how to treat persons, but it cannot do this” (Carl Cranor, “On Respecting Human Beings as Persons,” *J of Value Inquiry* 17 (1983) 103-17). One of the implications of my argument is that this view misconceives the function of respect for persons. The concept of respect does not contain the resources for telling us how to treat persons; its function is rather to keep in the forefront of our moral consciousness the attitude of valuing persons for their own sake and so to remind us of the reasons why we should treat persons as morality obliges us to. To place a principle of respect for persons at the heart of morality is to say that our moral attention ought to be focused in the first instance on persons in virtue of their fundamental worth, rather than, for example, on actions, consequences, rules, duties, or social cooperation.

This conception of respect seems equally central to the account of the care perspective as articulated by Robin Dillon. Caring attention and understanding, as primary modes of moral response and insistence on active sympathetic concern for another's good, form a pattern according to which we respect persons by caring for them as the particular individuals they are. These themes, according to Dillon, suggest that caring is significantly contributory to a robust conception of respect for persons (“Care and Respect,” in Coultrap-McQuin and Cole eds. *Explorations in Feminist Ethics: Theory and Practice*, IU Press, 1992).

It is notable that she makes reference to active-sympathy, which was a theme of Kant's, “it is a duty to sympathize actively in the fate of others.” To accomplish this it is also a duty to “cultivate compassionate . . . feelings in us” (*MoM*, 6: 457).

The themes developed by Dillon, which help us understand her robust conception of respect for persons include the following:

1. What matters about each of us is not (only) some abstract capacity but the fact that we are the specific concrete individuals that we are. So, respecting persons involves valuing and responding to others in their concrete particularity.

2. It is a morally significant fact about us that we each have our own perspective from which we try to make sense of the world and ourselves, and we each have a self-conception that is a significant dimension of who we are. So, respecting persons involves coming to understand them in light of their own self-conceptions and trying to see the world from their point of view.

3. Another of our morally significant features is that we are not as independent and self-sufficient as philosophical characterizations of autonomy might suggest. We must depend on others for help in satisfying our needs and wants and for the sustenance and realization of our projects and interests. But more importantly, we depend on others for our very existence and development both as persons and as the particular persons we are. We are not wholly self-making but are shaped and influenced by others, whom we also shape and influence; and what and who we are depends in deep and important ways on how others perceive and treat us. At the same time, however, and no less importantly, each of us is a separate individual, always engaged in living our own lives and in self-construction and self-interpretation. Respecting others also involves, more positively, caring for others by responding to their needs, promoting their well-being, and participating in the realization of their selves and their ends (ibid).

I find little to disagree with in her insightful contemporary summation of the contribution caring makes to respect for persons. I agree with her that we can only truly show appropriate respect for others by trying to understand them as they see themselves, as well as their needs and desires for themselves, just as Kant insisted in the formula of humanity. Respecting others also involves, Dillon emphasizes more positively, “caring for others by responding to their needs, promoting their well-being, and participating in the realization of their selves and their ends” (ibid). This would seem a paraphrase of Kant’s imperfect duties to others.

Dillon refers to her notion as ‘recognition respect.’ Respect for persons requires that we recognize our connection and mutual dependence as well as our uniqueness and individuality. From my reading of her, I hear the voice of a Kantian, yet we shall see that this is decidedly not the case.

Caring-respect requires not so much constraint from interfering with the autonomy of others as recognizing our power to build up and tear down each other as persons. Understanding this capacity is the first step toward exercising this capacity with care and respect. She would seem exclusively focused upon respect for individual persons based upon their particular characteristics, but I sense in her writing a universal respect for all persons, regardless of their particular traits (though she never states this explicitly). She is clear to indicate in the first statement that it is not *only* an abstract capacity that makes us respect-worthy. This wording seems to leave room for an unnamed abstract

capacity that is also, at least partially, the source of the respect-worthiness of persons (such as their humanity or their rational nature).

It is puzzling to me why Dillon argues, immediately after elucidating her three themes, that this understanding of respect for persons “contrasts significantly with the way of understanding respect for persons that derives from Kant” (ibid). In my understanding, Kant’s view (similarly to Dillon’s) holds that it is precisely because of the intrinsic moral value of each and every human person, based upon a commonly shared characteristic, that makes the particularity that distinguishes one individual from another also deserving of respect.

Even her choice of words in this last quotation sounds not only like Kant’s, but is virtually quoted from Kant’s explication of the positive indirect duties emergent from his second formulation of the categorical imperative. Being treated as ‘ends’ entails that the individual needs and desires of each person matter and engender duties that must be particularized for each individual if one is to fulfill the duties of the formula of humanity. It is for this reason that respect for persons does not provide us with a ‘cookbook’ method for specifying our moral duties in particular situations. This is a partial response to the complaint of Carl Cranor that the principle of respect for persons cannot tell us how we ought to treat persons.

Kant understood that, as Dillon puts it, “we are essentially fully specific and concretely particular individuals, each with our unique blend of needs, desires, and abilities, our own peculiar history, emotional constitution, concerns, and projects, each with our own way of viewing the world and our relationship to it”(1992). This fact should not be used as an argument against Kant’s moral theory as it so often mistakenly is. In this project I have cited countless passages from Kant’s work that support the importance of the particularity of persons that generate our specific imperfect duties in caring for them and that supports a physician’s duty and sensitivity to each patient’s particularity. We cannot determine the reasons or maxims of our action until we are contextually and personally cognizant of a patient’s circumstances.

So, on one hand, I believe that her insight is philosophically profound in assessing the conceptions of care and respect as not incommensurable (as a number of care theorists held), but as actually being co-dependent. On the other hand, she remains stuck in a perception of Kant that held him as the enemy of care, feelings, emotions and relationships of dependence. Generally Dillon thinks that Kant got it all wrong. This blind spot restrains her conception of *care respect* from offering or finding a solid moral foundation in respect for persons, even though she makes specific reference to it as quoted above. Nonetheless, her insightful reflections on care and respect have given me much food for thought and I am deeply indebted to her for her ideas and perspectives in the formulation of my own conception of caring-respect.

Caring-Respect Emerges from a Voluntary Commitment of Physicians to Their Patients

The caring respect physicians owe to their patients emerges from their voluntary and willing choice to take on this “life’s work.” Consequently, the indirect duties emergent from Kant’s formula of humanity motivate physicians to voluntarily, rationally and emotionally bind themselves to respect for persons and to treat all persons as ends. Medical ethicists and physician educators should understand that the doctor’s moral commitments arise voluntarily. Educators should work to create an educational climate in which physicians in training develop an understanding of their duties and obligations as willingly and gladly endorsed and carried out.

Competence and caring-respect are the essential tools of medical care and must take center-stage in the undergraduate and postgraduate educational training of young physicians. In recent years we have heard many laments about the overspecialized technical orientation of physician training and the neglect of the interpersonal aspects of medical care. As physicians, we have the primary obligation of relieving or reducing suffering, yet clinical education rarely focuses on how to communicate caringly with those in pain or distress and provides precious little guidance about what personal information we can share, in the way of feelings of empathy and caring concern. Teaching medical

students and house staff the art of truly being there in these difficult moments in which we confront suffering is limited to guidelines that are often indiscriminately applied. Regardless of our primary discipline, this skill—staying present with suffering—is of vital importance in all clinical specialties.

Many medical schools are now working hard to correct these problems, taking steps to develop patient-oriented interpersonal skills, to improve physician sensitivity and empathy, to increase appreciation for diversity, to sensitize physicians to ethical dilemmas, and to shed more light on the behavioral aspects of care (Marston and Jones, *Medical Education in Transition: Commission on Medical Education: The Sciences of Medical Practice*. 1992, Princeton).

The moral force of the duty of respect, according to Kant, cannot be compelled or coerced. Respect for persons can only be compulsory by the voluntary imposition of the doctor's own reason and her comprehension of the force of the moral law. The personal commitment view is clearly attractive from a variety of normative stances because it specifically grounds medical commitments in the more general moral norm of agreement, as actualized in covenant, rather than contract.

This is supportive of the ethics of respect for persons that assigns a high importance to the covenantal agreement and commitment. The physician knows that she must place the needs and interests of this patient above her own as well as, at least at this moment, the needs of her other patients. Her duty to this particular patient supersedes any other commitments she may also have, including those commitments to society and its resources that may impinge upon her decision-making with regard to the patient in front of her.

Recognizing that patients are due respect and embracing it voluntarily, however, has not clarified what caring-respect entails from the doctor for this particular patient. The caring virtues and intuitions of caregivers, coupled with their experience and clinical acumen, must be developed into a keen perceptiveness. This ability allows them to relate to those under their care and to be guided by the unique situation of each patient. That caring respect requires action is uncontroversial. Multiple types

of action, however, may be respectful in a given circumstance, provided they each communicate a correct moral valuation of the patient and are enacted with care and respect.

This means there is considerable flexibility for individual doctors to respond to similar clinical situations differently and still be acting in a morally permissible way. This is important, in that it affirms the value of each physician's particularity and independence to practice in a way that is consistent with her own value system. This also allows patients and doctors to work in partnership to develop and act on a patient-centered care plan that is based upon that particular patient's goals, preferences and capabilities. Physicians, in delivering patient-centered care, need to recognize and take into account the conditions that shape what is meaningful to this particular patient. Caring-respect is actualized when patients are allowed and encouraged to remain connected to what is meaningful for them and gives their lives purpose. The covenant of patient-centered care involves a movement towards sharing power and responsibility, which occurs when a physician encourages the patient to become an active participant in his own care. Rather than envisioning the patient as a passive recipient of care, a physician should empower patients to ask questions, receive and understand information, and participate in his own healthcare decisions.

This demonstrates respect clinically by acknowledging the beliefs, values, preferences and choices of individual patients. The patient-centered vision of sharing power and responsibility goes beyond a limited conception of respect for autonomy as simple non-interference with a patient's expressed preferences. Genuine sharing of power and genuine respect encourage patients to deliberate and form preferences, even those patients who might otherwise be passive in clinical situations. This approach takes patients' goals and needs seriously but does not force patients to assume power and responsibility that they would prefer to leave with their physicians. For willing patients, shared decision-making can help to restore a sense of control and self-efficacy and for at least some patients this is an essential part of respecting and preserving their dignity and autonomy.

Respect further entails developing the ability and willingness to look past the differences in power and status between a doctor and her patient in order to meet the patient at the ground level of their shared humanity. This encourages physicians to see the ‘best’ in patients and in humanity generally, even when they are non-compliant, self-abusing, disrespectful or ignorant.

Caring-respect does not, however, require doctors to be uncritical, to tolerate the intolerable, or to affirm the despicable or the inane. Caring-respect seeks a kind of acknowledgement and acceptance of others that does not require endorsement but instead provides a respectful framework in which withholding endorsement can be communicated with civility and understanding.

A conception of respect for persons that is responsive to the breadth of human reality must acknowledge persons as both the same and different. Caring involves an acceptance of the differences of a patient that goes beyond toleration, but every physician has, at some time or other, been pushed to her limit. Caring-respect, in such situations, requires the determination to discover, forge, repair and strengthen connections with such persons in ways that benefit everyone. It engages physicians in the task of finding new ways to make interactions with patients and the medical institutions within which they encounter them more fully and flexibly responsive. It also enjoins physicians to take the appropriate measures to avoid patient abandonment and to protect themselves.

Caring-respect joins individuals together in a community of mutual concern and mutual aid. Not only can caring respect be extended to the stranger, but it is properly extended to all human beings. It is what the patient as a human person needs and deserves from physicians. Each of us is a fully particular and concrete individual, and that fact about us calls for recognition and response. But we all also share a common humanity and moral community and warrant respect on that ground as well. Caring-respect enables us to keep both of these facts in sight, as it calls our attention to the moral significance both of the commonalities of persons and of this richly specific and contextualized individual. It might thus be thought of as care universalizing itself.

This process results in our concept of care being reshaped by the demands of the universal context. The most powerful aspect of caring-respect, I believe, lies in its ability to maintain constructive tension between the duty to regard each person as equally valuable and the caring capacity to consider this individual as special (Dillon, 1992:122).

Justice as Impartiality is Insufficient to Ensure Universalizability

Lawrence Blum attempted to capture a different understanding from Dillon's point of view. By conjoining the ethics of care with the impartiality of justice, instead of respect he argues:

Even though care considerations are distinct from universal principles and impartiality, and while they are genuinely moral, nevertheless their ultimate acceptability or justifiability rests on their being able to be validated or affirmed from an impartial perspective. It is the integration of justice and care that forms a single moral principle (Blum, Lawrence A. 1988. "Gilligan and Kohlberg: Implications for Moral Theory" in *Ethics*. Vol.98, no.3).

Blum contends that what care ethics values on the personal level, justice (understood as impartiality) may be able to achieve on the impersonal level. Consequently, as opposed to perceiving justice as the antithesis of care, he argues that it can be understood as the extension of care when personal connection is no longer possible. He has the belief that it is the synthesis of justice and care into a single grounding principle that is the fundamental principle of morality.

Blum's attempt to integrate two independent moral principles into a single grounding principle is a reasonable idea (and is quite similar to my efforts to synthesize care and respect). Blum, however, makes two fatal errors in his effort to combine care and justice, when justice is committed to impartiality.

The first error is not recognizing that principles that are polar opposites (either/or but not both) cannot be fully integrated without one or the other (or both) giving up some characteristic or entailment that is essential and constitutive of its nature. Impartiality and partiality exist as polar opposite principles. It is possible for persons to behave with impartiality in one situation and with

partiality in another, but one cannot be impartially partial, or partially impartial in one's commitments, moral judgments, or moral beliefs.

Blum's assertion is that care considerations are moral, but he also asserts that their ultimate acceptability or justifiability rests on their being able to be validated or affirmed from an impartial perspective. He makes this claim because he bought into the conclusion of Lawrence Kohlberg that impartial justice is the foundational principle of morality. To be foundational, impartiality would have to be universalizable and Blum erroneously believes it to be.

The concept of care, as understood by every ethics of care theorist, is founded on the notion of partiality. This means that the commitment to care is a commitment to someone. Someone with whom the carer has a relationship and has a connection grounded in reasons, feelings, or emotions that bring her to the role of caring and care-giving. This is not to the exclusion of all others, but is a bond with this particular person that is at least partly determined by becoming emotionally invested in this person's life, either out of love, empathy, sympathy, friendship, family ties or duty. Generally more than one of these moral/emotional feelings are involved and provide the motivation and the reasons for caring. Partiality is part and parcel of caring and in fact, it seems to me incongruous to conceive of impartial and impersonal caring.

The concept of justice, in the sense of impartiality that Blum uses here, is fundamentally concerned with an impersonal notion of justice as "blind." Clement points out rightly that the ethic of justice tends to focus on "general principles rather than paying attention to contextual detail; on the self as an independent individual rather than self in relation to others; and on varying commitments to equality rather than commitments to maintaining relationships" (Clement, G. 1996. *Care, autonomy and justice*. Colorado: Westview p. 110). Moreover, the ethic of justice mainly concerns our treatment of one person other than ourselves, in relation to another person other than ourselves. Impartiality, however, does not govern the treatment of others in relation to ourselves. The moral standpoint toward

others, in relation to ourselves, is governed by universalizability and respect for persons (the first and second Kantian formulations of the categorical imperative).

Care-based ethics depends on the importance of a subjective recognition of intimate relations, and it is born out of the more encompassing vision of how fully connected each and every individual is. The partiality of care, however, does not view itself as a relativistic orientation to the particular person or patient. It does not entail the isolation of the choices and decisions of caring and providing care to this particular case in some relativist sense at all. The rational faculties of the care-giver are employed to ensure that her methods of caring meet the standards of the first and second formulations of the categorical imperative (whether explicitly, intuitively or habitually). Thus caring as partiality is universalizable under the categorical imperative.

Blum's second error is his conflation of impartiality and universalizability. Blum understands the impartiality of justice to be universalizable, because he understands universalizability to be subsumed under justice, as impartiality was. Justice can be understood as a universal principle (applying to all persons at all times) but, as mentioned earlier, there is a significant difference between universality and universalizability. It is this distinction that Blum blurs and that consequently led him to attribute universalizability to justice.

He is right to think of impartiality as 'impersonal,' but universalizability is not committed to impersonality. In fact, universalizability is not a standpoint or state of being, but is a method for determining moral permissibility of a contemplated action. As a method or procedure it is intimately dependent upon the particularities of the persons involved and their relationship, as well as any context of the circumstances that bear upon the decision or action and the reasoning that lead to the action being considered.

In order to evaluate the moral permissibility of that action it should be formulated such that if A ought morally to do X in situation S, she ought to endorse the same judgment whether she is A, or she is another individual (perhaps one who will be directly affected by A's actions) or an entirely

neutral observer. A person whose judgments are universalizable will be morally consistent, in the sense that she will judge her own actions by the same standards she applies to others and not make an exception for herself. She also ought not to perform any other action that she would not accept if performed by another. To be moral a judgment or action must also result in the treatment of all others as ends in themselves.

The universalizability principle, unlike the principle of impartiality, does not imply that one is morally forbidden to be partial toward other persons (as demonstrated above). She cannot be partial to her own action, however, in the sense of making a special exception for herself (doing so would not satisfy universalizability).

Universalizability, in terms of the first formulation of Kant's Categorical Imperative, governs moral action and more generally must also override impartiality when a judgment considered just, based upon its impartiality, violates universalizability. The impartiality of one's judgment does not ensure the morality of that act and, as I have shown, actions from partiality can be morally permissible.

Therefore, Blum has ascribed too much moral authority to impartiality by subsuming universalizability within it, when it is clear from our consideration of partiality, that universalizability is not a characteristic of impartiality at all. In fact, as I have just shown, universalizability trumps impartiality as the principle that must be satisfied first. This distinction helps us arrive at the recognition that it is universalizability, not impartiality that ought to be integrated (or synthesized) with care into a single fundamental principle. This grounds caring-respect as a moral principle, under respect for persons.

The demands of justice or the principle of impartiality are too restricted in scope and there is no place in an ethic of justice for respecting the particularity of intimate relations. As Gilligan points out, we need both ethical perspectives in our private and public dealings with others:

All human relationship, public and private, can be characterized both in terms of equality and in terms of attachment, and . . . both inequality and detachment constitute grounds for moral concern. Since everyone is vulnerable both to oppression and to abandonment, two moral visions--one of justice and one of care--recur in human experience. The moral injunctions, not to act unfairly

towards others, and not to turn away from someone in need, capture these different concerns (1987, "Moral Orientation and moral Development." In E. Kittay & D. Meyers (Eds.), *Women and moral theory*, Roman & Littlefield, p. 20).

Subsuming both justice and care under respect for persons seems to me to be the only way to harmonize these disparate moral standpoints.

Gilligan and Dillon have both argued for the value of partiality (for family, loved ones and friends) in concrete, particular situations and relationships. This indicates that impartiality is not universally acceptable, at least not in ethics of care, yet universalizability is. On the other hand, partiality has its own difficulties in gaining universal acceptability. Dillon implies agreement with these premises stating that,

Care is...not something we could or probably even should extend to those who stand outside our networks of personal relationships. Although care and personal relationships I would argue clearly have moral significance, nevertheless since care is not universalizable, we would be hard pressed to regard it as the whole of morality or as by itself a fully adequate basis for morality. (1992: p. 130).

I agree with her perspective that care cannot be regarded as the whole of morality; I disagree with her restriction upon care to one's "networks of personal relationships." In fact, I have just argued for its universal entailments and contend that our conception of care as a moral concept has important elements of being a universal principle, when grounded in respect for persons. On the other hand, I agree with her assessment that care is not universalizable as a first principle. What many of the care theorists I make reference to miss is the need to maintain a clear distinction between impartiality and universalizability. Care cannot adhere to justice, but is easily incorporated into respect for persons. Importantly, the universalizability principle, unlike the principle of impartiality, does not imply that one is morally forbidden to be morally partial.

My contention is that in order for care to embrace universalizability and the fullness of morality, the actions and decisions it motivates must be vetted by respect for persons. Daryl Koehn observes, "What is universal about caring, is not its form but rather the demand upon each of us to be caring" (1998, *Rethinking Feminist Ethics: Care, Trust and Empathy*. Routledge, London. p. 22).

The foundational character of respect for persons as a basic moral consideration has more far-reaching implications than what is usually understood by the moral requirements of “rights,” “equality,” and “justice.” It is possible to observe people's rights, treat them as equals, and be just in our dealing with them and yet fail to respect them as persons. Hence we do (and should) go beyond our commitments to social justice in dealing with every member of the moral community. This is not to downplay the importance of regarding the rights of persons. Indeed, it is generally agreed that respecting persons involves at least not violating their rights. However, as Landesman and Cranor point out, if it is held that persons are to be respected just because they have rights or that respecting persons is simply having a proper regard for their rights, the notion of respect for persons tends to lose independent status and moral credibility (1982, “Against respect for persons” p. 31-43 and “Limitations on respect for persons theories,” p. 45-60, In O.H. Green (Ed.), *Tulane Studies in Philosophy* 31, New Orleans).

The point is that the ethic of justice is necessary, but not sufficient, as a requirement for the propriety of the principle of respect for persons. Additionally, the ethic of justice presupposes little knowledge of situational specifics (Nunner-Winkler, 1984). Rather, we must view ourselves in abstraction from our personal circumstances, and hence with a “detachment . . . from the level of all motivations and perceptions other than those of an impartial character” (Williams, B., 1981, “Persons character and morality” In B. Williams, Ed., *Moral Luck* pp. 2-5. Cambridge). What is required by the ethic of justice is not to act in a specified way at any time or location. All one needs to know are some general empirical facts valid for all situations.

Therefore aspiring to act according to impartialist principles alone not only denies us of the orientation of caring, which is a central requirement in respect for persons, but also alienates us from ourselves. By this I mean that we are estranged from our roles and relationships that situate who we are and enhance our self-respect. In addition, at the level of our basic human instincts, we are not primarily motivated to go out of our way for our friends and loved ones from a sense of duty or justice.

I do favors for a friend, for instance, not because of general obligations, but responsively to the particular, unique person that she is and our relationship of caring. (Orkar, Miriam. "The Ethics of Justice and Care in the Respect for Persons Principle: Implications for Education" *Centre for the Study of Curriculum & Instruction*, vol.5, 1, August 1999, U. of British Columbia).

Another idea Blum put forth that is salient to this discussion is that it is actually the ability to care that allows one to intelligently apply principles and rules. In his words, Blum explains:

Knowing that the particular situation which the agent is facing is one which calls for the particular principles in question and knowing how to apply the principles in question are capacities which, in the domain of personal relations are intimately connected with care for individual persons (Blum, 1993:61).

I would, however, modify his point of view as the ability to act with caring respect in place of care. This is an important distinction because, as noted previously, caring, by itself, cannot ensure good decisions or right moral action. My earlier connections between attention to particularity and the fact that relevant differences do not violate universality can be brought into synch with Blum's sentiments of the role caring plays in our ability to determine how the relevant principles, grounded in respect, might most effectively and caringly be applied in particular patient care situations.

It is a physician's caring capacity that allows her to be sensitive to subtle differences and to know which principles to apply and how to apply them. In other words, Blum's insights confirm my association between caring respect and the ability to see what is at issue. Essential to care ethics is the question of what is at stake. What is essential to practicing caring respect is the need to value contextual analysis and the particularity of each individual patient before assessing which mid-level principle (or principles), as moral guideline, best leads to caring treatment of this patient as a person. I am in agreement with Blum that a certain level of intelligence, sensitivity and attentive care to the situation at hand is necessary for correct ethical behavior.

Many ethical theories value contextual analysis and patient particularity as essential and this methodology is not proprietary to the "ethics of care." Sara Fry argues that caring "must be grounded within a moral-point-of-view of *persons* rather than any idealized conception of moral action, moral

behavior, or system of moral justification" and is fundamental to nursing ethics (Fry, Sara T. 1992. "The Role of Caring in a Theory of Nursing Ethics" in *Feminist Perspectives in Medical Ethics*. Indiana U, p. 94). While she agrees that there is value in such principles as autonomy and beneficence, she explains, "neither of these values, derived from theories of medical ethics, has been convincingly argued to be the primary moral foundation of nursing ethics" (Fry, 1992: 96). This is essentially the same argument I am making for medical ethics regarding the 4 principles of B&C.

In her discussion of the ethics of care in nursing, Anne P. Griffin claims that caring is part of the concept of personhood without which a person could be considered crippled. Caring for Griffin denotes a primary mode of being in the world (Griffin, 1983:289). The ethics of care in the context of nursing, she continues, necessitates a constant state of "emotional" interaction with, and the absence of egoism towards, the patient.

I disagree with this assessment and contend that the mandate to perform every duty with emotional interest in the patient renders the nurse (or physician) vulnerable to situations in which such emotional involvement is not warranted, and even undesirable. A patient may be abusive, for instance, or too demanding; a patient's physical and emotional state may be too traumatic and depressing to get emotionally involved in.

Anders Lindseth clarifies my point by making a distinction between focusing on relationships in an ethical theory and focusing on the feelings between the participants in this relationship:

If we are to justify our caring actions, we must look more closely at the caring relation and clarify what makes this relation ethical or unethical. We need a relation ethics which clarifies how we meet the challenges and relations in life in a good way. A relation ethics of this kind cannot be based on feelings ("Ethical reasoning in nurses' and physicians' stories about care episodes," *Journal of Advanced Nursing*, September 1992:102).

In other words, Lindseth recognizes that focusing on relationships and emotions as morally legitimate does not entail guiding moral action by emotional involvement. Although this is not the same claim as the suggestion that emotional involvement is a necessary criterion of care ethics, it is equivalent to Griffin's position insofar as Griffin heralds care as the primary ideal of nursing - its first principle.

Due to the fact that Griffin associates care with affective components of caring emotions, however, it follows that her version of care ethics does approximate the kind of ethical framework Lindseth warns against. Lindseth contends (as do I) that it is difficult to base a normative ethics on the concept of caring alone. This is due to the fact that our actions do not become ethically good by virtue of being caring actions (1992. "The Role Of Caring In Nursing Ethics" in *Quality Development in Nursing Care: From Practice to Science*: p 101). Care cannot be relied on *exclusively* as an emotion, or even as a virtue or principle by which we can determine what to do. This requires at least an implicit commitment to the dignity and value of patients articulated in the language of respect as caring-respect.

Jeannine Boyer Ross and James Lindemann Nelson suggest that caring's role should be understood "not as an alternative object of value, competing with autonomy or patient good, but rather as an alternative way of responding toward that which is of value." They elaborate that caring does not parallel 'autonomy' in the principle of 'respect for autonomy'; it does not parallel 'utility' in the principle 'maximize overall utility.' "What it more nearly corresponds to are the ideas of 'respect,' the way in which we comport ourselves regarding that which we value" (1994. "A Comment on Fry's 'The Role of Caring in a Theory of Nursing Ethics'" in *Feminist Perspectives in Medical Ethics*. I. U. Press. pp 107-108). The term Care, then, is not synonymous with caring emotions and feelings, but rather is synonymous with what a person sees as being of value and how she adjudicates among the things she values. In the medical context caring-respect is the caring recognition of the value of each patient and guides us in how this recognition translates respect for persons into the appropriate comportment of caring towards this particular patient.

Reconceiving Our Moral Principles in Alignment with Caring-Respect for Persons

Care and caring (both the ideal and the disposition or virtue) constitute a fundamental moral feeling, along with respect, in the development of ethical understanding. Care, however, cannot be

relied on exclusively (as the moral feeling of an emotion) to be the determinant of what we “ought” to do. Reliance on caring attitudes can only be admitted as foundational in collaboration with the considerations of respect for persons.

Under the edifice of respect for persons lies a malleable understanding of the relationship among mid-level principles and the non-hierarchical ordering of priority among them. Exponents of the contemporary bioethical principles need to be re-educated with regard to the kind of contextual sensitivity caring-respect requires and to the kinds of questions respect for persons demands that these ethical principles address. It may be the case that in such a process, new principles will be identified which simply cannot be accommodated by the limited issues which the currently employed principles cover. For the present, however, I am of a mind that there is ample room for significant corrective ethical work to be done in our re-conception of these secondary principles without rejecting the existing principles outright.

Caring-respect espouses a relationship of connectedness and interdependence that, in medical practice, is best actualized within a covenant of trust. A legalistic respect for autonomy within a model of legal contract, conversely, fosters self-interest between physician and patient. There is a historical tendency in bioethics to value, and particularly to protect, individual autonomy in response to the perception of antagonistic relations between doctors and patients. Many authors in the literature of care ethics discuss the thesis that such antagonism and differentiation led to the development of a conception of autonomy in the first place. Though that may be true, it has become the principle of respect for autonomy in the work of B&C that often results in the distancing of patients from physicians.

If the concept of an autonomous individual is considered in an alternative manner (if instead of antagonistic and defensive states of nature, cooperative and interdependent dispositions are posited), individualism does not necessarily entail the same kinds of self-interested considerations as it

generally does in the context of the theory of biomedical ethics. Virginia Warren suggests that we need to explore alternative moral principles or values.

Those we have now are best suited to handling conflicts over power and authority. I believe that autonomy, in particular, needs to be reconceived. In medical ethics, the principle of autonomy is most frequently used to fend off others' attempts to make one's decisions. Alternative conceptions might include self-expression (as opposed to self-mastery) ("Feminist Directions in Medical Ethics," *Hypatia*, Summer 1989: p. 80).

Insights such as this, point to the work of reconceiving our moral principles in medicine that I am promoting, grounded in our foundation of caring respect. I propose that autonomy might be better understood as empowerment.

The tendency in medical ethics to marginalize emotions as partial sources of knowledge or decision-making is disputed in George David Miller's citation of Paul Lauritzen: "Emotions are essential, not 'morally peripheral' to the moral domain" (Miller, 1993: p.105). Blum supports this challenge to traditional epistemological assumptions in a quasi neo-Kantian position. His position suggests that one can see the categorical imperative essentially as a tester, rather than a generator, of maxims; the original source of maxims is allowed to lie in intuitions, feelings and emotions. This rejects a traditional understanding of Kant in which moral principles or actions are themselves derived from pure reason alone (Blum, 1993:55). More recent interpretations of Kant on this point (such as is offered by Allen Wood) understand Kant as relying upon moral feelings and intuitions and even being informed by the emotions.

According to these premises (the validity of which I will not challenge due to the parameters of this dissertation), it follows that emotional content in what constitutes "autonomy" does not invalidate rational decision-making, nor does it imply coercion by forces alien to moral decision-making. I think that implicit in the notion of empowerment are feelings of self-esteem and self-confidence that are required to think for oneself and act upon one's own considered judgments.

With regard to adequate information, medical ethicists and practitioners of medicine may see the dilemma of providing patients with full versus partial information in a different light. In general,

the justification given for withholding information is the argument that the knowledge of certain facts will cause emotional reactions in patients which will (or may) result in irrational decision-making processes. If, however, emotional reaction is included as a viable aspect of autonomous deliberation, it follows that what is usually classified as justifiably undisclosed information will be reassessed as necessary information for an autonomous decision. Emotional reactions could and should be seen as important states to recognize, consider and respect, rather than as states to avoid and devalue. Furthermore, since the singular alleged justification for withholding information is suspect, if not specious, the acceptance of emotions into our deliberations removes the last hurdle to full disclosure.

An example of how beneficence could be reconceived through the lens of caring-respect is evident in Sally Gadow's definition: "The covenant of care I have in mind is the commitment to alleviating another's vulnerability." In response to the potential criticism that this is consistent with everything a physician does, Gadow hastens to add, "The treatment measures that first come to mind as the most dramatic efforts to alleviate vulnerability - for example, surgical interventions - are actually the least consistent with the concept I am proposing" (1988. "Covenant without cure: Letting go and holding on in chronic illness" in *The Ethics of Care and the Ethics of Cure: Synthesis in Chronicity*. Eds. Watson and Ray. New York: National League for Nursing).

Thus for Gadow, the paramount dilemma in health care is not life or death, but rather the difference between intensifying as opposed to acknowledging and addressing vulnerability. Gadow continues that:

The question is not whether to hold onto or let go of life, but whether or not to hold or let go of the special covenantal relationship of caring. Giving up on cure and giving in to death need not mean letting go of that relationship (1988: p. 14).

Howard Leventhal corroborates this hypothesis by reporting that "the usual process of informing patients, i.e., naming medical procedures, describing how they are performed...does not tell patients how it will effect their lives (Benner, P. & Wrubel, J. 1989. *The Primacy of Caring*. Ontario: p.12).

Given the connection between an interpretation of autonomy as interdependent and the

recognition and respect for emotions and affective ties among individuals, the following comment from Benner's research is pertinent. She writes that "if we understand the patient as constituting and constituted by relationships, we gain new perspective on the role of the body, of the situation, and the role of personal concerns in the processes of stress and coping" (1989: p.12).

Instead of the legalistic contractual model of patient and doctor relations in which self-interested contractors follow rules whose purpose is to protect those rights, I have proposed a covenant of trust, in which rights are recognized because they discipline the desire to help, as well as block the temptation to exploit. Caring-respect does not merely entail a different emotive and affective response on the part of the health care practitioner towards the patient. Rather, the ethics of caring-respect asserts an alternative conception of autonomy, and re-evaluates the worth and importance of emotions. They are not, however, constantly brought into play; in most relationships most of the time they lie unused and unnoticed in the background of caring interactions. This approach has not merely shifted the battle lines, but offers the genuine possibility for a confluence of positive influences upon enriching the central relationship of patient and doctor. Acknowledging that there are many poorly understood mechanisms by which ground level communication, respect and trust can prosper in unconventional ways within covenantal medicine calls contemporary medical ethicists to embrace, develop and re-write the terms of doctor-patient engagement.

I have argued that caring-respect for persons draws our attention to a higher level of particularity and context while not violating consistency, universality, or human dignity. As long as similar cases are treated in similar ways, neither medicine nor physicians should hesitate to endorse an approach that is more flexible and malleable to the particular vicissitudes of specific patient situations; rather, they should find it more practical and useful.

Should we decide that a system that cultivates trust, and facilitates regular, healthy doctor-patient relationships is critical to good and effective medical care, then bold and committed steps need to be taken in our health care delivery system.

Adopting a patient-centered philosophy in the doctor-patient relationship imposes the duty on doctors to do the utmost in caring for patients, and allows the sick to claim their right to humane and dignified care from doctors. Only by restoring the element of trust in this ageless patient-physician covenant, can the soul of the medical profession be restored and preserved regardless of technological and social changes in society.

I have been arguing that this robust concept captures both the world of the universal and moral obligations and the world of the particular and the need for empathic care in the treatment of patients as persons. I think I have also demonstrated why the notion of care, alone, as suggested by Jonathan M. Breslin in his dissertation, “A Care-Based Model of the Physician-Patient Relationship” (briefly discussed in the last chapter) cannot ground the physician-patient relationship in care itself, for care cannot generate universalizable moral oughts unless it is grounded in respect for persons.

‘Caring respect,’ as I conceive it, anchors care and respect within an integrated ethical theory and tells us to respect persons as the persons they are. The fundamental moral orientations of respect and of care involve the same perception of their objects as persons and regard the same dimensions of human beings as worthy of attention. This intersection of accounts locates the same moral concern of caring-respect for persons in both the universal and in the particular.

Recognizing a connection between care and respect invites us to see care, care respect, and Kantian respect as arranged on a continuum of responsive stances toward others, rather than as competing or mutually exclusive. The notion of person considered in the abstract establishes commonality among all persons. Considered in the particular, it involves the details of similarities, connections, and relationships among individuals, as well as the many differences, characteristics and idiosyncrasies which identify and differentiate each person. Caring-respect responds to persons both in their distinguishing detail and in their shared humanity.

Care, when grounded in universal respect tries to achieve harmonious moral relationships in particular interpersonal situations by acknowledging differences, calling us to affirm others in their

differences and to embrace and perhaps even to celebrate human differences. Care demands that physicians take seriously, stay open to, and appreciate the differences in perspectives and values of their patients. Caring-respect thus enables caring doctors to value difference rather than seeing them as something that separates them from their patients or as an obstacle to 'ideal' medical care. The freedom to recognize and respond to individual differences in caring for their patients, while simultaneously respecting each patient equally and universally as persons, resolves the perceived conflict that must be overcome in the quest to provide for their patient's well-being. At the same time, the theoretical disputes between care-based, case-based, virtue-based and principle-based medical ethicists become manageable, if not resolvable, under the mutually shared commitment to caring respect for patients as persons.

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