The Relationship of Autonomy and Integrity in Medical Ethics[1]

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The emergence of autonomy as a sociopolitical, legal, and moral concept has profoundly influenced medical ethics. It has shifted the center of decision-making from the physician to the patient and reoriented the whole physician-patient relationship toward a relationship more open, more honest, and more respectful of the dignity of the person of the patient. But autonomy is insufficient to guarantee the nuances and the full meanings of respect for persons in medical transactions. As a foundation for medical relationships, the concept of integrity is richer, more fundamental, and more closely tied to what it is to be a whole human person. So, for reasons outlined in this article, we should deepen our grasp of the notion that autonomy depends upon preserving the integrity of persons and that both integrity of persons and autonomy depend on the physician.

"Integrity without knowledge is weak and useless, and knowledge without integrity is dangerous and dreadful."
SAMUEL JOHNSON (*Rasselas*, 1759)

In the last 25 years autonomy has superseded beneficence as the first principle of medical ethics. This is the most radical reorientation in the long history of the Hippocratic tradition. As a result, the physician-patient relationship has become more honest, open, and respectful of the dignity of patients.

This shift in the locus of decision-making is a response to the coalescence of sociopolitical, legal, and ethical forces that make it well-nigh irreversible. The central ethical question today is not whether patient autonomy will remain a predominant principle. Rather, the issue involves a critical assessment of patient autonomy's full impact on the relationships between physicians and patients. Does the principle of autonomy as now construed encompass the full meaning of respect for the dignity of persons? May the tendency to absolutize autonomy defeat some of the purposes for which it has been so vigorously propounded? Is there a deeper source for the principle of autonomy that more fully encompasses the special nuances required by authentic respect for persons?

In this essay I shall argue: (1) that autonomy as now construed has certain moral and practical limitations; (2) that these limitations can be ameliorated by linking autonomy to the principle of respect for the integrity of persons; and (3) that this move encompasses a more fundamental and richer safeguard for the dignity of both patient and physician

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than current interpretations of the principle of autonomy.

I shall attempt to advance these propositions by examining the following: (1) the origins and nature of the concept and principle of autonomy and its expression in today's paradigm for ethical decision-making; (2) the concept and principle of integrity, its relationships to autonomy, and the distinctions between integrity and autonomy; and (3) the relationship of the principles of autonomy and the integrity of persons to the virtue of integrity.

AUTONOMY: ITS ORIGINS AND NATURE AS A CONCEPT AND PRINCIPLE

Autonomy, despite its universal usage in medical ethics, is too often simplistically interpreted, as Faden and Beauchamp have so cogently pointed out (*1*). For example, they make a sharp and valid distinction between the autonomous person and the autonomous action, preferring in their treatment of informed consent to emphasize the autonomous act, rather than the autonomous person. While agreeing with their distinction, this essay will place more emphasis on the autonomous person and on the relationship of that concept to the concept of the integrity of persons which underlies it.

Autonomy, in keeping with its Greek etymology, literally means self-rule. In today's parlance, autonomy has variously been interpreted as a moral and legal claim or as a right, duty, concept, or principle. For purposes of this essay, I shall take it to be a capacity for self-rule, a quality inherent in rational beings that enables them to make reasoned choices and take actions based on a personal assessment of future possibilities weighed in terms of their own value systems. In this view, autonomy is a capacity that flows from the fact that humans can think and feel and make judgments about what they deem to be good.

The universal existence of this capacity in rational beings does not guarantee that it can or will function fully or at all. Both internal and external constraints can impede autonomous decisions and actions. Internal constraints include such things as brain damage or dysfunction induced by disordered metabolic states, drugs, injury, lack of mental competence related to infancy and childhood, mental retardation, psychoses, obsessive-compulsive neuroses, etc. In these instances the physiological substratum requisite to the exercise of the capacity for autonomy is impaired—sometimes reversibly, sometimes not.

Or else autonomy, while unimpaired internally, may be prevented from operating by external events like coercion, physical and emotional deception, or deprivation of essential information. In these cases the person has the capacity for self-rule, but that capacity cannot be realized in an autonomous act, i.e., an act that gives evidence of "autonomous authorization" (*2*). (An autonomous act satisfies the criteria for informed consent. It is a decision and act free from internal or external constraints, informed as fully as the situation requires, and consistent with the person's evaluation at the moment of choice of that person's own value system.)

The existence of the capacity for self-rule is so deeply embedded in what it means to be a human being that it constitutes a moral claim, a claim which generates a duty of respect in other persons. This claim is expressed as the principle of autonomy: i.e., so act in relationships with others that their capacity for autonomy (and thus their moral claim) can be exercised as fully as circumstances will permit.

Social and Political Sources

The recent shift in the locus of the decision from physician to patient, while seemingly abrupt, had been developing in the Western world since the birth, in the eighteenth century, of the modern idea of a participatory democracy. This article is not the place to review that history. We need only enumerate the sociopolitical forces that coalesced in the mid-1960s to place autonomy in the forefront of medical ethics legally and philosophically: the Nuremberg trials; the worldwide spread of participatory democracy; mistrust of authority in general and technical expertise in particular; the expansion of public education; the civil rights movement; the intrusions of law, economics, and commerce into medical decisions; and the challenges of biotechnology that had to be faced in a progressively pluralistic society that could muster little moral consensus.

These forces converged to engender both mistrust of the physician's traditional paternalism and a demand for self-determination and informed consent in medical relationships. "Autonomy" has become the watchword that symbolizes the moral and legal claim of patients to make their own decisions without constraint or coercion, however beneficent the physician's intentions might be. The sociopolitical claim to autonomous decision and action was reentered by the legal concept of privacy and by the philosophic principle of autonomy.

The Legal Basis for Individual Autonomy

Though still debated among legal scholars, the legal basis for the claim to autonomy is usually grounded in the right to privacy (*3*). Such a right is not specifically stated in the United States Constitution, but has been derived in a series of Supreme Court decisions as a "penumbra" of several amendments of the Bill of Rights (*4*). This right to privacy has been applied in practical terms to the right of personal decision regarding the education of children, choice of a marriage partner, religious preference, access to contraceptive devices, and termination of pregnancy (*5*). This same right has been explicitly invoked to protect a patient's right to refuse medical treatments (*6*).

In the last two decades, the legal right to self-determination has been progressively extended from the patient to his or her surrogate, from mechanical respirators to food and fluid, from terminal to nonterminal patients, and from the patient himself to his or her living will.[3] This legal right to self-determination and privacy has acted as a powerful restraint on the traditional benevolent paternalism of the physician. It has also given impetus to the doctrine of informed consent.

The Philosophic Roots

The principle of autonomy has several sources in moral philosophy. One is Locke's *Second Treatise on Government*, which held Man in the state of Nature to be free and equal so that none might have sovereignty over another except through a social contract freely entered into (*7*). Locke's arguments gave rise to

[3] *In re Quinlan*, 70 N.J. 10, 355 A. 2d 647 (1976); *In re Eichner*, 52 N.Y. 2d 363, 420 N.E. 2d 64, 438 N.Y.S. 2d 266, *cert. denied*, 454 U.S. 858 (1981); *In re Conroy*, 98 N.J. 321, 486 A. 2d 1209 (1985); *Bouvia vs. Superior Court (Glenchur)*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (Ct. App. 1986), *review denied* (Cal. June 5, 1986); *In re Jobes*, 108 N.J. 394, 529 A. 2d 434 (1987); *Brophy vs. New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E. 2d 626 (1986). One exception is the Missouri Supreme Court in *Nancy Beth Cruzan vs. Robert Harmon et al.* (#70813 Miss. Sup. Ct., Nov. 16, 1988), which expresses "grave doubts as to the applicability of privacy rights to decisions to terminate food and water to incompetent patients."

the notion of "negative rights"—rights of a person not to be interfered with by others. These negative rights have come to be the foundation of liberal democracy for many people (*8*).

A second powerful and influential philosophical moral claim to autonomy is propounded in Kant's *Groundwork for the Metaphysics of Morals* (*9*). Here Kant argues that freedom is essential to all morality, that it is identical with autonomy, and that autonomy is "the ground of the dignity of human nature and of every rational nature" (*10*). Kant unites the idea of a rational being with dignity this way: ". . . a rational being himself must be the ground for all maxims of action *never merely as a means*, but as a supreme condition restricting the use of every means, that is, *always also as an end*" (*11*). "And the dignity of man consists precisely in his capacity to make universal law, although only on condition of being himself subject to the law he makes" (*12*).

A third source for a moral claim to autonomy is John S. Mill's essay *On Liberty*. Mill asserts that the only restraint on liberty is harm to others, not harm to self (*13*). This latter notion, joined with the Lockean idea of negative rights, is the major connecting link between the philosophic notion of autonomy and the legal notion of privacy. This link is most influential with the courts in America. It is the principle generally used to resolve conflicts about who should make the final decision in accepting or rejecting medical treatments. It is the dominant concept as well in the report of the President's Commission on withholding and withdrawing life-sustaining treatment (*14*).

This conjunction of the legal concept of privacy and the moral concept of autonomy has resulted in a widely accepted medical decision-making paradigm: Competent patients have the moral and legal right to make their own decisions, and these decisions take precedence over those of the doctor or the family. When patients are no longer competent (or have never been competent—e.g., patients such as infants or the retarded), their rights of decision are transferred to a valid surrogate or to some anticipatory statement by the patient (such as a living will, medical directive, or durable power of attorney), or in the absence of these to a legally appointed guardian. Some have so absolutized the principle of autonomy and the right of privacy that they would place no limits on its exercise. Others accept varying degrees of limitation on autonomy. We shall return to these exceptions later when we examine the links between autonomy and integrity.

The most concrete actualization of the principles of privacy and autonomy lies in the doctrine of informed consent that has become the central requirement of morally valid medical decision-making. For consent to fulfill the claims of human persons to self-governance, it must be based on sufficient information to make a reasoned choice and must be free of coercion or deception. The procedures surrounding informed consent are designed to facilitate the capacity of rational beings to make judgments of what they consider best rather than what the physician or any other person might consider best for them.

Deficiencies of Autonomy as a Moral Guide

There can be no question of the importance of the sociopolitical, legal, and moral emphasis on autonomy in protecting the patient's right of self-determination. But there are certain limitations to the concept of autonomy itself that may impede the fullest expressions of the respect for persons which autonomy is supposed to enhance.

For one thing, autonomy has come to have a strong legalistic quality centering

all too often on invasion of privacy, assault, battery, and tort law in general. Such conceptions tend to moral minimalism, i.e., to fulfillment only of what is specifically prescribed. Documentary evidence and protection against lawsuit become almost obsessive concerns, rather than the moral quality of the consent process. This focus fosters the all-to-frequent view of the physician-patient relationship as a contract rather than a fiduciary relationship or a covenant. The fiction is encouraged that a contract is possible in a relationship in which one party is ill, vulnerable, and exploitable while the other holds the needed knowledge and power. In this contractual view, the procedures for making a valid informed consent, important as they are, come to take the place of the substantive moral issue itself.

A strong emphasis on self-determination also minimizes the physician's obligations of beneficence and effacement of self-interest. Some even see beneficence as antipathetic to autonomy—a false dichotomy I shall treat a little further on in this essay. Autonomy, when viewed as a legal right or even as a moral claim, can severely circumscribe the range of discretionary decisions—those unanticipated choices the clinical situation may force on the physician. Ordinarily the physician would feel free to act in the patient's best interests as he himself perceives them. For example, the proposed "medical directive," which consists of six pages of detailed instruction on how the physician should manage life-sustaining and other treatments, could easily lead to a paralysis of decision-making injurious to the patient (*15*). When patients are unable to spell out everything in advance, the physician may spend more time trying to figure out what the patient wishes than deciding what is in the patient's best interests.

Finally, the prevailing emphasis on autonomy generates a cult of moral privatism, atomism, and individualism that is insensitive to the fact that humans are members of a moral community. When autonomy is absolutized, each person is a moral atom who asserts his or her rights independently and even against the claims of the social entity to which he or she belongs. Conflicts between the rights of a community and the rights of its individual members raise serious questions of economic and social justice that demand a better balance between autonomy and the common good than now prevails.

Many of the moral shortcomings of the concept and principle of autonomy are ameliorated if we look to the more fundamental concept of integrity of persons—of which autonomy is a partial, but not a full, expression.

INTEGRITY OF PERSONS AND PERSONS OF INTEGRITY

Etymologically, integrity is from the Latin *integer*, and it means wholeness, completeness, or unimpaired unity. It is a more complex notion than autonomy. Integrity encompasses autonomy, because loss of autonomy impairs acting as an intact and whole human being. But autonomy is not synonymous with integrity of the person, since integrity includes physiological, psychological, and spiritual wholeness. Autonomy is a capacity of the whole person, but not the whole of a person's capacities. As Karol Wojtyla puts it, "integration is an essential condition for the transcendence of the person in the whole of the psychosomatic complexity of the human subject" (*16*). Gabriel Marcel puts it this way: "I want to run my own life" is "the radical formula of autonomy." Autonomy belongs to the

order of *having*, to the things we possess, while true freedom belongs to the order of *being*, to what we *are*. In this view, freedom may paradoxically include even nonfreedom (*17*).

Integrity has two senses of significance for medical ethics. One sense refers to the integrity of the person, of the patient, and of the physician; the other refers to being a person of integrity. In the first sense, integrity is a moral claim which belongs to every human simply by virtue of being human. In the second sense, integrity is a virtue, a moral *habitus* acquired by constant practice in our relation with others. Integrity belongs to all persons as humans, but not all are persons of integrity. Each sense of integrity has important ethical implications in medical ethics.

Integrity of the Person

By the integrity of the person we mean the right ordering of the parts to the whole, the balance and harmony between the various dimensions of human existence necessary for the well-functioning of the whole human organism. The integrity of a person is expressed in a balanced relationship between the bodily, psychosocial, and intellectual elements of his or her life. No one element is out of proportion to the others. Each takes the lead when the good of the whole requires it. Each yields to the other in the interest of the whole. Integrity in this sense is synonymous with health. Disease amounts to disintegration, a rupture of the unity of the person (*18*). This rupture may occur in one or more of three spheres, each with its own ethical implications: the corporeal, the psychological, and the axiological.

Bodily integrity implies a physiologically well-functioning organism, a body that can serve the aims and purposes of the person efficiently and effectively with a minimum of discomfort or disability. With physical illness, corporeal unity is shattered. The body (or one of its organs) becomes the focus of attention and loses some or all of its capacity for work, play, or human relationships. There may even be loss of an organ or a function. The functional integrity of the whole organism is disrupted by a sick organ, organ system, or metabolic mechanism.

Illness may also assault the psychological integrity of the person in two ways. First, emotional illness is a form of disintegration in which anxieties, obsessions, compulsions, illusions, and other psychopathologic disorders assume control of existence. The resulting distortions of the balance and unity of the person interfere with that person's well-functioning as much as the rupture of corporeal unity.

Second, psychological integrity is the unity of the self in its relationship to the body. When illness afflicts a part of the body, we feel alienated from that part, we stand in some senses away from the offending body, and we sometimes reject it and resent it as an enemy. The image we have fashioned of our self-identity relative to our bodily integrity is threatened. We all live with a unique balance we have struck over the years between our hopes and aspirations and the limitations imposed by our physiological, psychological, or physical shortcomings. Serious illness forces a confrontation between that image and the impact of disability, pain, and death. It confronts us with the possibility of a substantially altered self-image or even nonexistence. A new image, new points of balance, and a new definition of what constitutes health must be established if we are to become "whole" again.

Another facet of the integrity of persons is axiological integrity, i.e., the intactness of the values we cherish and es-

pouse. Each of us is in a real sense defined by the particular configuration of values we have chosen as our own. In illness these values may be in conflict with those of the physician, our families, or society. Our conception of healing reflects our personal assessment of what constitutes well-functioning. This is as much a value-determined conception as it is a physical or psychological one. In order for us to be cured or treated, our most cherished values must also become the subject of the physician's scrutiny and possible manipulation. Thus, our values are at risk of challenge or damage in the medical transaction.

The potential for the tripartite disintegration of the person, which is part of being ill, creates obligations for the physician—who is bound by covenant to heal and help. Healing means to make whole again, that is, to reestablish the wholeness that constitutes a healthy existence. To be faithful to this covenant the physician is obliged to remedy disease-inflicted disintegration of the person. In this view, restoration of the integrity of the person is the moral basis of the physician-patient relationship. That is why any morally authentic doctor-patient relationship must by definition be "holistic."

In illness the vulnerability of the patient's body, psyche, and values generates the obligation to enhance and restore the patient's autonomous capacity for decision-making. Autonomy is thus grounded ultimately in the integrity of the person. To usurp the patient's human capacity for self-governance is to violate that integrity. To ignore, override, repudiate, or ridicule the patient's values is to assault the patient's very humanity. This affront aggravates the disintegration of the person already there as a result of illness. Nothing could be further from a morally defensible healing relationship.

Paradoxically, however, in order to repair the disintegration produced by disease the integrity of the person must to some degree be violated. The physician lays hands on the patient, peers into every orifice, inquires into the details of the patient's social relationships and psychological responses. This is a licit invasion of integrity to which the patient gives assent. But consent cannot obviate the exposure of integrity to serious risk attendant upon medical treatment. Such risk is another source of moral obligation that binds the physician, in exercising the right to invade the integrity of the patient, to do so with the utmost care and sensitivity.

The Limits of the Patient's Claim to Autonomy

However fundamental, the patient's moral claim to respect for his integrity and autonomy is not absolute. There are several limitations that arise when the patient's moral claim conflicts with the equivalent claim to integrity made by other persons.

One such limitation is the claim of the physician, as a person, to his own autonomy. The patient cannot violate the physician's integrity as a person. If the physician is morally opposed to abortion, euthanasia, withdrawal or withholding of food or fluid, or artificial insemination, for example, he cannot be expected to comply with the patient's autonomy and suppress the integrity of his own person. This will become an increasingly important matter as morally debatable procedures such as voluntary and involuntary euthanasia become legalized or, eventually perhaps, become eligible for the benefits of health insurance. Both physician and patient are obliged to respect the integrity of each other's person; neither may impose his or her values on the other. Therefore, respectful withdrawal from the relationship may be nec-

essary for the physician or the patient in order to avoid cooperation in acts that might compromise personal moral integrity.

Another limitation on a patient's autonomous decision occurs when action might produce a serious, definable, and direct harm to another person. An example here is the patient who is HIV seropositive and refuses to have that fact revealed to his or her spouse or sexual partner. In this instance the physician cannot withdraw, but instead has the obligation in justice to tell the person at risk, after first offering the patient the opportunity to do so. The same limitation applies to the patient who wishes to conceal some health problem that might compromise his or her capacity to fulfill a position of trust—e.g., as a pilot, surgeon, or cleric.

The autonomous decision of a valid surrogate must also be resisted if there is clear evidence of a conflict of interest that might lead to the overtreatment or undertreatment of an infant or incompetent adult. The physician's primary obligation is the preservation of the integrity of the person who is his patient. Under circumstances like these, the physician cannot withdraw but must take the measures available in a democratic society to protect the patient's interests. This protection may involve referral of the matter to an ethics committee, appointment of a legal guardian, or court intervention to limit the autonomy of the surrogates in emergencies, when the outcome is in doubt and when, in the absence of a specific instruction, the physician must act in the patient's best medical interests—at least until the patient's wishes are clear.

Finally, the patient may, on the moral strength of his or her own moral claim to autonomy, yield up his or her claim to autonomy. Sometimes the physician has made a sincere effort to involve the competent patient, yet the patient does not wish to participate as fully as others might. The patient might then ask that the physician should decide what is "best." Under such conditions, and only these, the physician has a moral mandate to decide for the patient—that is, to act in the patient's place and in the patient's interests. Not to do so is a form of moral abandonment. But the physician must never assume this mandate nor accept it too eagerly or lightly.

Carried to extremes, the morally justifiable claim to autonomy could erode the communality of human existence. Autonomy absolutized leads to moral atomism, privatism, and anarchy. Humans are social animals. They cannot be fulfilled except in social relationships, as Aristotle so wisely pointed out (*19*). The community within which the patient resides has moral claims as well. This communitarian dimension of biomedical ethics is in danger of compromise if the current drive for autonomy is not modulated and balanced against the moral claims of other persons and the community.

The community, too, has a claim to integrity, i.e., to the same kind of wholeness, completeness, and intactness to which the individual lays claim. The fabric of a society can be torn, and the existence of society itself threatened, if individuals retreat into private morality independent of the community. We are in some danger of this when individuals or groups with special interests irresponsibly use resources common to all. Economically, the entrepreneur threatens the integrity of society when he despoils the environment. To a certain degree so do physicians, patients, or families who demand and use scarce medical resources when treatment is futile or the benefits disproportionate to the costs.

Patients, therefore, owe a debt to the community for the lifelong benefits they derive from being members of human

communities. They should feel some duty to limit their demands for expensive or marginally beneficial treatments and technologies that impose financial burdens on society and their families. Among other things, out of a sense of social justice, voluntary limitations should be placed on life-support measures that are futile or that merely prolong the act of dying.

Finally, if we look at autonomy as a derivative of the integrity of the person and not as an isolated ethical principle, the presumed conflict between autonomy and beneficence should disappear. Paternalism should not be equated with beneficence, as some authors propose (*20*). Paternalism involves the physician's usurpation of the patient's moral claim as a human being to decide what is in his or her own best interests. This action violates the integrity of the person and can under no circumstances be a beneficent act. Rather, to be beneficent, respect for the patient's values and choices is essential. As Thomasma and I have pointed out elsewhere, the physician holds beneficence in trust (*21*), a point I will enlarge upon a little later.

Autonomy and Integrity Contrasted

We may summarize the differences between autonomy and integrity as follows:

Autonomy is a capacity inherent in being a rational person. It is something we have or possess. If we have never developed our capacity for rational judgment we do not have autonomy, and we can lose our autonomy when we lose this rational capacity. We can have degrees of autonomy, however, depending on the interactions of internal and external impediments to the operation of our capacity for self-determined choices and actions. Under these circumstances our right to autonomy can be transferred to the decisions of a morally valid proxy or to a document like a living will, a durable power of attorney, or a medical directive. To transfer our autonomy is to violate an important part of our humanity, but it does not deprive us of our status as human persons.

Integrity, on the other hand, is a matter of being. It is an attribute possessed by all humans—competent or not, adult or not, conscious or not. It does not admit of degrees, nor can it be lost. Hence, integrity is not something we have but is part of our being. It cannot be transferred to someone else. To violate our integrity is to violate our whole being as humans.

Integrity of the Decision

The principle of respect for integrity can and does ameliorate some deficiencies of the principle of autonomy. For one thing, respect for integrity is inconsistent with the minimalistic view of some physicians—namely, that autonomy is reducible to a right to refuse treatment. In order to truly respect the integrity of the person, we must strive to give integrity to his or her decision as well, to respect a wholeness that places that decision within the history and the background of the patient's life. A particular decision can never stand isolated from the whole narrative of the patient's life, the drama he or she has lived and is living, and the way he or she perceives self, family, and community in relation to the decision in question. All of these particulars must enter into the final choice if that choice is to have integrity in itself and be the act or decision of a whole or complete person.

Respect for the integrity of persons also moves the patient's decision from the level of simple assent or dissent to the level of consent—because it implies mutual and consensual arrival at a decision by the doctor and patient acting together. In this view, respect for the integrity of

persons requires a positive effort to get not just a decision that is autonomous by external criteria but one that represents the common ground of knowing and feeling that exists between the doctor and patient. It is not a case of the patient assenting or dissenting as an isolated entity, but of the doctor and patient consenting—that is, acting together, with each respecting the integrity of the other's person.

The Person of Integrity

The law of privacy, the principle of autonomy, and respect for the integrity of persons are necessary but not sufficient to fully preserve the integrity of the sick person in the medical transaction. What is indispensable is the person of integrity, the person of moral wholeness, who can be trusted to respect the nuances and subtleties of the moral claim to autonomy. The physician, therefore, must be a person who exhibits the virtue of integrity, a person who not only accepts respect for the autonomy of others as a principle or concept but who can also be trusted to interpret its application in the most morally sensitive way.

The ultimate safeguard of the integrity of the patient's person is the fidelity of the physician to the trust inherent in the healing relationship. It is the physician who interprets and applies the principle of autonomy. Much depends upon how the physician presents the facts, which facts are selected and emphasized, how much or how little is revealed, how risks and benefits are weighed, and how the fears and anxieties unique to the patient are respected or exploited—in sum, how the physician uses his or her "Aesculaean power." Every patient, the most educated and the most independent, is potentially a victim or a beneficiary of that power. As a result, the physician has a heavy responsibility to be sensitive to the dependent, vulnerable, frightened state of the patient and not to exploit that state, even if the physician deems it to be in the patient's best interests.

Clearly, no contract, law, or abstract ethical principle can eradicate the need for trust, just as trust cannot be eradicated from any other human relationship. The present emphasis on autonomy has served to reduce the grosser violations of the integrity of persons. But the physician's character remains the ultimate safeguard of the patient's autonomous wishes.

The physician is the pathway through which decisions, actions, and policies relating to the patient must pass. He or she is in a position to enhance and protect the patient's capacity for self-determination. This sensitive position does not give the physician privileges, but only a heightened responsibility to be a steward of the moral quality of the healing relationship and the integrity of the person of the patient. The physician must never forget that he or she is automatically a moral accomplice in any policy, act, or decision that endangers the patient's integrity and autonomy. The fiduciary relationship is never entirely eradicable from the medical relationship. The physician must therefore be a person of integrity and must cultivate the virtue of fidelity to trust. In fact, fidelity is perhaps the most fundamental of the virtues of the physician—as essential as beneficence and effacement of self-interest (22).

The relationships between autonomy, integrity, and trust that I have outlined for the medical relationship are of course not unique. But the nature of illness (what it portends physically and emotionally) and the invasions of the integrity of persons that are entailed in being healed—taken together—form a constellation of obligations rarely encountered in other kinds of human activity. To be sure, medical ethics is a part of general

moral philosophy—but an exquisitely sensitive part, given the phenomenology of being sick, being healed, and offering to heal.

For these reasons, a formula for morally defensible decision-making appears to be this: The decision should not be made by the physician in place of the patient, nor by the patient in isolation from the physician or the community. Phenomenologically, these elements of a medical decision are inseparable from each other. The morally optimal condition is one in which the decision arises between doctor and patient. That is, the physician should make the decision for, and with, the patient—the "for" signifying not "in place of" but "in the interests of" the patient. This formulation preserves the legal right to privacy, the moral claim to autonomy, and the deeper moral claim to the integrity of persons.

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