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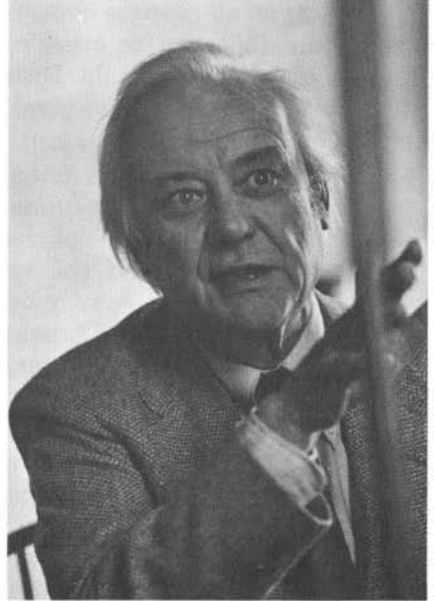
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The Distinction Between Rights and Responsibilities: A Defense

John Ladd

The author is a professor of philosophy at Brown University, Providence, R.I., where he was the first head resident faculty fellow from 1952-55. He was a visiting professor at Harvard University in 1961 and a visiting lecturer at Smith College in 1961-62. Prof. Ladd served as president of the American Society for Political and Legal Philosophy from 1976-78. This article relates to the one preceding, on page 111.



The purpose of this article is to clarify and defend certain ideas about rights and responsibilities that I set forth in an earlier article entitled "Legalism and Medical Ethics." (Hereafter referred to as LME.)¹ I shall be specifically concerned with answering criticisms of the distinction between rights and responsibilities that have been brought against it in two recently published articles.²

In LME, I compared and contrasted two different conceptual models for dealing with problems in medical ethics in general and more specifically with problems concerning the relationship between physicians and their patients. I called them "the model of rights" and "the model of responsibilities." In commenting on what I called "legalism," represented by the model of rights, I observed that the ethical vocabulary employed in the current literature in medical ethics is almost entirely restricted to the language of rights. I argued in rather specific terms that this choice of a narrow, specialized vocabulary has the effect of limiting our understanding of some of the basic issues of

medical ethics and diverts our attention from other important issues that are not directly related to questions of rights. In general, my position is that the vocabulary of ethics is a very rich one indeed. There are many different ways of conceptualizing moral relationships and a multiplicity of useful conceptual models for dealing with moral problems and issues besides the language of rights. In this vein, I did not intend to suggest that the language of rights be abandoned altogether; rather my underlying position was anti-reductionist. I was simply pleading for greater conceptual flexibility and less slavish adherence to a narrow and restricted ethical vocabulary. To use "rights" as an all-purpose conceptual tool in medical ethics is a bit like using a meat cleaver for every cutting purpose — for sewing as well as for brain surgery. Ronald Dworkin likens rights to trumps; but I should add, it is not always good or necessary to play trumps.³

The two critical articles with which I am concerned here are reductionist in effect, if not in intent, for they imply that in dealing with problems in medical ethics, one has to choose between the concept of rights and the concept of responsibilities. However, interestingly enough, the authors of the two articles approach the issues quite differently and reach exactly opposite conclusions. In the first article, Sara Ann Ketchum and Christine Pierce opt for the language of rights against the language of responsibilities. In the second article, on the other hand, Clifton Perry contends that the distinction between rights and responsibilities is a "distinction without a difference" and that the difference between the two concepts is therefore simply a difference in "defeasibility" (i.e., stringency) and not a qualitative one at all. As a result, he discards the ethics of rights (in my sense) in favor of an ethics of responsibilities. Accordingly, insofar as both articles are conceptually reductionistic, either in favor of reducing the language of medical ethics to the language of rights or of reducing it to the language of responsibilities, it is easy to see how they could not fail to come to conclusions that are inconsistent with mine, which presuppose an anti-reductionist approach.

The Ambiguities of "Rights"

Although I did not emphasize the point as strongly as I should have in LME, one of the chief difficulties in most present-day medical ethics discussions which refer to rights is that they hardly ever explain which particular meaning of the term "rights" is involved, for example, in expressions like "the right to life," "the right to medical care," "the right to die," "the right to an abortion," "the right to see one's medical record," "the right to have a second opinion," "the right to refuse treatment," etc. (I assume that we are speaking here of moral and not purely legal rights.)⁵ In my discussion of rights in LME, in order to avoid being trapped by the ambiguities of the term

"rights," I tried to specify as carefully as I could what I meant by the term. The concept of rights that I intended in that article is a widely accepted and ethically important sense of "rights" that might be called "choice-rights."⁶ I shall henceforth refer to this sense of rights as *rights in the strong sense*. However, I did not specifically mention other senses of "rights" that are found in the literature of medical ethics. Since my failure to mention them may account for various misunderstandings of my position in LME, it will be worthwhile for me to discuss briefly some other concepts of rights. In addition to the concept of rights in the strong sense, there are several concepts of rights in what might be called extended senses. Under the latter I shall include the right not to be harmed, need-rights, and what I shall call "implemental rights." I shall discuss these various concepts of rights presently, but first I need to say more about rights in the strong sense.

Rights in the strong sense are essentially rights to choose. As such, they are based on the notion of freedom of choice, which Locke describes as "a liberty to dispose and order, *as he lists*, his person, his actions, possessions, and his whole property, within the allowance of those (natural) laws under which he is; and therein not to be subject to the arbitrary will of another, but freely follow his own."⁷ Freedom of choice in this sense is often referred to (incorrectly) as moral autonomy.⁸ Thus, Ketchum and Pierce say that rights talk focuses on persons as "autonomous agents" and "in talking about patient's rights we portray the patient as an autonomous agent" (p. 276). As Benn points out, it would be more accurate to use the term "autarchy" rather than "autonomy" in this context, for "autarchy" represents the model of a "chooser" rather than of a moral ideal suggested by the term "nomos" (i.e., law).⁹

A distinctive feature of rights in the strong sense, in contrast to rights in extended senses, is that it is perfectly intelligible to say of such rights that a person has a *right to do wrong*, that is, that he can exercise his right wrongly; for, after all, he can choose wrongly and his right gives him the freedom to choose "as he listeth."¹⁰ In contrast, rights in the extended senses of "rights" that I shall consider presently entail that no one can have a right to do what is wrong, i.e., one only has a right to do what is right. The right to do wrong, which only characterizes rights in the strong sense, includes the right to make mistakes, the right not to help others in need, and even the right, under certain circumstances, to hurt others or to hurt oneself.

Inasmuch as the exercise of a right in the strong sense is a function of the right-holder's will, his choice rights in the strong sense can, as I observed in LME, be waived. (In the extended senses, rights cannot be waived.) For the same reason, by virtue of his right, a person's choice is binding on others without regard to whether or not what is willed (or chosen) is reasonable.¹¹ In general, then, if a person has a right in

the strong sense, his choice is both a necessary and a sufficient condition for it to be binding. In other words, rights in the strong sense become effective on *demand*, that is, on being demanded and claimed by a "will." The essentially discretionary or arbitrary character of rights in the strong sense that their connection with choice and will entails is what I intended to convey by calling them "peremptory."¹²

Historically and conceptually rights in the strong sense are assimilated to property rights, with which they have many features in common. For if one has a property right in something, say, Black-acres, then one can do whatever one chooses with it. For, other things being equal, a person's having a property right in a thing is logically independent of what he intends or wants to do with that thing. The distinctive thing about a property right is that it confers on the owner the freedom to do whatever he chooses to do with his property and prohibits others from interfering with the exercise of his choice.¹³ Insofar as a person's body is construed as part of his property, a person has somewhat the same kind of rights over his body as he has over his other possessions, i.e., to do what he wants with it and to exclude interference by others in what he chooses to do with his body. A direct violation of one's property rights, including the integrity of one's body, is legally regarded as trespass.¹⁴

The seemingly paradoxical aspects of rights in the strong sense disappear when we realize that rights talk is not really so much about the rights of the right-holder as it is about the obligations owed by rights-owers to the right-holder.¹⁵ For rights consist both legally and ethically in a relationship between a right-holder and right-owers and the rights of the one are reflected in correlative obligations of others.¹⁶ The shift in focus from right-holder to right-ower is portrayed very graphically by Hart when he writes of the bonds between right-holder and right-ower that "the precise figure is not that of two persons bound by a chain, but of *one* person bound, the other end of the chain lying in the hands of another to use if he chooses."¹⁷ The latter, of course, may choose foolishly, mistakenly or wrongly; yet the rights-ower has an obligation to do or refrain from doing what the right-holder chooses. It is apparently this aspect of rights that Ketchum and Pierce are thinking of when they speak of a person's right to refuse medical treatment on religious grounds or "even for reasons of vanity" (p. 277).

As Hart and others have pointed out, inasmuch as the concept of a right in the strong sense has its basis in the right-holder's "autonomous" (= autarchic) will, i.e., his ability to choose, it can be attributed only to "adult human beings capable of choice." Thus, animals and babies, perhaps even children, cannot have that kind of right, simply because they do not have the requisite capacity to choose. *A fortiori*, the notion of a fetus having a right or of having a right against a dead

person would be logically absurd if "rights" is used in the strong sense. Hence, Perry's examples, just mentioned, are beside the point, for the rights I was concerned with in LME were rights in the strong sense. On the other hand, Ketchum and Pierce, who are quite clearly using the notion of rights in the strong sense, can consistently attribute the rights of which they speak only to adult human beings who have complete control over their faculties, i.e., are "autonomous" (= autarchic).

Extended Senses of "Rights"

Let us now turn to some extended senses of "rights." I shall consider only four of them here, because they are the ones encountered most frequently in writings on medical ethics.¹⁸ As I have already pointed out, rights in these extended senses imply that exercising a right is *eo ipso* doing something right, i.e., one never has a right (in the extended sense) to do wrong. Thus, an act of will or choice is neither necessary nor sufficient to activate a right in the extended sense and one cannot waive a right in this sense. Therefore, unlike rights in the strong sense, rights in the extended sense are not peremptory.¹⁹

The first extended sense of "rights" is a *trivial* one where having a right to do something simply means that it is not wrong to do it and, conversely, having no right to do something simply means that it is wrong to do it.²⁰ I mention this trivial sense merely in order to warn against slipping into it in discussions of rights. Rights in this sense have completely lost the property of being "trumps."

A second and less trivial extended sense of "rights" will be called the *harm sense of right*. This is a person's right not to be wrongfully harmed; if he has this right, then others have the correlative obligation not to harm him wrongfully.²¹ In this sense of rights, the deliberate infliction of any sort of wrongful harm on a person is taken to be a violation of his rights. It follows that if rights are understood in this way, then the whole of the Decalogue could be translated into a Bill of Rights: the right not to be killed, the right not to have one's property stolen, etc. However, the identification of every harmful act of this sort as a violation of rights does not appear to add anything more to its wrongfulness. Indeed, perhaps it even diminishes the wrongfulness; for there seems to be something strange in accepting this translation of harms into rights language, which implies that one is saying such things as that a woman has a right not to be raped, that the Jews in Germany had a right not to be massacred in the gas chambers, or that people have a right not to be tortured, etc. Instead of strengthening the moral condemnation of these evils, the use of rights language to categorize the evils in such cases has the effect of trivializing them.²² It should be observed in passing that, if there are harm rights, such rights, unlike rights in the strong sense, can be

attributed to babies and animals, perhaps to fetuses and possibly even to physical objects like the environment or the Mona Lisa! It should be noted that some of Perry's examples seem to be about rights in the harm sense.

Another closely related extended sense of "rights" gives us what I call *need-rights*. Such rights are based on needs and create correlative obligations in others to fill them. To make sense of the notion of need-rights, it is absolutely necessary to distinguish needs from wants, choices, or interests, for otherwise we would be forced to accede to the proposition that everybody has a right to whatever he wants in the sense that, other things being equal, others have an obligation to give him what he wants. Unlike wants, which may be arbitrary and capricious, needs are objective and "rational," in senses that could be specified. This difference can be seen in the fact that, although a person may know better than others what he wants, someone else may be a better judge of what he needs. For example, although a patient may want to have a finger amputated, a doctor may be a better judge of whether or not he needs to have it amputated.²³ Furthermore, it should be pointed out that the concept of a need-right implies that, regardless of whether or not the patient wants a certain treatment or even if he refuses it, if he really needs it then he has a right to it in the need sense of right and it would be wrong for him to refuse because to do so would violate his own right! (Of course, in the strong sense of right he *would* have a right to refuse.)

Still, I submit that even if a need of an especially pressing sort creates some sort of *prima facie* claim on others in the sense that, other things being equal, others ought to try to meet the need, it does not follow that anything is added by calling needs "rights," except that in some situations it might be permissible to use coercion to fulfill a pressing need. The assumption that other people's needs can create duties only because they are rights exemplifies the impoverishment of ethical language that I have already complained about. Thus, with regard to Perry's example of the starving man in need of food, I would contend that we ought to help, not because he has a right or even as an act of supererogation, but simply because he desperately needs food and we have it to give. An ethics of responsibility is, in this case, more humane than an ethics of rights! Again, as with rights in the harm sense, it should be pointed out that rights in the needs sense may be attributed to babies, to animals, and to fetuses (at least when they are fairly well developed).

It is clear from Perry's examples that he has in mind rights in an extended sense of one sort or another, e.g., either of rights in the harm or in the needs sense. For, as I have just pointed out, if a fetus could be said to have rights, these rights could only be rights in one or other of these senses.

Indeed, Perry's interesting discussion of the "right to life" shows quite clearly that this alleged right, when attributed to fetuses, is an amalgam of a harm-right and a need-right, and not a right in the strong sense at all.²⁴ But, inasmuch as my remarks on rights in LME were concerned only with rights in the strong sense, Perry's comments on rights are beside the point as far as my article is concerned. My own position is that harms and needs can stand on their own feet, as it were, as far as ethics is concerned and it is unnecessary and misleading to assume that they could have ethical import only if they are labeled as rights. Assuming that this is the main point of Perry's attack on rights, I think that I can accept much of what he says about relationships and needs, although, of course, I would have to reject what he says about rights, because I mean something different from what he means by "rights."

Finally, there is a fourth extended sense of rights which is especially important for medical ethics. Rights in this sense might be called *implemental rights*. They are the rights a person has to the necessary means for carrying out his obligations, duties and roles. Thus, it has been traditionally held that the state (the Prince) has certain (implemental) rights over its citizens, e.g., to exercise coercion over them in some form or other, because it needs such rights to carry out its duty to secure justice, prevent crime and preserve the peace. The rights of parents over their children might be regarded as implemental rights in the same sense, for they need them in order to carry out their parental duties to care for their children, to nourish and educate them, etc. Sometimes it is alleged that physicians have similar implemental rights that are necessary to carry out their task of caring for their patients, e.g., the right to freedom from interference, the right to decide about treatment, the right to certain kinds of information, and so on. Historically, the derivation of rights from duties, as reflected in the notion of an implemental right, has provided an important rationale for rights. For example, according to some philosophers in the Thomist tradition, the rights of persons follow from the natural law and acquire their authority from the natural law itself (or from God's will), because it is necessary for persons to have these rights in order to fulfill their duties under the natural law (e.g., to God).²⁵ An interesting argument using the implemental concept of rights is given by Albert Jonson, who uses this particular concept as a basis for certain rights of doctors, e.g., their rights to autonomy and to non-interference, on the grounds that they are necessary means for fulfilling their obligations correlative to the rights of people to health care.²⁶

Before concluding this general review of different senses of "right," I want once more to emphasize how important it is for writers using the term to specify which particular sense of "rights" they have in mind. Otherwise, in their discussions they will be arguing past each

other, simply because they are using "rights" in different senses. (I have pointed out how this is so in Perry's critique of LME.) I also want to add that there are many other ways of classifying rights, as well as many other kinds of rights that I have failed to mention. The *principium divisionis* of the classification adopted here relates to the kind of moral rationale that is offered for the particular rights being discussed; it is this aspect of rights, i.e., their grounding, that is most pertinent to the issues raised by my critics.

Defeasibility and How Rights Become Inoperative

Perry's claim that the distinction between rights and responsibilities is a distinction without a difference rests to a large extent on his use of two words, "peremptory" and "defeasible." He argues that rights are not peremptory but defeasible, and in that regard they are similar to responsibilities. Consequently, he concludes, the distinction between rights and responsibilities breaks down and merely reflects a "difference in defeasibility of obligatory relationships . . . rather than a qualitative difference in such relationships."

It is evident, however, that, in his critique of LME, Perry assigns "peremptory" an entirely different meaning from the one that I had in mind in LME. As I used it, it was intended to capture the core meaning of rights in the strong sense.²⁷ Perry, on the other hand, seems to mean by "peremptory" something like "absolute" or "unconditional." His use of the term "defeasibility" also presents difficulties for again, he departs from the standard usage of the term and uses it to mean something like the opposite of absolute or unconditional.²⁸ Quite apart from the choice of words, Perry brings up some important questions about the absoluteness and unconditionality of rights that need to be discussed. I find it easiest to treat them by subsuming them under the general question: how do rights become inoperative, i.e., of no effect? There are three ways in which this can happen.

To begin with, a right might become inoperative simply by being shown not to exist! Thus, under ordinary circumstances, I have no right to refuse treatment for you: the right in question is non-existent. I never had it. Sometimes a right may be rendered non-existent through some act or other that cancels or annuls it; for example, one person's property right in a thing is extinguished when he sells it to someone else. Again, a right may be forfeited, i.e., taken away, as when a criminal forfeits his right to liberty. A person may also lose some of his rights by becoming incompetent, e.g., he loses his right to make certain decisions about his medical treatment. Exactly how and why rights are inoperative in this sense depends obviously on what kinds of rights, what senses of "rights," we are concerned with.

Another and quite different way in which a right can become

inoperative is by being waived by the right-owner, either explicitly or tacitly. In cases involving invasive treatment, patients generally waive their rights to refuse. It should be noted that one can only waive a right if one already has it and one does not necessarily give away a right completely by waiving it. Even when a person waives a right on a particular occasion, it still remains his right, to use again if he chooses. Sometimes a person can withdraw a waiver, as when a person changes his mind about consenting to a certain kind of medical treatment. The details of where, when and what are the effects of waiving a right are beyond the scope of this essay. But, as I pointed out earlier, only rights in the strong sense can be waived.

Finally, a right may become inoperative because it conflicts with another right, say, of another person. We find a lot of nonsense in discussions of so-called "conflicts of rights" as when, for example, one right is said to "override" or "outweigh" another right, making the latter (following Ross) only a "prima facie" right or (in Perry's sense) a "defeasible" right. Such talk, however, systematically conflates outweighing and overriding with annulling, that is, the first with the third way of becoming inoperative.

There are two ways in which rights might be said to conflict. First, your right to Blackacres might be said to conflict with my right to Blackacres; but that means only that our two claims to Blackacres are incompatible; in that case, one person's having the right to Blackacres cancels and excludes the other person's right; he has no right. On the other hand, one person's right might be said to conflict with the right of another in the sense that it is physically impossible for someone to fulfill both of them; in that case, neither of the parties thereby loses his right in the sense that it is cancelled or annulled; what happens is that one of the rights is simply *suspended* — put on ice, so to speak. To say that it is suspended means that if *per contra* it were (or becomes) possible to fulfill both rights, both of them should be fulfilled.

It may be easier to see what is involved in this kind of "conflict of rights" if we approach the problem from the point of view of the right-owner rather than from that of the right-holder. If we do so, we can interpret the conflict just mentioned as essentially a conflict between different correlative obligations owed by a right-owner. Thus, so-called "conflicts of rights" would be reducible to conflicts of obligations, i.e., moral dilemmas.²⁹ An example may help to clarify this analysis. Consider the case of a pregnant woman who refuses treatment, thereby endangering the life of a baby she is about to bear; there are a number of rights that might be involved here, not only the mother's right, but also the father's right, society's right, the baby's right, etc. The health care provider (and the state) is faced with opposite and incompatible obligations, one to respect the mother's right to refuse

and the other to preserve the baby's life. It is, for physical reasons, impossible to do both and so the right-owner has to choose which to do and which not to do. But in choosing for the baby, he is not denying the mother's right in the sense that he denies that she has the right; rather, he is simply admitting that he cannot fulfill both of his correlative obligations: *impossibilia nulla obligatio est*.³⁰ That in such cases the right is not extinguished (annulled) but only suspended may be seen in other cases of inability to perform where the right-owner is required to provide some sort of compensation, if possible, as when a piece of property is seized by eminent domain. The distinction I am making should be clear if we consider the case of a person who is unable to pay two debts because he does not have enough money. The debt that is not paid is not *eo ipso* cancelled and the creditor's right extinguished; rather, it is simply suspended (as in a moratorium).

In general, then, it seems preferable to hold to the position that rights, if they are valid, cannot be overridden, that is, rendered of no effect, except in the indirect sense that the right-owners, the other parties in the rights relationship who have the correlative obligations, are unable to honor them all under the circumstances. In this way, the absoluteness of rights, if you wish, their "peremptoriness," can be saved while room is made for the kind of flexibility demanded by the real world of contingent impossibilities; at the same time, the distinction can be preserved between extinguishing and suspending a right along the lines that I have suggested.

It follows from this analysis that rights in the strong sense are, in important respects, qualitatively different from need-rights and harm-rights, and from what were called "responsibilities" in LME. Rights in the strong sense are absolute — black and white; they cannot be weighed against each other — my liberty is not to be measured against yours. These rights are not "defeasible" in Parry's sense of the word, that is, outweighable; they can only be rendered inoperative in the three ways indicated, namely, by being extinguished (annulled, forfeited), waived or suspended. On the other hand, harms and needs and the associated rights and responsibilities are not rendered inoperative in the three ways mentioned but, unlike rights in the strong sense, they can be compared and weighed against each other; and so can the corresponding responsibilities. One harm or one need may outweigh another morally and the corresponding responsibility with respect to the weightier claim may be more stringent than another responsibility with respect to another less weightier claim, that is, it would be morally preferable to pursue one rather than the other. If my contentions about these differences are accepted, then Parry's claim that the difference between rights and responsibilities is a distinction without a difference along with his attempted assimilation of rights to responsibilities must be rejected.

From the critical comments made in the two articles on the question of equality, it is clear that my brief remarks in LME on this subject have been misunderstood. Thus, Ketchum and Pierce complain that my arguments overlook "the fact of inequality of power between the parties" (i.e., physician and patient), which it is the purpose of the rights model to rectify. They conclude that in downgrading the model of rights, I am conferring "unquestioned moral authority" on the physician. Since this outcome is exactly the opposite of what I intended in LME, which was to defend a non-authoritarian conception of the physician-patient relationship, I obviously need to explain more clearly what I had in mind about equality.

Perry also seems to have had some difficulty in understanding my remark that the rights model, like a contractual model, presupposes an "antecedent equality." It is clear that there are a number of different senses of "equality," which need to be kept separate. There is, of course, one sense in which a person enters a contractual relationship in order to overcome an inequality, a disparity, e.g., my not having what you want and your not having what I want. What I had in mind in using the term "antecedent equality" for a rights-relationship, was simply that the model of rights in the strong sense presupposes that all the parties involved are "adult human beings capable of choice," who on that account have an equal right to be free.³¹ Now sometimes, of course, patients have this equal capacity to exercise choice when they first meet with their physicians and in such cases they would be antecedently equal in the sense intended. However, many physician-patient relationships are initiated under circumstances where the patient is not a free and equal agent at all. He may be entirely incapable of making a choice, e.g., he may be in a coma or helpless in some way or other; and if the initial encounter is an emergency, he will have no opportunity to shop around or to bargain with his physician. In such situations, patients begin their relationship to physicians as unequals, and the physician has a lot of power to determine what happens. But as a patient recovers, he gradually regains equal status with the physician and can relate to him as a free and equal agent. What I want to emphasize is that, even though the relationship starts as an unequal one, subsequently every effort should be made by all of the parties, especially physician and patient, to equalize the relationship as much and as quickly as possible. Indeed, restoring equality, or bringing it about might be included as one of the aims of medical treatment.³²

In their critique of LME, Ketchum and Pierce begin by attacking my suggestion that the physician-patient relationship be regarded as a kind of friendship. In citing Aristotle on friendship to illustrate what I

meant, I did not think that my readers would assume that I was thereby committed to everything that Aristotle says about friendship, including what he says about the inequality of men, women and slaves.³³ My position would be that what is basically wrong with Aristotle's account is not what he says about friendship but what he says about equality and inequality, superiority and inferiority, virtue and merit, and the kind of authoritarianism that he bases on them.³⁴ I could as well have cited Kant, whose grossly disregarded discussion of friendship is somewhat like Aristotle's except that it emphasizes equality.³⁵ Perhaps what is most important is their contention that everyone needs friends.

The position taken by Ketchum and Pierce seems to be a very strong one, namely, that the physician-patient relationship never can be and never ought to be a personal relationship such as exists between friends (*philia*), e.g., one in which the physician may be expected to feel concern for the patient and to regard him, as Aristotle says, as an *alter ego*.³⁶ Their attack on the interpersonal, friendship model has two sides. First, they maintain that it is inconsistent with the institutional character of the physician-patient relationship. And second, they maintain that it overlooks "the fact of inequality of power between the parties, and the effect of this inequality on the nature of their friendship" (p. 276).

The general argument that Ketchum and Pierce bring against the ethics of responsibility may be summarized as follows: the physician-patient relationship is an institutional relationship, therefore it is a power relationship and as a power relationship the physician-patient relationship needs to be analyzed by a medical ethics based on rights rather than responsibilities. For ease of discussion, I shall break the argument down into three parts, which I shall refer to as theses, namely: (1) the institutional thesis; (2) the power thesis; and (3) the rights thesis. In my comments on these three theses, I shall try to show that whatever initial plausibility they might have is due to the ambiguities of the terms "institution," "institutional" and "power." When these ambiguities are cleared up, the theses and the argument as a whole will be seen to be a congeries of *non sequiturs*.

Medicine as an Institution

The first thesis is that "the profession of medicine is an institution defined by laws, practices and rules . . . (And) the physician/patient relationship qua physician/patient relationship is therefore an institutional relationship" (pp. 273-274).

Before proceeding any further we should note that the term "institution" itself is a weasel word with a multiplicity of meanings. (And so, of course, is the adjective "institutional.") As I used the word "institution" in LME, it referred to "an establishment, organization or

association" such as a hospital, a medical center or, perhaps even the AMA. I would suppose that the physician-patient relationship is not institutional in that sense! The fact that I did not discuss whether or not the physician-patient relationship is institutional in some other sense does not mean that I deny that it is institutional in any sense at all. Since Ketchum and Pierce fail to explain what they mean by "institution" and "institutional," it will be necessary for us to examine some other possible senses of these terms.

To begin with, there is the sense of "institution" in which we speak of property, marriage, slavery, promising, etc., as institutions. We might call them *social institutions*. that is, clusters of accepted social rules, practices and norms defining, for example, roles and role-relationships.³⁷ In this sense, medicine is probably a universal institution, as is the nuclear family, for there are "doctors" in almost every society and culture. Institutions in this sense, i.e., social institutions, are "not created by laws, institutions, and government actions" (p. 273); they existed before and independently of them, although, of course, they are controlled and regulated by laws, etc. But the use of the word "create" suggests that we are dealing with a necessary and sufficient condition of a thing's coming into existence; and governmental action is neither necessary nor sufficient for the existence of any of the social institutions of the kind that we are considering.

If by "institution" one means what I have called a "social institution," then I have no difficulty in admitting that medicine is an institution and that the physician-patient relationship is institutional. But being a social institution does not make the physician-patient relationship non-personal or impersonal any more than the fact that marriage (courtship, parenthood) as a social institution makes the relationship between spouses a non-personal or impersonal relationship. Perhaps just being married or being in a physician-patient relationship is insufficient to guarantee that there is a personal relationship, e.g., one of concern and caring. On the other hand, *being institutional does not rule it out*. Rather, social institutions provide, as it were, the framework for our everyday activities and relationships, telling us in very general terms what is and what is not to be done, what is and what is not to be expected, and so on. But they allow considerable leeway as to how things should be done. We might compare institutional norms to the rules of chess. You cannot play chess unless you play by the rules. On the other hand, playing by the rules is not enough to make someone a good chess player. By the same token, being a good spouse or a good doctor may require following rules of some sort, but that does not make a person a good spouse or a good doctor. To be good at these things requires judgment, experience, sensitivity, devotion, and responsibility.

But when they say that the physician-patient relationship is institu-

tional, Ketchum and Pierce seem to have in mind by "institution" something much stronger than simply a social institution; they say, for example, that it is "political . . . in the straight-forward conventional sense of being organized, constituted, and created by laws, institutions [*sic*], and government actions" (p. 273). They go on to say that "an institution is a way of structuring human relationships," etc. I do not find the term "structure" very helpful here, because it has a number of different meanings. In this context, we seem to be dealing with something that is government-created or that *by definition* involves power relationships. If the physician-patient relationship is by definition a power relationship, then we might as well skip to thesis (2), because the question has been begged: to say that it is institutional does not add anything to the argument. But let us suppose that in calling the physician-patient relationship "institutional," Ketchum and Pierce wish simply to call attention to a strong and ethically significant connection with government. If so, it is worthwhile asking what that connection is. As I have already pointed out, it is quite absurd to say that the physician-patient relationship itself, e.g., between individuals, is created by laws in a way that, for example, laws might bring into existence a new kind of financial institution or a new military rank.

Now the government connection might be that some of the *powers* of physicians or of the medical establishment are "created" by the government. There is no question that these powers, including economic powers, have been enormously expanded through the growth of public bureaucracies, for example, by Medicare. But to say this is to say something entirely different than that the government creates the relationship and something that is perhaps true. It may be true, for all I know, that requirement of licensure by the state which, for a long time did not obtain, has tended to augment the power of physicians in society, because it has given them a monopoly. The problem of the social power of physicians is an important one from the point of view of ethics, but a problem I did not address in LME, which was concerned with quite a different set of problems, namely, problems regarding relationships between individuals. But questions about the social power of physicians as a group are different from questions about the power of individual physicians over individual patients. I shall return specifically to the question of individual power when I examine the third thesis.³⁸

Perhaps the government connection that Ketchum and Pierce have in mind when they say that the physician-patient relationship is institutional (structured, political) is that government regulates and controls the practice of medicine, as it regulates and controls many other activities, such as driving an automobile, getting married, or running a business. It is obvious that government (or legal) interven-

tion has a significant influence on the character of the operations regulated. The effect may be to facilitate the activity, to control the activity in the public interest, e.g., through licensure, to expand or to restrict its scope, or even to create a monopoly. But to say that by virtue of regulating and controlling something, government (or law) *creates* that thing, whether it be the physician-patient relationship, a marriage, or a business is a strange thing to say. After all, a thermostat controls the furnace, but it does not, on that account, create the heat provided by the furnace.

The question of public regulation and legal control leads to what are sometimes referred to as the physician's *gate-keeper* functions, which Ketchum and Pierce imply are important institutional aspects of medicine. These functions are, for the most part, created by law and are designed to serve the purposes of government. It is impossible to get born or to die — legally speaking, — without a certificate from a physician! Health certificates are required from physicians for various purposes. Physicians are authorized to prescribe certain drugs that laymen cannot buy without a prescription, although there are also drugs that even physicians are not permitted to prescribe.³⁹ There are numerous legally defined gatekeeper functions such as these that are assigned to physicians by society, although what they are in particular varies from time to time and from place to place.⁴⁰ Many of these functions serve political and social ends that have little to do with medicine and that are often resented by physicians. Thus, society uses physicians in the USA to control the distribution of drugs and it uses physicians in the USSR to control who will be permitted to have a vacation at a seaside resort. The question that we need to ask is how crucial these gatekeeper functions are for an ethical understanding of the doctor-patient relationship. After all, there is nothing unique to medicine about being gatekeepers. Society assigns gatekeeper functions to many different occupations — to inspectors and examiners of various sorts, that is, persons without whose permission one is not allowed to do what one wants to do. Gatekeepers are essential cogs in the machinery of a bureaucratic society. Furthermore, licensing is also a bureaucratic control device and does not automatically confer "political power" on the licensee; does the fact that airline pilots need to be licensed give them political power?⁴¹

Before turning to the next part of the argument, I need to make two general comments about the institutional thesis. First, institutions, in all of the senses mentioned here, can and do change. Physicians tell me that their relations with patients have changed quite radically in the last 10 years: patients expect more and are more demanding, while new sorts of legal and organizational requirements are imposed on physicians in their day-to-day practice. Thus, it is risky to be dogmatic about the physician-patient relationship, simply because change is in

the air. Second, institutions, in all senses, are subject to ethical review, evaluation and critique; after all, slavery was once an institution in American society, both a social institution and a legally sanctioned institution, but that fact does not vindicate it morally. By the same token, even by granting that the physician-patient relationship is institutional, in somewhat the same sense in which slavery used to be institutional, it does not follow that that is the way it ought to be ethically.

In sum, with regard to the institutional thesis, none of the various considerations relating to institutions that have been mentioned prove what Ketchum and Pierce are trying to prove, namely, that the physician-patient relationship cannot be and ought not to be a personal relationship and that it is *essentially* a power relationship that, as such, overrides personal relationships. Thus, unless this thesis is taken to be true by definition, we need some kind of additional supporting evidence for it.

Power and the Physician-Patient Relationship

Let us now turn to the second thesis, the power thesis, namely, that the physician-patient relationship is a power relationship. We must start with the question: what kind of claims are being made for it? Is it always true? Usually true? Often true? True for important and critical cases? True where significant ethical issues are to be found? Is it true for primary care physicians as well as for tertiary care physicians? Is it true for Russian physicians as well as American physicians?⁴²

At the outset, we must acknowledge the obvious empirical fact that there *often* is a power dimension to the physician-patient relationship as, for example, when a physician unilaterally imposes his will on a patient by making decisions for him that he does not want to accept (i.e., medical paternalism). It is easy to see that the existence and exercise of this sort of power create ethical problems. The question we have to ask with regard to it is: what kind of power are we talking about when we speak of a physician's power and how is it best ethically to deal with this kind of medical power?

We must first determine what Ketchum and Pierce mean by "power." From what they say about it, it is clear that they mean power in some sort of manipulative sense, that is, a kind of power that one person exercises over another. Power in this sense is epitomized in the question: who will prevail?⁴³ It takes for granted a zero-sum situation in which, if one person has power, then other people do not have any power vis à vis him and are, therefore, subject to him as the person who has the power. Given this concept of power, the crucial question becomes, in the words of Ketchum and Pierce: who is to be the "final arbiter"? Needless to say, by insisting on asking this ques-

tion, they beg the question in favor of a particular and narrow concept of power.

The particular conception of power and of decision-making that is implied here is founded on the Hobbesian-Lockean notion that "men are perpetually in competition for unequal power or wealth, all seeking to invade each other." McPherson calls this notion the "bourgeois model of man" and the morality founded on it "bourgeois morality" (= the ethics of natural rights).⁴⁴ It follows from this *a priori* model of human nature, which views men as naturally competitive and contentious, that physicians and their patients will always be in an inevitable and insuperable competition for power and that whoever wins, or ought to win, becomes, or ought to become, the "final arbiter" in any medical situation. It is important to observe that the model in question does not simply assert that there frequently is in fact a play for power; no one would deny that. Rather, it posits that competitiveness is an essential part of human nature and of the human situation.

It hardly needs to be pointed out that the Hobbesian-Lockean theory of human nature, even if for present purposes we restrict its scope to the physician-patient relationship, is not an empirical theory at all. No *a priori* theory can prove that collaboration and cooperation are impossible in principle. The mere fact that there often is some kind of "manipulation," either by physician or by patient, and that some sort of unilateral decision-making often takes place, such as, for example, the irrational refusal of treatment by a patient or the performance of unnecessary surgery on the part of a doctor, does not prove that this sort of manipulation is necessary or inevitable. The model in question is simply part of a particular political ideology.

The ethico-political theory of power taken for granted by Ketchum and Pierce is one that I reject for a number of reasons, but primarily for ethical reasons. Their assertions to the contrary notwithstanding, the fact is that human beings can, do, and often must collaborate and make decisions together. For ethical reasons, they should do so. The issue between us is due to our differing conceptions of power; I regard this as an ethical issue. For a number of reasons, I prefer to define power as the capacity to bring about changes in the world.⁴⁵ In this sense of power, new technology has greatly increased the power of physicians as nuclear physics has increased the power of generals. According to the definition that I offer here, although there may be competition for power, there need not be. Power in my sense can be shared; power in the sense assumed by Ketchum and Pierce cannot be shared.

As is well-known, on the political level, the rights theory is not the only political theory of how to cope with excessive governmental power. There is an alternative, namely, the democratic theory of participation. By analogy, on the level of individual relationships, as in the

physician-patient relationship, one way — I think the best way — to cope with excessive physician power is to have a participatory kind of decision-making in which all interested parties take part.⁴⁶ Under ideal conditions this kind of participatory decision-making is by consensus. This is the model of the doctor-patient relationship that Szasz and Hollender refer to as the “model of mutual participation,” which, as they say, is: “Philosophically . . . predicated on the postulate that equality among human beings is desirable. It is fundamental to the social structure of democracy, etc.”⁴⁷ To the extent that it is possible, this is the kind of decision-making that is called for by the ethics of responsibility. A responsible physician will aim for it, while a physician who, under ordinary circumstances imposes a decision unilaterally on others would *eo ipso* be irresponsible. Patients can, of course, also be irresponsible, although it is difficult to be irresponsible if they do not have any power; for, as Lukes argues, there is a close conceptual relationship between power and responsibility.⁴⁸

Ideals and Rules

Now, I do not deny that often some kind of “manipulation,” either by physician or patient, takes place and that, sometimes, we have to accept unilateral decisions. The ethics of responsibility and the model of equal participation are, however, concerned with what is ideal; as such, they provide a rough measuring rod for distinguishing a good physician-patient relationship from a bad one, a responsible physician from an irresponsible one, responsible (good) from irresponsible (bad) decision-making and, in general, responsible medical care from irresponsible care. It should be noted that the kind of responsibility involved here is *moral responsibility*, sometimes called “virtue-responsibility.”⁴⁹ Responsibility in this sense should not be confused with task, role, or official responsibility, which are simply requirements imposed on a person by his job. (Job responsibility is limited and may be non-moral or even immoral.) In the ethics of responsibility we are concerned with moral ideals and moral virtues, i.e., what ought to be, and not simply with rules and jobs, i.e., what is, what is accepted and what is expected.

The conception of medical decision-making that is required by the ethics of responsibility denies that it is always necessary to identify a “final arbiter,” which is an essential ingredient in the analysis presented by Ketchum and Pierce. Mutual, participatory decision-making of the kind involved in this ethics entails candid and honest sharing of information and attitudes, a frank discussion of differences, and joint participation in the formation of, say, a treatment plan. This process presupposes mutual respect and trust among all the parties and requires extensive consultation, which itself is a process of mutual education, not only patient education but also physician education.

The position advocated here reflects the view of physicians who say that "ultimately the success of the doctor-patient relationship is the degree to which patient and physician are able to communicate."⁵⁰ From the ethical point of view to aim for this ideal kind of resolution of moral-medical problems is a moral duty of every one of the parties concerned, including the physician, nurses and family, as well as the patient himself.

We must remember that we are talking here about an ideal to be aimed at; the fact that it is not always feasible or attainable does not impugn its validity as a moral ideal. Sometimes it is more feasible than at other times. No hard and fast rules can be drawn up as to how or when what it requires is to be done, for circumstances and values vary so widely. However, as a moral ideal, everyone who is involved must constantly bear in mind the end-in-view, namely, the patient's well-being, which is not only a function of his purely physiological needs, but also of his psychological, social and moral needs. What my critics seem to have overlooked in their comments on LME is my insistence, there and elsewhere, that a patient's welfare includes his "security, health, education and *moral integrity*" and that to be responsible means to be responsible for all of these.⁵¹ Thus, forcing a person to do what he firmly believes to be wrong, e.g., making a Jehovah's Witness have a blood transfusion or making a physician perform what he knows to be an unnecessary operation, is a violation of their moral integrity, a concept which, I think, is much deeper, richer and more basic than the concept of rights in the strong sense, which I claim is derivative from it.⁵² I should add that part of moral integrity requires sharing one's concerns for oneself and for others and accepting the responsibility for what they entail. In this way, and in many others, we come back to the concept of responsibility, which I believe is basic to this kind of ethics.

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2. See Sara Ann Ketchum and Christine Pierce, "Rights and Responsibilities," *Journal of Medicine and Philosophy*, vol. 6, no. 3 (Aug., 1981). Also see Clifton Perry, "Rights and Responsibilities in Medical Ethics," *Linacre Quarterly*, vol. 49, no. 2 (May, 1982), pp. 111-120.
3. The concept of rights is also discussed in *Ethical Issues Relating to Life and Death*, ed. by John Ladd (New York: Oxford University Press, 1979), especially pp. 129-141. The concept of responsibility is discussed in more detail in "The Ethics of Participation," in J. Roland Pennock and John W. Chapman, *Participation in Politics: NOMOS XVI* (New York: Atherton-Lieber, 1975).
4. Since the word "right" can be used either as an adjective, as in "X is right," or as a noun, as in "Jones has a right to A," I shall adopt the device of using the

plural, "rights," to indicate that I am using the word as a noun, i.e., in the substantial sense. This is simply a convenient terminological device and is not intended to beg the question as to whether, in the final analysis, there is more than one right (in the substantial sense).

5. In this regard, I am distressed to find that most writers in medical ethics who allude to rights completely ignore the large extant philosophical literature on the subject of rights, including the classics on the subject. For a useful collection, see *Rights*, David Lyons, ed. (Belmont, Calif.: Wadsworth, 1979). Also recommended for anyone interested in rights: A. I. Melden, *Rights and Persons* (Berkeley: University of California Press, 1977); Joel Feinberg, *Rights, Justice, and the Bounds of Liberty* (Princeton: Princeton University Press, 1980); J. Roland Pennock and John W. Chapman, eds., *Human Rights: NOMOS XXIII* (New York: New York University Press, 1981); and *Ethics*, vol. 92, no. 1 (Oct., 1981) — a special issue on rights.

6. The concept of rights I had in mind is virtually the same as the concept described by H. L. A. Hart in his "Are There Any Natural Rights?," *Philosophical Review*, vol. 64 (1955), pp. 175-191. This article is reprinted in a number of collections; see, for example, Lyons, *op. cit.*, pp. 14-25.

7. Locke, John, *Second Treatise of Government*, section 26. (Italics added.)

8. It is not moral autonomy in Kant's sense, for autonomy applies to the will (Wille) and not to choice (Willkuer). Kant's autonomous will would not permit the willing of wrongful actions.

9. See Stanley I. Benn, "Freedom, Autonomy and the Concept of a Person," *Proceedings of the Aristotelian Society*, N.S., vol. 76 (1975-1976), pp. 109-130.

10. For an excellent treatment of this question, see Jeremy Waldron, "A Right to Do Wrong," *Ethics*, vol. 92, no. 1 (1981), pp. 21-39. I have found this article very useful in clarifying my own views on rights.

11. I have called this particular logical feature of rights their *opacity*. See "Legalism and Medical Ethics," *op. cit.*, p. 17; *Ethical Issues*, *op. cit.*, p. 131. Joseph Raz uses the helpful term "protected reason."

12. "Peremptory" means "governed by, or manifesting, a strong tendency to impose one's will on another . . . the term implies authoritativeness and a refusal to brook disobedience or delay or to entertain any objections however valid, etc.," *Webster's Dictionary of Synonyms*, First Ed. (Springfield, Mass.: G and C Merriam, 1951), p. 534. Other dictionaries contain similar definitions. The term "peremptory" is basically a legal term.

13. Provided, of course, that he does not violate the rights of others.

14. For an insightful discussion of proprietary rights in the context of political philosophy, see C. M. McPherson, *The Political Theory of Possessive Individualism* (Oxford: Clarendon Press, 1962); and *Democratic Theory* (Oxford: Clarendon Press, 1973). McPherson's conception of possessive individualism throws a good deal of light on the bourgeois economic background of what I have called rights in the strong sense.

15. For a number of reasons, including historical ones, I prefer to use the term "obligation" as the correlative of a right rather than "duty." In LME, I consistently used "obligation" in this narrow sense, and used the word "duty" more generally for duties (oughts) that are generated in other ways than through rights. For further discussion of the concept of obligation as a special concept, see my "Legal and Moral Obligation," in J. Roland Pennock and John W. Chapman, *Political and Legal Obligation: NOMOS XII* (New York: Atherton, 1970), pp. 3-35.

16. See Wesley Newcomb Hohfeld, *Fundamental Legal Conceptions* (New Haven: Yale University Press, 1919). What I have called "rights in the strong sense" corresponds to Hohfeld's demand rights. His other three kinds of right are not relevant to the present discussion.

17. Hart in Lyons, *op. cit.*, p. 19.
18. Since our concern here is with the physician-patient relationship, I do not need to discuss more general social rights such as those that I have called "ideal rights," and others have called "manifesto" or "welfare" rights. (Perhaps the right to health care is such a right.) See *Ethical Issues*, *op. cit.*, pp. 137-140.
19. In my sense of "peremptory"! See note 12.
20. "Right" in this trivial sense is the moral counterpart of what Hohfeld calls a "privilege right," i.e., a non-duty.
21. The qualification of "wrongfully" has to be added in order to make room for inflicting harm on someone for the protection of others or as punishment. For a discussion of the harm principle, see Joel Feinberg, *Social Philosophy* (Englewood Cliffs, N.J.: Prentice-Hall, 1973), p. 25 *et passim*.
22. This effect may be due to the fact that we ordinarily assume that rights can be waived, but the evils involved here are too serious to be waived. On the other hand, it makes sense to say that people have the right to be protected against such evils or to be compensated for them. But such rights would be an entirely different sort of right; they might be rights in the strong sense.
23. This example is taken from Elizabeth Morgan, M.D., *The Making of a Woman Surgeon* (New York: Berkley Books, 1981), pp. 305-306. Ketchum and Pierce appear to collapse the distinction between needs and wants when they say that "B is the final arbiter of his own needs" (p. 277, my italics). Are patients always the best judges of what they need medically?
24. The right to an abortion or the right over one's body, on the other hand, would be rights in the strong sense, since they are founded on the freedom of choice principle.
25. See Jacques Maritain, *The Rights of Man and Natural Law* (New York: Charles Scribners, 1943), pp. 73-83. As I read Locke, at least some of the natural rights that he mentions are derived in this way from the natural law, which he also calls the divine law.
26. See Albert Jonson, *The Rights of Physicians* (Washington: National Academy of Sciences, Institute of Medicine, 1978).
27. See the dictionary definition of "peremptory" quoted above in note 12.
28. The term "defeasible" came into philosophical literature through an early essay by H. L. A. Hart. Hart used it to characterize certain legal concepts that are not definable by necessary and sufficient conditions and that are always open to "defeat" by an open list of heterogeneous conditions ("defenses"). See H. L. A. Hart, "The Ascription of Responsibility and Rights," reprinted in *Logic and Language*, First Series, A. Flew, ed. (Oxford: Blackwell, 1953). For a discussion of Hart's concept, see G. P. Baker, "Defeasibility and Meaning," in P. M. S. Hacker and J. Raz, *Law, Morality and Society* (Oxford: Clarendon Press, 1977). Hart did not use the term to mean "overridable" or *prima facie* (in W. D. Ross's sense).
29. On this subject, see my "Remarks on the Conflicts of Obligations," *Journal of Philosophy*, vol. 55, (Sept. 11, 1958), pp. 811-819. See also Ruth Marcus, "Moral Dilemmas and Consistency," *Journal of Philosophy*, vol. 77 (March, 1980), pp. 121-136.
30. There is no obligation to do impossible things. *Digest*, vol. 50, no. 17, p. 185. Cited in *Black's Law Dictionary*, p. 889.
31. Hart, *op. cit.*, p. 14.
32. Here by "equality" I mean autonomy (an ideal) rather than just autarchy. See the reference to Benn in note 9. Some of my own ideas about equality may be found in "Egalitarianism and Elitism in Ethics," *L'Egalite*, Vol. V (Brussels: Centre de Philosophie du Droit, 1977).
33. To be fair to Aristotle, however, he does say that, although "one cannot be friends with a slave qua slave, one can be friends with him qua man." *Nicomachean Ethics*, 116 1b5.

34. I assume that much of this has to do with the special connotations of the Greek word *arete*. For details, see A. W. H. Adkins, *Merit and Responsibility: A Study in Greek Values* (Oxford: Clarendon Press, 1960).

35. Kant defines friendship as the "union of two persons through equal and mutual love and respect." Kant, *The Doctrine of Virtue*, trans. by Mary J. Gregor (New York: Harper, 1964), p. 140.

36. The *philia* model is adopted by a number of writers on the physician-patient relationship, although they do not always accept the authoritarian interpretation of it adopted by Ketchum and Pierce. See, for example, Pedro Lain Entralgo, *Doctor and Patient* (New York: McGraw Hill, 1969).

37. See Talcott Parsons, *The Social System* (New York: Free Press, 1951), p. 39.

38. My own position regarding the social power of physicians is set forth in "Physicians and Society: Tribulations of Power and Responsibility," in *The Law-Medicine Relation*, ed. by S. F. Spicker, J. M. Healey, and H. T. Engelhardt (Dordrecht, Holland: Reidel, 1981). See also "Medical Ethics: Who Knows Best?", *Lancet*, Nov. 22, 1980.

39. See George J. Annas, Leonard H. Glantz and Barbara F. Katz, *The Rights of Doctors, Nurses and Allied Health Professionals* (New York: Avon, 1981), chap. VI: Drugs and Controlled Substances.

40. On this point, a cross-cultural comparison is very enlightening, for in the USSR, doctors are given many more and quite different gatekeeper jobs from those they have in the USA or in Great Britain. See Marie R. Haug, "The Erosion of Professional Authority: A Cross-Cultural Inquiry in the Case of the Physician," *Health and Society*, Winter, 1976.

41. Ketchum and Pierce argue that there is something especially political about medicine, because, although you can acquire the technological knowledge and materials necessary to repair an auto without "legal hindrance," you need authorization from a licensed physician to be able to use any medical knowledge on your own. But this argument would also make driving a car political, not to mention all the other things one is not legally permitted to do on one's own, such as installing a phone or making whisky.

42. Note that the majority of Russian physicians are women.

43. Lukes calls this the one-dimensional view of power. See Stephen Lukes, *Power: A Radical View* (London: MacMillan & Co., 1974).

44. See C. B. McPherson, *Democratic Theory* (Oxford: Clarendon Press, 1973), pp. 225-237. He develops the same theme in his earlier book, *The Political Theory of Possessive Individualism* (Oxford: Clarendon Press, 1962).

45. McPherson defines "power" as "man's ability to use and develop his capacities," *op. cit.*

46. I defend this concept of participation in "The Ethics of Participation," in *Participation in Politics*, *op. cit.*

47. See Thomas S. Szasz and Marc H. Hollender, "The Basic Models of the Doctor-Patient Relationship," reprinted in part in Samuel Gorovitz *et al.*, *Moral Problems in Medicine* (Englewood Cliffs, N.J.: Prentice-Hall, 1976), p. 66.

48. See Lukes, *op. cit.*

49. See Graham Haydon, "On Being Responsible," *Philosophical Quarterly*, vol. 28, no. 110 (Jan., 1978). See also my "Ethics of Participation," *op. cit.*

50. Robert I. Lawrence and Samuel M. Putnam, "Criteria by Which Patients Assess the Outcome of Care," in *Primary Care and the Practice of Medicine*, John Noble, ed. (Boston: Little, Brown and Co., 1976), p. 27. This article contains a great deal of data substantiating the practical value of the model that I advocate here.

51. "Legalism and Medical Ethics," *op. cit.*, p. 25. Italics added here.

52. *Ibid.*, p. 34; also *Ethical Issues*, *op. cit.*, p. 139.