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# Beyond Autonomy: Coersion and Morality in Clinical Relationships

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# ARTICLES

# BEYOND AUTONOMY: COERCION AND MORALITY IN CLINICAL RELATIONSHIPS

*M. Gregg Bloche**

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## I. INTRODUCTION

**ON NOVEMBER 14, 1988,** during her fifth month of pregnancy, thirty-eight-year-old Carol Doe was informed by a nurse at New York City's Jamaica Hospital that she had become infected with the virus that causes AIDS.[1] According to

1. Kings County, Supreme Court, IA Part 3, Justice Scholnick, Doe v. Jamaica Hospital, N.Y.L.J., May 6, 1991, at 27 [hereinafter *Jamaica Hospital*, N.Y.L.J.] This is an unreported opinion by a New York State trial court, ruling on a defendant physician's motion for summary judgment in a tort action against Jamaica Hospital, the New York City Health and Hospitals Corporation, and the individual physicians and other professionals who cared for Ms. Doe. *See also* Doe v. Jamaica Hospital, 608 N.Y.S.2d 518 (N.Y. App. Div. 1994) (affirming the trial court's decision); Verified Complaint for Declaratory and Monetary Relief and Jury Demand, Doe v. Jamaica Hospital (November 1989) (on file with the Center for Constitutional Rights) [hereinafter

Ms. Doe, a patient in the hospital's high-risk prenatal program, she was told that her chances of giving birth to a baby with AIDS were "great"[2] and that an abortion was desirable.

Three days later, Ms. Doe met with Dr. Maurice Abitol, chief of obstetrics and gynecology at Jamaica Hospital. By Ms. Doe's account, Dr. Abitol advised that failure to obtain an abortion would be wrong and that having an HIV-infected child would impose a burden on society.[3] Moreover, according to Ms. Doe, Dr. Abitol said she could no longer receive prenatal care at Jamaica Hospital's high-risk clinic. She was referred to Kings County Hospital, where three weeks later she had an abortion.[4] A year later, Ms. Doe filed suit against Jamaica Hospital, Kings County Hospital, and her individual caretakers at both institutions. She alleged that their conduct constituted unlawful discrimination on the basis of a physical handicap and that they breached their duties to provide appropriate care and obtain her informed consent.

Through the distorting lens of an inchoate adversary proceeding, the nuances of Ms. Doe's conversations with her clinical caretakers are not easy to discern. In a motion for summary judgment, Dr. Abitol characterized his conversation with Ms. Doe as considerably less directive, although he acknowledged having referred her to Kings County Hospital.[5] Quite possibly, Dr. Abitol dealt carelessly or abusively with Ms. Doe, misleading her about the risk that she could infect her child or castigating her for considering giving birth to a child that might suffer and impose a financial burden on society. And quite possibly, he barred her from receiving further prenatal services at Jamaica Hospital, thereby cutting off her

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Complaint in Doe v. Jamaica Hospital]. The following account of Ms. Doe's allegations is drawn from these two sources.

2. *Jamaica Hospital*, N.Y.L.J., *supra* note 1, at 27.

3. Ms. Doe, who had previously borne a child with spina bifida, also alleged that Dr. Abitol said that having an HIV-infected baby would be even worse. *Id.*

4. According to Ms. Doe (who said she wanted to carry her pregnancy to term), she pleaded with Dr. Abitol and others at Jamaica Hospital to permit her to continue prenatal care in the facility's high-risk program, but she was told she could not do so. *Id.*

5. Dr. Abitol stated in his affidavit that he counseled Ms. Doe about the physical and emotional ramifications of testing positive for HIV and discussed her fears about giving birth to another child with spina bifida. Dr. Abitol also averred that he referred Ms. Doe to Kings County Hospital because it was more qualified than Jamaica Hospital to treat HIV-infected pregnant women. *Id.*

access to high-risk prenatal care. If so, then Dr. Abitol violated his duty of care, as understood within the medical profession and imposed by the courts.[6] But if he — or Ms. Doe's other caretakers — merely *recommended* that she end her pregnancy after advising her about the risks of childbearing and abortion and listening respectfully to her concerns, then their actions were consistent with then-widely accepted clinical norms.

During the mid and late 1980s, a series of articles in leading medical journals and pronouncements by public health and professional authorities took the position that HIV-infected women should be counseled not to bear children. These academic commentaries[7] and official pronouncements[8] focused primarily on the reproductive choices of women prior to conception. However, their unmistakable implication for women who tested positive for HIV during pregnancy was that abortion represented the preferred outcome.[9] If Ms. Doe's obstetri-

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6. *See* Martinez v. Long Island Jewish Hillside Med. Ctr., 512 N.E.2d 538, 539 (N.Y. 1987) (granting a cause of action for emotional harm suffered when a physician's erroneous prediction of a congenital birth defect in utero prompted a woman to consent to an abortion despite her belief that abortion is sinful, absent extraordinary circumstances). *See also* Bloskas v. Murray, 646 P.2d 907, 915 (Colo. 1982) (holding that inaccurate information negligently given to patients by physicians in order to obtain consent constitutes negligent misrepresentation).

7. *See* Donald P. Francis & James Chin, *The Prevention of Acquired Immunodeficiency Syndrome in the United States: An Objective Strategy for Medicine, Public Health, Business, and the Community*, 257 JAMA 1357, 1361 (1987) (asserting that women who test positive for HIV should "postpone pregnancy"); *see also* Howard L. Minkoff & Richard H. Schwarz, *AIDS: Time for Obstetricians to Get Involved*, 68 OBSTETRICS & GYNECOLOGY 267, 267 (1986) (concluding that "pregnancy should be discouraged" when women test positive prior to conception); Anthony J. Pinching & Donald J. Jeffries, *AIDS and HTLV-III/LAV Infection: Consequences for Obstetrics and Perinatal Medicine*, 92 BRIT. J. OF OBSTETRICS & PERINATAL MED. 1211, 1216-17 (1985) (asserting that HIV-infected women "should be strongly advised to avoid pregnancy").

8. In 1985, the U.S. Centers for Disease Control (CDC) recommended that HIV-infected women be advised to postpone pregnancy. Centers for Disease Control, *Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-associated Virus and Acquired Immunodeficiency Syndrome*, 34 MORBIDITY AND MORTALITY WKLY. REP. 721, 725 (1985). This peculiar choice of words, according to CDC observers, reflected the agency's reluctance to state its evident conclusion baldly—that HIV-infected women should forego pregnancy. State health departments displayed no such reluctance. John D. Arras, *AIDS and Reproductive Decisions: Having Children in Fear and Trembling*, 68 MILBANK Q. 353, 367 (1990) (citing Ronald Bayer's 1990 survey, which found that all states except New Jersey advised HIV-infected women to avoid future pregancies).

In 1987, the American College of Obstetricians and Gynecologists (ACOG) took a similar position, recommending that HIV-infected women be "strongly encouraged not to become pregnant." AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PREVENTION OF HUMAN IMMUNE DEFICIENCY VIRUS INFECTION AND ACQUIRED IMMUNE DEFICIENCY SYNDROME, ACOG Committee Statement No. 53 (1987).

9. The politics of abortion probably led the CDC to refrain from recommending that in-

cal caretakers advised abortion while reassuring her that the decision was hers, then they acted in accordance with an accepted clinical practice.

This accepted practice was consistent with the jurisprudence of informed consent and the conception of autonomy that undergirds it. The doctrine of informed consent contemplates that clinicians will make recommendations to their patients in addition to instructing them about the risks and benefits of medical alternatives.[10] The law of informed consent does not require a physician to withhold her opinion when advising patients about alternatives.[11] Rather, it is premised on the belief that a clinician can express her opinion without compromising her patient's autonomy. Most leading bioethics commentators adhere to this view.[12] In the event that Ms. Doe

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fected women who are pregnant be counseled about pregnancy termination. *See* David A. Grimes, *The CDC and Abortion in HIV-Positive Women*, 258 JAMA 1176 (1987) (CDC panel convened to develop guidelines for prevention of perinatal HIV transmission advised that abortion option be presented to pregnant, HIV-infected women, but this recommendation was deleted from published CDC report).

Academic medical commentators have addressed pregnancy termination in almost as gingerly a fashion. Minkoff and Schwarz elliptically stated that a pregnant, HIV-infected woman "is entitled to exercise the same options as a woman whose fetus is exposed to any other viral pathogen." Minkoff & Schwarz, *supra* note 7, at 267. Pinching and Jeffries were more direct, concluding that "termination is advisable" for both fetal and maternal reasons and that all pregnant, HIV-positive women "should be considered for and counselled about" abortion. Pinching & Jeffries, *supra* note 7, at 1216. The authors of an HIV screening protocol for pregnant women at Boston's Brigham and Women's and Beth Israel Hospitals were less revealing but suggestive regarding their preference for pregnancy termination when patients test positive. In an article describing their approach, the protocol's developers reported that women testing positive at less than 23 weeks' gestation were "offered the option" of abortion. Benjamin P. Sachs et al., *Acquired Immunodeficiency Syndrome: Suggested Protocol for Counseling and Screening in Pregnancy*, 70 OBSTETRICS & GYNECOLOGY 408, 409-410 (1987). At another point in this article, however, the authors referred in passing to the abortion "option" as "recommended." *Id.* at 409.

10. *See, e.g*, Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1 (1972); Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1969) (holding that physicians have a duty to disclose material risks associated with recommended therapies). *See generally* Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L. J. 219, 220-56 (1985).

11. Shultz, *supra* note 10. On the other hand, some argue that professional restraint in this regard would enhance patient autonomy in clinical relationships. Jay Katz contends that protection for "psychological autonomy" should include a professional obligation to "facilitate patients' opportunities for reflection" by engaging them in exploratory conversation. JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 121-28 (1984). Katz proposes that when a patient asks her doctor to choose between alternatives, the doctor should consider answering along the following lines: "[o]f course I shall eventually give you my recommendation, but I prefer not to do so yet.... I would like to hear first what your preferences are. After all it is *your* body that I intend to treat... and you must have some opinions about which consequences would be easier or more difficult for you to tolerate." *Id.* at 126.

12. *See, e.g.*, TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL

was accurately informed about the risks of pregnancy and abortion (including the risk of HIV transmission to the fetus[13]), a recommendation that she terminate her pregnancy would not have undermined her autonomy, as conventionally conceived, and thereby vitiated her consent.[14]

As an application of prevailing legal and bioethics thinking about informed consent and autonomous action, this conclusion is unremarkable. Yet, were a court to have reached such a conclusion in Ms. Doe's case, it surely would have become a focus of bitter dispute. In the context of reproductive decision making by HIV-infected women, the ability of patients to choose autonomously after being advised not to bear children has been disputed by scholars and others who view such advice as inherently coercive. These critics contend that the unequal relationship between HIV-infected women and their clinical counselors renders advice to abort, or to refrain

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ETHICS 76 (3rd ed. 1989) (informed consent to a recommended intervention occurs when a person "with substantial *understanding* and in substantial *absence of control* by others *intentionally authorizes* a professional to do something") [hereinafter BEAUCHAMP & CHILDRESS]; Shultz, *supra* note 10, at 257-99 (urging greatly expanded legal protection for informed patient choice while retaining the premise that physicians are "personally and professionally responsible for recommending" decisions). *Cf.* ALBERT R. JONSEN ET AL., CLINICAL ETHICS: A PRACTICAL APPROACH TO ETHICAL DECISIONS IN CLINICAL MEDICINE 99 (1982) (asserting that physicians are ethically obliged to try to persuade patients to comply with beneficial treatment).

13. Whether Ms. Doe was accurately informed about the risk of maternal transmission cannot be discerned from the available information. The public record does not reveal whether she was given a numerical estimate of the probability of transmission. If, as Ms. Doe alleged, she was told only that the risk was "great," then she was arguably given an exaggerated idea of its magnitude. Current estimates put the risk in the 25% to 35% range absent prophylactic antiviral therapy during pregnancy. Intensive combination treatment, including administration of antiretroviral drugs during the first trimester, viricidal cleansing of the birth canal, use of HIV hyperimmune globulin, and C-section delivery, can reduce this risk to as little as eight percent. Centers for Disease Control, *Recommendations for Human Immunodeficiency Virus Counseling and Voluntary Testing for Pregnant Woman* 44 MORBIDITY & MORTALITY WKLY. REP. RR 7, 4 (1985). *See* Jody W. Zylke, *Another Consequence of Uncontrolled Spread of HIV Among Adults: Vertical Transmission*, 265 JAMA 1798, 1798 (1991). On the other hand, estimates employed clinically at the time Ms. Doe tested positive put the probability of transmission as high as 65%. *See* Sachs et al, *supra* note 9, at 410 (counselors instructed to tell HIV-positive pregnant women that risk of transmission "is unknown, but may be as high as 65%").

Recent research suggests that HIV-infected patients with different biological markers may have dramatically different risks of *in utero* transmission. *See* Michael E. St. Louis et al., *Risk for Perinatal HIV-1 Transmission According to Maternal Immunologic, Virologic, and Placental Factors*, 269 JAMA 2853, 2853-59 (1993) (reporting that vertical transmission risks for identified biological subgroups of HIV-infected women varied from 7% to 71%).

14. However, were such a recommendation accompanied by a threat to discontinue treatment, thereby effectively cutting off Ms. Doe's access to prenatal care, her assent could hardly constitute legitimate informed consent.

from conceiving, inconsistent with the preservation of reproductive autonomy.[15]

In making this claim, critics of giving such opinions can draw support from the genetic counseling context. Among genetic counselors, the prevailing standard of care since the early 1970s has been to avoid expressing an opinion with respect to patients' childbearing decisions.[16] Some advocates of this standard contend that promoting reproductive forbearance for the purpose of preventing genetic disease interferes with autonomous reproductive decision making.[17]

More broadly, understandings of autonomy-negating influence in clinical settings appear to vary according to context. The different norms that prevail with respect to opinion-giving in medical treatment and genetic counseling relationships are just one example. Another example is the apparent disconnec-

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15. *See* Nancy E. Kass, *Reproductive Decision Making in the Context of HIV: The Case for Nondirective Counseling*, *in* AIDS, WOMEN, AND THE NEXT GENERATION 308, 313 (Ruth R. Faden et al., eds., 1991) (noting that some critics believe that since the relationship between counselor and patient is unbalanced, "any attempt at persuasion or advocacy is inherently coercive"). *Cf.* Kathleen Nolan, *Ethical Issues in Caring for Pregnant Women and Newborns at Risk for Human Immunodeficiency Virus Infection*, 13 SEMINARS IN PERINATOLOGY 55, 63 (1989) (stating that "unwanted advice by a paternalistic counselor may not only violate the ethical principles of autonomy and procreative freedom, but may also paradoxically drive the counselee into a defiant rejection of the counselor's position"); Carol Levine & Nancy Neveloff Dubler, *Uncertain Risks and Bitter Realities: The Reproductive Choices of HIV-infected Women*, 68 MILBANK Q. 321, 322 (1990) (positing that counseling programs aimed at preventing pregnancies or births "will inevitably give way to widespread and systematic coercive measures").

Some commentators couple this claim to a parallel objection with respect to intervention at the public health level. They maintain that the public promotion of reproductive restraint, by means ranging from advertising campaigns to the use of government benefits or private charity as levers of influence, also endangers the reproductive autonomy of HIV-positive women. *See, e.g.*, *id.* at 345.

16. *See* Aubrey Milunsky, *Genetic Counseling: Principles and Practice*, *in* THE PREVENTION OF GENETIC DISEASE AND MENTAL RETARDATION 64, 66-67 (Aubrey Milunsky ed., 1975) (indicating that the genetic counselor should not tell consultants what to do, but should help them to recognize and anticipate issues connected to their condition).

17. *See, e.g.*, George J. Annas, *Problems of Informed Consent and Confidentiality in Genetic Counseling*, *in* GENETICS AND THE LAW 111, 111-22 (Aubrey Milunsky & George J. Annas eds., 1976). Annas characterizes the clinical advocacy of reproductive abstinence as "propaganda" that aims to "impos[e] the beliefs of the counselor on the patient" in pursuit of ends that "could be viewed by some as racist or even genocidal." *Id.* at 112-13. Other supporters of the non-directive model of genetic counseling do not go so far as to claim that opinion-giving compromises autonomy. Rather, they present the non-directive model as a means for keeping counselors focused on their patients' concerns and as a safeguard against the influence of counselors' moral beliefs about the social consequences of reproductive decisions. *See* James R. Sorenson & Arthur J. Culbert, *Professional Orientations to Contemporary Genetic Counseling*, *in* GENETIC COUNSELING: FACTS, VALUES, AND NORMS 85, 85-102 (Alexander M. Capron et al. eds., 1979).

tion between the widely held view that coercive pressures bar prisoners from consenting freely to take part in medical research[18] and the belief that even desperately ill inmates can consent autonomously to treatment. Nor is the phenomenon of apparent inconsistency between understandings of autonomy-negating influence in different contexts limited to clinical counseling. As Alan Wertheimer has observed, the law draws varying lines between coercive and non-coercive external influence in different doctrinal settings.[19] For example, many influences that suffice to void a contract fall short of what is needed to establish that a criminal confession was involuntary.[20] Underlying such inconsistencies, as Wertheimer notes, is the law's tendency to incorporate a myriad of context-based moral judgments into its accounts of coercive influence.[21]

To no small extent, the conflict over the desirability of discouraging childbirth by HIV-infected women has been cast as a debate over whether efforts to influence their decisions preserve or undermine autonomous choice. This Article considers the problem of line-drawing between autonomy-preserving and autonomy-negating influence in clinical relationships. My purpose is not to propose particular boundaries, either with respect to reproductive decisions by HIV-infected women or

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18. *See, e.g.*, Jessica Mitford, *Experiments Behind Bars, in* BIOMEDICAL ETHICS 172, 172 (Thomas A. Mappes & Jane S. Zembaty eds., 1981) (expressing doubt about whether a prisoner's consent can be sufficiently free and informed); THE NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, RESEARCH INVOLVING PRISONERS: REPORT AND RECOMMENDATIONS 61-64 (1976) (concluding that with certain safeguards, "the law generally will recognize the informed consent of a prisoner to participation in research"); Kaimowitz v. Dep't of Mental Health for State of Mich., 2 PRISON L. RPTR. 433, 477 (Cir. Ct., Wayne Cty., Mich. 1973) (holding that involuntarily detained mental patients cannot give informed and adequate consent to experimental psychosurgical procedures on the brain). For arguments to the effect that such consent can be given autonomously, see THE NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, STAFF PAPER ON PRISONERS AS RESEARCH SUBJECTS (1975), *reprinted in* JUDITH AREEN ET AL., LAW, SCIENCE, AND MEDICINE 1049, 1051 (1984) (citing arguments by Paul Ramsey & Paul Freund); Carl Cohen, *Medical Experimentation on Prisoners, in* BIOMEDICAL ETHICS 177, 177-86 (Thomas A. Mappes & Jane S. Zembaty eds., 1981) (arguing that even though prisoners are in a "coercive" environment, it does not follow that they are always "coerced" into volunteering for biomedical experiments).

19. ALAN WERTHEIMER, COERCION 19-175 (1987) (reviewing the differing approaches judges have taken to defining coercion when confronted with allegations of contractual or other duress, assumption of risk, failure to obtain informed consent, undue influence, blackmail, and use of coercion to obtain confessions or plea bargains).

20. *Id.* at 118-21.

21. *Id.* at 173-74.

for other clinical choices. Rather, I attempt to shed some light on what drives our disputes about whether one or another influence method is compatible with autonomous choice.

I argue that such disagreements reflect underlying conflicts between normative commitments, and that resolving these conflicts is essential to settling controversies over whether particular influences unduly interfere with autonomous choice. Alternative understandings of the prerequisites for autonomous choice are informed by differing normative visions. Although the ideal of a unified conception of autonomy has broad appeal, in practice we live with multiple understandings. Typically, this presents few problems; each governs within its own sphere of clinical or other activity. Indeed, it may be that illusory belief in autonomy as a unified concept, analytically separable from competing normative visions, facilitates the tranquil coexistence of contrary ideas about the scope of personal responsibility.[22]

Yet at times, differing understandings of autonomous choice collide. The counseling of HIV-infected women about their reproductive options represents an example. When this happens, underlying normative commitments should be candidly explored, with an eye toward the clarification of differences and the discovery of possibilities for accommodation. I conclude by briefly considering how such exploration might proceed with respect to clinical counseling and reproductive choices by HIV-infected women. Unless we probe beneath the notion of autonomy to its normative foundations, our arguments about autonomy-negating influence are likely to be bitter and fruitless, especially in such painful contexts as the AIDS epidemic.

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22. Put in other terms, the illusion of a unified conception of autonomy may function as a useful "subterfuge" — a tool for obscuring inevitable but distressing contradictions between cherished values. *See* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 195-96 (1978) (arguing that society relies upon subterfuges to avert the high moral cost of conflict between its most cherished concerns), and *see infra* text accompanying notes 85-87 and 217.

## II. THE BIOETHICS TREATMENT OF AUTONOMY: CHILDBEARING BY HIV-INFECTED WOMEN AS A CASE STUDY

Debate over the meaning of reproductive autonomy for HIV-infected women was inspired by the implementation of some influence strategies and the anxious anticipation of others. At the clinical level, the counseling of reproductive abstinence was once recommended[23] widely and was probably an established practice.[24] For the purposes of the discussion below, such counseling can be placed into two categories, which I shall refer to as "advisory" and "directive." By advisory, I mean statements that are phrased as suggestions, recommendations, or personal opinions and framed in a manner that acknowledges the counselee's decision-making role. A counselor might say, for example: "Because of the risks we have been discussing, I advise against having a child. It is important for you to understand, though, that the ultimate decision is yours." Or, after reviewing the relevant risk data (and discussing the satisfactions of parenting), a counselor might offer: "The choice is up to you, but, personally, I do not think I would do it." By a "directive" approach, I refer to counseling that takes an imperative form and fails to acknowledge the patient's or client's role as ultimate decisionmaker.[25] Examples include such statements as "you should not become pregnant" or "do not have this child."

My dichotomy between "advisory" and "directive" approaches constitutes an oversimplification: one easily can conjure up clinical remarks that straddle the two categories or are "advisory" or "directive" to varying degrees. Moreover, tone of voice matters at least as much as choice of words, and the manner in which data about risks is presented can deliver strong advisory and directive messages. Nevertheless, I believe these categories will prove useful in developing the argument

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23. *See supra* notes 7-9.

24. The frequency of this practice during the AIDS epidemic's early years is unknown, since reproduction counseling styles for HIV-infected women were not systematically surveyed.

25. My use of the word "directive" is thus narrower than that of some advocates of "non-directive" genetic counseling, who employ the term "directive counseling" to characterize *all* expressions of opinion as to what a counselee should decide.

set forth below.

Comments by health professionals to the effect that they will not provide prenatal or other medical care to women who decide to bear children[26] constitute a more aggressive influence strategy.[27] Although nowhere advocated in print, such pressure may have been endemic in clinical practice.[28] If a woman has no alternative source of care, such pressure amounts to conditioning access to care upon reproductive abstinence. The reproductive forbearance requested might range from a promise not to become pregnant to the use of a particular contraceptive method or even consent to abortion. In addition, some have expressed concern about a more extreme prospect — that providers could condition their services upon consent to sterilization.[29]

Additional influence strategies are possible at the public health level. These range from the public promotion of reproductive abstinence via mass media campaigns[30] to the creation of financial and other material incentives to refrain from

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26. Such warnings might be given either before or after conception. Provision of clinical services could be conditioned on a woman's promise to use contraception or her consent to abortion.

27. Characterization of *all* such statements as influence attempts is not appropriate. Such statements may at times reflect the hard reality that obstetric or other services needed by pregnant women are not provided within a particular facility. Even if one were to object to the priority choices made by such an institution (e.g., to argue that it ought to provide prenatal care instead of open-heart surgery), a further leap is needed to characterize these choices as an attempt *by an individual clinician* to influence her counselees' reproductive decisions. Such a leap might be plausible, e.g., if the clinician advocated (or acquiesced in) an institutional decision not to offer the services at issue. But since my focus in this Article is on autonomy-negating influence *within the counseling relationship*, I will not address this possibility here.

Another possible explanation for some such statements should be noted. Quite apart from any intent a counselor might have to influence her counselee's childbearing decision, the counselor might be a conscientious objector with respect to childbirth by HIV-infected women. Whether or not one thinks conscientious objection legitimate in this context, it is conceivable that a would-be conscientious objector could decline to provide prenatal care to HIV-infected women without in any sense *intending* to influence their reproductive decisions.

28. Dr. Abitol's alleged statement to the pregnant Ms. Doe that she could not continue in Jamaica Hospital's high-risk prenatal care program, *see* text accompanying notes 2-3, may have been an example.

29. Thus far, there have been no published allegations of such conduct by providers who care for HIV-infected women. However, providers have reportedly conditioned their services upon consent to sterilization in other contexts. *See, e.g.*, Walker v. Pierce, 560 F.2d 609, 613 (4th Cir. 1977), *cert. denied*, 434 U.S. 1075 (1978) (holding that a physician who conditioned obstetrical services to poor women with two or more children upon their submission to post-partum sterilization had not "forced" his views upon patients).

30. Some state health departments have already begun such campaigns.

childbearing.[31] These strategies lie beyond the scope of this Article. Nonetheless, the analysis that follows is applicable, with adaptations, to public health interventions.

### A. Conceptual Analysis and Moral Judgment

The notion that clinical efforts to dissuade HIV-infected women from having children are coercive per se and therefore objectionable squares poorly with prevailing bioethics theory. To begin with, an influential body of bioethics scholarship aspires toward the definition and analysis of coercion as a *concept*, quite apart from the *moral* status of coercion in particular contexts. For commentators who hold that such a definition is possible, the conclusion that an influence method constitutes coercion does not by itself imply that the method is morally wrong. For them, an additional, explicitly moral argument is necessary to support this second conclusion.[32] Conceptual analysis and moral assessment, in other words, are entirely separate philosophic tasks. On the other hand, this view holds, the former is a prerequisite for the latter to be fruitful.[33] An implication of this position is that when the word "coercion" is employed to convey a moral judgment, unsupported by a separate moral explanation, it is used untidily, in a manner that avoids the hard work of moral analysis. Those who object to the counseling of reproductive abstinence on the sole ground that such counseling is coercive provide no analytic basis for

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31. Such incentives, still purely hypothetical as a strategy targeted toward HIV-infected women, might include the provision of public subsidies for contraception or the conditioning of government benefits (*e.g.*, health insurance or welfare payments) on reproductive abstinence.

32. Ruth Faden states this position as follows:

> [T]here is (obviously) no moral conclusion necessarily to be drawn about the rightness or wrongness of a public policy from the determination that the policy is an instance of coercion, manipulation, etc.... Some coercive policies will be justified (in the light of our commitments, values, etc....) and others will not.

Letter from Ruth Faden to M. Gregg Bloche (June 22, 1992) (on file with author). *Cf.* GERALD DWORKIN, THE THEORY AND PRACTICE OF AUTONOMY 9, 32 (1988) (distinguishing between "conceptual" and "normative" analysis of autonomy and asserting that it is an "intellectual error" to "assimilat[e]" such virtues as sympathy, integrity, and concern for human welfare into our understanding of autonomy).

33. *See, e.g.*, Felix Oppenheim, *"Constraints on Freedom" as a Descriptive Concept*, 95 ETHICS 305, 305-09 (1984) (arguing that conceptual analysis of coercion and freedom must be morally neutral if discussion about the morality of coercive measures is to be intelligent and fruitful).

their moral judgment unless they explain *why* coercion in this context is wrong.

Such explanations are difficult to find in writings by those who opposed the counseling of reproductive forbearance. The premise that coercion is a bad thing per se seems deeply embedded in this work. One simply might dismiss this premise as an instance of fuzzy thinking — a failure of rigor by writers with passionate beliefs. Alternatively, however, one might take it more seriously, as a challenge to the notion that conceptual and moral analysis of coercion are separable.[34] Such a challenge draws support from myriad commentators on the concept of coercion, many of whom take the position that it is intrinsically wrong.[35] From this perspective, the coerciveness of an action creates a presumption against its desirability,[36] albeit a presumption open to rebuttal under sufficiently compelling circumstances.[37]

Underlying the sense that coercion is intrinsically wrong is the notion that to call something "coercive" is to render a normative judgment. In recent years, a number of academic writers have endorsed variations on this theme, contending that distinctions between coercive and non-coercive influence cannot be explained intelligibly except by reference to normative standards. Adherents to this view debate the appropriate sources of such norms.[38] Some take the utilitarian position that an attempt to influence coerces if it leads to socially suboptimal

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34. A broader possibility — that the analysis of a concept can *never* be wholly separated from its moral assessment — will not be considered in this Article.

35. *See, e.g.*, David Zimmerman, *Coercive Wage Offers*, 10 PHIL. & PUB. AFF. 121, 127 (1981) (asserting that an accurate account of coercion must explain its prima facie wrongfulness); Michael D. Bayles, *A Concept of Coercion*, *in* NOMOS XIV: COERCION 16, 29 (J. Roland Pennock & John W. Chapman eds., 1972) (stating that "[c]oercion is the most morally offensive form of the exercise of power over others"); Virginia Held, *Coercion and Coercive Offers*, *in* NOMOS XIV: COERCION 49, 61-62 (J. Roland Pennock & John W. Chapman eds., 1972) (asserting a "*prima facie* obligation" to avoid coercion); Robert Paul Wolff, Is Coercion *"Ethically Neutral?"*, *in* NOMOS XIV: COERCION 144, 145-46 (J. Roland Pennock & John W. Chapman eds., 1972) (contending that coercion is "intrinsically evil" because it is degrading).

36. *See, e.g.*, Held, *supra* note 35, at 61-62 (stating that there is a presumption against coercion).

37. *See, e.g.*, Edmund D. Pellegrino, *Autonomy and Coercion in Disease Prevention and Health Promotion*, 5 THEORETICAL MED. 83, 88-90 (1984) (describing circumstances which would justify employing coercive measures in order to encourage beneficial behavior).

38. *See* Kathleen M. Sullivan, *Unconstitutional Conditions*, 102 HARV. L. REV. 1413, 1442-50 (1989) (reviewing efforts by philosophers, legal scholars, and even some judges to derive definitions of coercion from competing conceptions of utility, autonomy, fairness, and just desert).

results.[39] Others pursue more particularized moral inquiries, focusing on the propriety of the would-be influence agent's behavior toward her target or the justice of the target individual's circumstances.[40]

This challenge to the separateness of coercion as a concept and as a normative judgment is consonant with a central insight of contemporary semiology — that the connotations of a term are essential to its signifying function. The communicative content of a term, in semiologic theory, is an integrated function of the term's denotative meaning (loosely equivalent to what philosophers call conceptual analysis) and its evolving connotations.[41] No term can be used in a purely denotative

39. *See, e.g.*, RICHARD A. EPSTEIN, BARGAINING WITH THE STATE 39-48 (1993) (arguing that once *ex ante* entitlements are accepted as legitimate, influence attempts should be deemed coercive if they impose social welfare losses). For Epstein, the welfare loss experienced by the target of an influence attempt bears on the determination of the attempt's coerciveness only because the target's loss is a good *proxy* for the *social* loss. *Id.* at 43 (arguing that when force becomes coercion the social losses increase). Epstein's approach to the legitimacy of *ex ante* entitlements centers on the potential of voluntary exchanges to maximize welfare. He argues (along Coasean lines) that minimization of transaction costs ought to determine the allocation of initial entitlements. *Id.* at 32-38.

40. Alan Wertheimer has developed the most comprehensive account of coercion along these lines. He argues that the allegation that *A* coerced *B* is best understood as a claim that *B* should be deemed not responsible for some action, and that such claims are best evaluated via the conduct of two, explicitly moral inquiries: (1) did *A* propose to make *B worse off*, relative to some *moral* baseline, and (2) was *B morally entitled* to succumb to *A*'s influence? Only if both questions are answered in the affirmative, Wertheimer holds, can *A* be said to have coerced *B*. WERTHEIMER, *supra* note 19, at 179-310. Taking issue with utilitarian theorists, Wertheimer contends that these moral inquiries should exclude "considerations of social utility" and center instead on "considerations of justice and rights." *Id.* at 174, 284-86. Beyond this, he says little about the substantive content of these inquiries, explaining that this lies beyond the scope of his project. *See also* CHARLES FRIED, CONTRACT AS PROMISE: A THEORY OF CONTRACTUAL OBLIGATION 95-99 (1981) (arguing that a proposal coerces if it offers something that its maker has no "right" to offer, as measured by moral criteria "deeper, more general, or at any rate independent" of the moral issue presented by the proposal).

*Cf.* Robert Nozick, *Coercion*, *in* PHILOSOPHY, SCIENCE, AND METHOD: ESSAYS IN HONOR OF ERNST NAGEL 440 (Sidney Morgenbesser et al., eds. 1969) (arguing that a contingent proposition constitutes a threat, and is therefore coercive, when it makes the recipient's situation worse than what would have been *expected* in the absence of the proposition, and asserting that what would have been *expected* is informed both by moral requirements and empirical probabilities). Where moral requirements and empirical probabilities diverge, Nozick proposes, the recipient's conscious preference (between the *ex ante* states implied by each) ought to be determinative. *Cf.* Seth F. Kreimer, *Allocational Sanctions: The Problem of Negative Rights in a Positive State*, 132 U. PA. L. REV. 1293, 1352-78 (1984) (suggesting that coercive and non-coercive propositions be distinguished by comparing them to baseline states derived from historical experience, the ideal of equality, and predictions of what might happen in a proposition's absence). Kreimer argues that reliance upon history and empirically grounded prediction can constrain, but not eliminate, the normative discretion inherent in the making of distinctions between coercive and non-coercive proposals. *Id.*

41. *See, e.g.*, ROLAND BARTHES, ELEMENTS OF SEMIOLOGY 89-94 (First American ed.,

sense; connotative significance is inescapable. Connotative meaning is "general, global, and diffuse"—a "fragment of ideology."[42] Nonetheless it is the mechanism by which language accommodates to changes in society and culture. Through connotation, "the environmental world invades the system,"[43] thereby compelling the language to evolve new denotative meanings.[44] Connotation, in short, is the cutting edge of denotation. To insist that terms like "coercion" and "autonomy" be defined as conceptual abstractions, in isolation from their context-linked, normative valences, is to deny much about the words' actual signifying functions. To a diverse range of writers and speakers, including those opposed to encouraging HIV-infected women not to bear children, coercion connotes something inherently negative.

If coercion is an intrinsically moral (and negative) idea, then those who condemn the clinical advocacy of reproductive abstinence as wrongful *because* it is coercive make a defensible normative claim. This claim is open to a form of rebuttal that I will not discuss here: it is possible to argue that an influence strategy judged to be coercive and therefore prima facie objectionable should nevertheless be tolerated because it

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Annette Lavers & Colin Smith trans., 1968) (arguing that a word or other sign signifies one or more meanings on the plane of denotation; in turn, use of a sign to denote a meaning signifies additional, more "general" and "diffuse" content on another plane — that of connotation).

This usage of the term "connotation" is sharply different from that employed by logicians and some analytic philosophers. Connotation in this latter sense is no less specific or focused than denotation: both are logical relations between linguistic expressions and particular things in the world. A word connotes a quality, in this analytic sense, if possession of that quality is the necessary and sufficient condition for the word's application to a person or thing. *See* WILLIAM P. ALSTON, PHILOSOPHY OF LANGUAGE 16-17 (1964) (illustrating the point with the word "courageous," which connotes the "disposition to remain steadfast in the face of danger" because "possession of that disposition by someone is the necessary and sufficient condition of the term 'courageous' being correctly applied to that person"). I thank Anita Allen for bringing this usage to my attention. Within this analytic tradition, the dichotomy between "cognitive meaning" and "emotional meaning," comes much closer to capturing semiologists' distinction between denotation and connotation. *Id.* at 47. However, the notion of "emotional meaning" does not fully capture the ideological, indeed moral, import of connotation in the semiologic sense.

42. BARTHES, *supra* note 41, at 91.

43. *Id.* at 91-92.

44. The word "discrimination" provides an example. Its denotative meaning involves the drawing of distinctions between things, but in the bitter context of American race relations it developed a powerful and negative connotative meaning (in the semiologic sense). This meaning has so crystallized — i.e., the term "discrimination" has become so closely linked to invidious differentiation based on race or other social groupings — that it is now arguably denotative in character.

achieves some overriding good.[45] I leave to others the question of whether coercion ever can be justified in the clinical contexts upon which this Article focuses. I turn instead to the persuasiveness of the prima facie claim itself—i.e., to whether the clinical advocacy of reproductive abstinence plausibly can be said to coerce. I consider this question as part of the larger problem of making distinctions between autonomy-preserving and autonomy-negating influence in clinical contexts.

### B. Autonomy-Negating Influence in Contemporary Bioethics

I submit in this section that bioethics theory provides, at most, equivocal support for the proposition that the clinical pursuit of reproductive abstinence is per se coercive or otherwise inconsistent with autonomous reproductive choice. The diversity of views on autonomy-negating influence in the bioethics literature precludes easy generalization. Yet, as I suggest below, bioethics commentators concerned with enhancing patients' role in medical treatment decisions have tended toward understandings of autonomous choice (and of coercion) that tolerate advice-giving and disregard pressures arising from adverse life circumstances.

These understandings, I argue, permit the conclusion that conditioning the provision of medical care upon abstinence from childbearing can preclude autonomous reproductive choice. They are also compatible with the belief that "directive" counseling (in the sense described above)[46] forecloses autonomous choice, though they leave room for the opposite view. Such understandings make it more problematic to assert that the "advisory" counseling described above interferes with reproductive autonomy, but they leave some space for arguments to this effect.

Conceptions of autonomous choice that permit advice-giving and, as a rule, disregard pressures arising from adverse

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45. *See, e.g.*, Held, *supra* note 35, at 61-62. To the extent that coercion is seen as an intrinsically normative concept with a negative moral valence, such an argument would seem to be at war with itself. Its virtue, on the other hand, lies in its respectful treatment of the values it proposes to sacrifice: characterization of an influence strategy as coercive acknowledges that a moral price would be paid to achieve a preferred end.

46. *See* text accompanying note 25.

life circumstances neatly fit the normative aims of commentators concerned principally with empowering patients in medical treatment settings. Given these aims, such conceptions are appealing, even persuasive. But this persuasiveness is contextual. Other normative ends, e.g., the pursuit of change in the chooser's life circumstances or intrapsychic world, may render other visions of autonomous action more persuasive, within different contexts.

### 1. Requiring a Purposeful Autonomy-Negating Agent: The Faden and Beauchamp Model as an Example

No single conception of coercion or autonomy-negating external influence dominates the bioethics literature. The empowerment of patients as choosers, however, has animated bioethics scholarship and activism,[47] inspiring models of autonomous action that preserve the possibility of patient self-determination in the face of medical authority and the pressures of illness and life circumstances. By contrast with scholars who contend that autonomous choices must cohere with a person's deep and enduring values,[48] bioethics commentators have tended toward less stringent criteria for autonomous action. The work of Tom Beauchamp and James Childress is illustrative. In their influential bioethics textbook,[49] Beauchamp and Childress state that choosers who act "intentionally," "with understanding," and "without controlling influences" act autonomously.[50] Beauchamp and Childress add that the last two requirements can be met by the average person without the reflective effort contemplated by philosophers who demand coherence between a person's choices and enduring values:

> To chain adequate decision making by patients to fully or completely autonomous decision making strips the rules of informed

47. DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION-MAKING 241-46 (1991).

48. *See, e.g.*, Harry G. Frankfurt, *Freedom of the Will and the Concept of a Person*, 68 J. PHIL. 5, 6-7 (1971) (arguing that autonomous action must be motivated by "first-order" preferences with which a subject identifies, via enduring "second-order" desires about which "first-order" preferences should be acted upon). For Frankfurt, actions inconsistent with lasting, "second-order" desires cannot be autonomous — indeed, such actions cannot be plausibly regarded as a person's own. *Id.* at 13.

49. BEAUCHAMP & CHILDRESS, *supra* note 12.

50. *Id.* at 69.

> consent of any meaningful place in the practical world, where people's actions are rarely, if ever, fully autonomous. A person's appreciation of information and independence from controlling influences in the health-care setting need not exceed a person's information and independence in making a financial investment, hiring a new employee, or attending a particular college. The goal, realistically, is only that such consequential decisions be substantially autonomous.[51]

Although some commentators on clinical ethics have espoused more stringent requirements for adequately autonomous choice,[52] the Beauchamp and Childress position probably represents the prevailing view.[53] Their pragmatic approach to the question of "controlling" external influence allows for patient self-determination without a radical restructuring of doctor-patient relations[54] or background social circumstances. This approach to autonomy-negating external influence is developed in greater depth by Beauchamp and Ruth Faden.[55] I turn now to their work, especially their definition of coercion, first because its clarity facilitates close examination, and second, because it is representative of the inclination in bioethics com-

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51. *Id.*

52. Jay Katz argues for a conception of "psychological autonomy" that emphasizes the chooser's capacity to reflect in a manner that takes unconscious mental processes and irrational beliefs into account. KATZ, *supra* note 11, at 116. For Katz, psychologically autonomous choice requires the exercise of this capacity to a greater degree than is now common in clinical practice. Katz ties this challenging conception of autonomous action to a call for enriched doctor-patient conversation, aimed at deepening both parties' awareness of their beliefs and biases. *Id.* at 121-64.

Along similar lines, Gerald Dworkin describes autonomy as "a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes, and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values." DWORKIN, *supra* note 32, at 20. But unlike Katz, Dworkin provides little guidance (in his extensive discussion of the importance of patient autonomy, *id.* at 100-20) as to how his demanding conception of autonomy might translate into prerequisites for autonomous patient choice.

53. The Beauchamp and Childress model of four prima facie principles — nonmaleficence, beneficence, autonomy, and justice — has been broadly and enthusiastically embraced by medical ethicists and health professionals. For nearly a generation, it has been widely taught to ethicists and clinicians who consult in health care settings, teach in medical schools, and direct centers of bioethics. *See* Edmund D. Pellegrino, *The Metamorphosis of Medical Ethics; A 30-Year Retrospective*, 269 JAMA 1158, 1160 (1993).

54. By contrast, Jay Katz's more demanding approach to the prerequisites for autonomous choice leads him to call for far-reaching change in doctor-patient conversation so as to remake clinical decision making into a much more deeply reflective enterprise for patients and physicians. *See* Katz, *supra* note 11, at 104-64.

55. RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 337-81 (1986).

mentary toward conceptions of autonomous action that permit both professional opinion-giving and a high degree of circumstantial pressure. My aim is to offer a sense of how bioethics scholars who share this inclination might analyze claims that the aforementioned efforts to influence reproductive decisions preclude autonomous choice.[56] I also will highlight the normative commitments that inform this analysis and question their relevance to the drawing of lines between influences that permit and those that preclude autonomous choice outside the medical sphere.

Faden and Beauchamp set forth an apparently simple, three-part definition of coercion. First, an "agent of influence" (one or more persons) must "intend to influence" another person "by presenting a severe threat." Second, this threat must be "credible." Third, the threat must be "irresistible."[57] A notable thing about this definition is its requirement of a purposeful coercing agent.[58] Faden and Beauchamp hold categorically that influences bearing on a decision do not diminish the autonomy of the chooser, whether by coercing or by otherwise controlling her actions, unless such influences are the product of a purposeful agent.[59] Purposeful agency is an element of some classic philosophic models of coercion,[60] but it is notably absent from definitions that focus on the experience of those being influenced. An example of the latter is Harold Lasswell's influential model of coercion, which requires only

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56. Working with a single, richly developed conception of autonomy-negating influence facilitates deeper analysis of such claims than would generalization about the many treatments of autonomous action in bioethics that share the above-described pragmatic stance toward "controlling" influence. This strategy cannot yield broadly validated conclusions about how bioethics as a movement treats such claims. But this in-depth approach permits illustration of the tight linkage between bioethics commentators' understandings of autonomy-negating influence and their aspirations for the reform of doctor-patient relations.

57. FADEN & BEAUCHAMP, *supra* note 55, at 339.

58. Faden and Beauchamp appear to use the term "intent" narrowly, as synonymous with purpose. But they nowhere foreclose the possibility of a broader reading of "intent" — *e.g.*, as knowledge with substantial certainty.

59. Within the Faden and Beauchamp framework, autonomous choice can be compromised by some types of "manipulation" as well as by coercion. Purposeful agency is also a prerequisite for manipulation. *See infra* text accompanying notes 68-70, 90-92.

60. Nozick's model of coercion is the most influential contemporary example. Nozick, *Coercion*, *supra* note 40. *See also* Bayles, *supra* note 35, at 19-20. These models portray coercion as a relationship between the victim and the purposeful perpetrator. They take background social forces and pressures as givens, beyond the scope of the personal relationship between the victim and the perpetrator, and thus beyond the reach of the concept of coercion.

"a high degree of constraint and/or inducement."[61]

From a medical ethics perspective, the requirement of a purposeful agent serves an essential strategic function. Without this requirement, fears inspired by illness, dependency, or the impersonality of medical routines could constitute coercion in clinical settings, rendering autonomous patient decision making impossible in many circumstances.[62] An obvious example is a patient with a life-threatening malignancy who has been advised (accurately) by her physician that only a disfiguring operation can improve her prospects for survival. Absent the requirement of a purposeful agent, this situation would appear to constitute coercion. A "high degree of constraint and/or inducement" clearly is present. On its face, this situation meets the other two tests in the Faden and Beauchamp formula: the patient's cancer poses a threat that is surely "credible" and seemingly "irresistible." Patients often confront such circumstances. Absent a purposeful agency requirement, coercion in clinical work would be commonplace,[63] and non-autonomous patient decision making would be par for the course.

Were non-autonomous patient decision making to be seen as unavoidable, insistence on respect for the autonomy of patients would seem quixotic. The rationale for requiring informed consent — protection for autonomous choice[64] — then would lack its current moral force. If patients are commonly unable to act autonomously, regardless of how their doctors interact with them, then why look to physician-patient conversation to preserve autonomy? Indeed, why bother to involve patients in medical decision making at all?

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61. HAROLD D. LASSWELL & ABRAHAM KAPLAN, POWER AND SOCIETY: A FRAMEWORK FOR POLICICAL INQUIRY 97 (1950).

62. This presumes, of course, that coercion precludes the possibility of autonomous choice. This assumption is consistent with evident scholarly consensus. To my knowledge, no commentator has proposed that choices understood as coerced be simultaneously deemed autonomous.

63. *Cf.* F. J. Ingelfinger, *Informed (But Uneducated) Consent*, 287 NEW ENG. J. MED. 465, 466 (1972) (arguing that patients' incapacitation, fears for their health, etc. . . . lend "some element of coercion" to all consents given by human subjects in medical research). Like Lasswell, Ingelfinger's interpretation of the concept of coercion does not require a purposeful coercive agent.

64. *See* BEAUCHAMP & CHILDRESS, *supra* note 12, at 75 ("primary function of informed consent is protecting and enabling individual autonomous choice"); *See generally* Schultz, *supra* note 10.

The intent requirement urged by Faden and Beauchamp (and others) nicely averts this dilemma. By drawing a line between "credible," "irresistible" threats posed purposefully by human agents and impersonally by circumstances, Faden and Beauchamp preserve the conceptual possibility of autonomous decisions by patients in the most dire medical straits. Even the most desperate medical (or other) circumstances do not "coerce," once this line is drawn, unless a human agent intervenes by purposefully posing a threat. In Faden and Beauchamp's words, "nonintentional, situational factors can neither coerce nor otherwise control actions so as to compromise autonomy, no matter how desperate the person's circumstance."[65] This definitional strategy channels attention to constraints on choice that are imposed willfully by human agents. By making such constraints decisive with respect to an actor's capacity to decide autonomously, Faden and Beauchamp set their sights on the behavior of those who impose them.[66] Given their project — the alteration of physician behavior so as to preserve the possibilities for patient self-determination that remain after illness and social circumstances are taken as givens — this definitional strategy makes contextual sense.

### 2. Applying the Model: Childbearing by HIV-Infected Women

The Faden and Beauchamp model of autonomy-negating influence yields mixed results — and much indeterminacy — when applied to the above-mentioned methods for influencing the reproductive choices of HIV-positive women. The model permits the conclusion that conditioning medical care upon abstinence from childbearing is incompatible with autonomous reproductive choice. But the model's analytic framework is equally consonant with the opposite view. This framework also

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65. FADEN & BEAUCHAMP, *supra* note 55, at 368. Faden and Beauchamp acknowledge that a person in dire circumstances "can be described as not free." *Id.* at 344. But they contend it is "a serious confusion to move from a correct claim about a deprivation or loss of freedom caused by desperate circumstances to a (fallaciously drawn) conclusion that there has been a loss of autonomy because of a coercive situation." *Id.* at 345. They do not explain the difference between their conceptions of freedom and autonomy.

66. *See id.* at 345 (noting their decision to "restrict the notions of 'control' and 'coercion' to the intentional acts of others for which they are responsible and which they could eliminate").

is indeterminate with respect to whether the "directive" and "advisory" modes of counseling described earlier constitute autonomy-negating influence. This indeterminacy is traceable to the model's pervasive, tacit dependence upon external normative reference points as grounds for making the analytic distinctions upon which it overtly relies.

a. Conditioning Medical Care Upon Reproductive Abstinence: The Problem of Resistibility

A clinician who instructs her patient that continued care is contingent upon reproductive abstinence[67] issues a proposal that is clearly "intentional" and presumably "credible." If seen as a threat (as opposed to an offer), this sort of proposal plainly satisfies two of the three elements in the Faden and Beauchamp definition of coercion. Only its "irresistibility" seems open to question. Intuitively, the resistibility of such propositions would seem to depend on such factors as access to other sources of care, the intensity of the patient's wish for a child, and the particular behavior solicited by the counselor — e.g., a general promise not to become pregnant, a commitment to use a particular contraceptive method, or consent to an abortion. A case could be made against the irresistibility of such proposals in any event, on the ground that medical care, though desirable, can be forgone without assured calamity. Certainly this prospect does not seem so constraining as that quintessentially coercive proposition, "your money or your life." Conversely, a strong emphasis on protection for self-determination by women in reproductive matters might incline one toward the view that such proposals are irresistible under most or all circumstances.

The Faden and Beauchamp approach to autonomy-negating external influence is complicated by another, parallel line of inquiry in which resistibility plays a critical role. Some contingent propositions that do not qualify as coercive can

67. Such a statement might reflect either the provider's personal preference or the policy of an institution that employs her. The discussion above does not distinguish between these two possibilities; nor does it explore an individual counselor's options when faced with such an institutional policy.

nevertheless preclude autonomous choice if they meet a relaxed non-resistibility standard. Autonomous action, within the Faden and Beauchamp framework, is precluded by some forms of manipulation as well as by coercion. Faden and Beauchamp define manipulation as "any intentional and successful influence of a person by noncoercively altering the actual choices available to the person or by nonpersuasively altering the other's perception of those choices."[68] Successful threats (and offers[69]) that do not constitute coercion thereby qualify as manipulation, since they alter the available range of choices. When such propositions cannot be "reasonably easily resisted" (a seemingly less stringent criterion than "irresistibility"), they preclude autonomous decision making.[70] Thus, in theory, a proposal to render medical care on condition of reproductive abstinence may be resistible (and hence not coercive), but nevertheless inconsistent with autonomous choice.

Faden and Beauchamp offer little guidance as to how resistibility ought to be assessed. They characterize the resistibility of a proposition as something empirically measurable, via an inquiry into the "subjective responses" of those at whom it is targeted.[71] But they say nothing about how these "subjective responses" might be explored.[72] This open-endedness precludes an incontrovertible answer, within the Faden and Beauchamp framework, to the question of whether conditioning medical care upon reproductive abstinence compromises autonomous choice.

A more basic problem underlies this analytic difficulty. The resistibility of a threat (or offer) cannot be judged without reference to a *normative* standard — a premise about the degree of external or psychological pressure that a person *ought*

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68. FADEN & BEAUCHAMP, *supra* note 55, at 354.

69. Faden and Beauchamp take the position that offers are never coercive and that the distinction between threats and offers is not purely a matter of how choices are framed — i.e., that a "genuine offer" can be distinguished from a "veiled threat." *Id.* at 340-41.

70. *Id.* at 360.

71. *Id.* at 342, 360.

72. They explicitly decline to make "suggestions as to how to measure or test whether a given threat would prove irresistible to any particular individual." *Id.* at 342. They propose however, that "for policy purposes," resistibility be assessed based on "evidence and predictions about how most people would respond" to a proposition. *Id.* They acknowledge that "[p]iling so much on the notions of 'resistance' and 'resistibility' without a deeper analysis of these terms . . . leaves a certain incompleteness." *Id.* at 360-61.

to resist, under the circumstances at issue. To see why, consider the alternative proposition — that resistibility is a purely empirical matter. Thus conceived, the question of resistibility calls for a *counterfactual* inquiry, into whether a person who in fact yielded to pressure might have withstood its influencing effect. But such an inquiry into the subjunctive is an act of imagination, not real-world observation. As Douglas Hofstadter observes about counterfactual thinking, "it is obvious that anything that didn't happen didn't happen. There aren't degrees of 'didn't-happen-ness.'"[73] At times, we intuit that a counterfactual possibility almost happened, but "the 'almost' lies in the mind, not in the external facts."[74]

Our ability to think subjunctively may be central to our capacity for creativity.[75] Yet our inclination to do so is curiously selective. As Hofstadter notes, "some counterfactuals strike us as 'less counterfactual' than other counterfactuals."[76] Intuitively, often unconsciously, we set limits to the subjunctive slippage we allow between reality and what might have been. These limits derive from our mental representations of the world, not from unprocessed, external reality. These representations incorporate background assumptions about what should and should not be varied in our subjunctive imaginings. Such assumptions frame our counterfactual thinking. Hofstadter offers a trivial but instructive example. A football player catch-

73. DOUGLAS R. HOFSTADTER ET AL.: AN ETERNAL GOLDEN BRAID 641 (1979). Hofstadter drives home this point with an anecdote: "[a]fter reading [a whimsical, counterfactual dialogue written by Hofstadter], a friend said to me, 'My uncle was almost President of the U.S.!' 'Really?' I said. 'Sure,' he replied, 'he was skipper of the PT 108.' (John F. Kennedy was skipper of the PT 109)." *Id.*

74. *Id.*

75. GEORGE STEINER, AFTER BABEL: ASPECTS OF LANGUAGE AND TRANSLATION 227 (1975); *see also* HOFSTADTER, *supra* note 73, at 643. Steiner argues, "[i]t is unlikely that man, as we know him, would have survived without the fictive, counter-factual, anti-determinist means of language, without the semantic capacity, generated and stored in the 'superfluous' zones of the cortex, to conceive of, to articulate possibilities beyond the treadmill of organic decay and death." STEINER, *supra*, at 227.

76. HOFSTADTER, *supra* note 73, at 641. Hofstadter illustrates this point as follows:

Driving down a country road, you run into a swarm of bees. You don't just duly take note of it; the whole situation is immediately placed in perspective by a swarm of "replays" that crowd into your mind. Typically, you think, "Sure am lucky my window wasn't open!" — or worse, the reverse: "Too bad my window wasn't closed!" "Lucky I wasn't on my bike!" "Too bad I didn't come along five seconds earlier." Strange but possible replays: "If that had been a deer, I could have been killed!" "I bet those bees would have rather had a collision with a rosebush."
*Id.*

es a third-down pass and turns upfield toward the end zone. Unfortunately for his team, which trails by a touchdown, his momentum carries him out of bounds. Predictably, the team's frustrated fans imagine what might have been had he been able to stay in bounds. We would be surprised, by contrast, were the fans to focus on what might have happened had the ball been round.[77] We would be similarly surprised if the fans turned to dreaming about what might have been had there not been a rule against going out of bounds.

Why do the last two variations strike us as less plausible — or more counterfactual — than the first? Why, in other words, are we less inclined to vary our background assumptions about the shape of the ball and the rule against stepping out of bounds? An answer is that it makes heuristic sense to take the shape of the ball and the rules of the game as givens if our aim is to understand what the team (and its fans) are hoping to accomplish. By contrast, it makes heuristic sense to vary, in the subjunctive, the player's steps along the sidelines, since *he* wants badly to stay in bounds.[78]

Analogously, in considering the situation of a person confronting a threat (or offer), it is heuristically useful to frame the problem by taking some circumstances as givens and allowing others to vary in the subjunctive. Among the circumstances that might be either varied or held constant are the existence and character of the threat and the possible response(s) of the threatened person. By depicting a threat as irresistible, we hold the threatened person's response constant, in the subjunctive. We assume, in other words, that the threatened person must yield. This assumption frames our counterfactual inquiry. It channels our subjunctive speculation toward other circumstances — e.g., the presence (or absence) and the character of the threat itself. From the perspective of the threatened person, varying these circumstances offers the only (counterfactual) way to avoid yielding to the threat, once the impossibility of resistance to the threat (as actually posed)

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77. *Id.* at 635-37.

78. These framing decisions make heuristic sense *from a football fan's perspective* since they are the choices the *player* has implicitly accepted: instead of questioning the shape of the ball or the out-of-bounds rules, he focuses his attention on catching the ball and then staying in bounds.

is assumed.

By depicting a class of threats as merely "difficult to resist,"[79] Faden and Beauchamp make a similar framing choice, but they signal that the frame can be adjusted more easily. They represent the threatened person's response as constant, in the subjunctive, but they leave open the possibility of counterfactual variation in this response. Our subjunctive speculation is thereby guided toward other factual circumstances, such as the presence and nature of the threat posed. We are not so "locked in" to the assumption that the threatened person will yield: resistance to the threat remains an available counterfactual alternative.

In contrast, characterization of a threat as "easily resistible" channels subjunctive attention to the possibility of variation in the threatened person's response. It renders variation in the threat situation into a less interesting possibility — less interesting because it seems less significant from the perspective of a person confronting such a benign threat.

The choice between these different framing possibilities has critical normative consequences, for it determines the focus of creative, counterfactual thinking about how a threatening situation might be addressed. Characterization of a threat as easy to resist casts the threatened person as a responsible agent, with feasible options. It thereby focuses attention on her moral agency, as opposed to the moral role (and feasible alternatives) of the one posing the threat. By contrast, depiction of a threat as irresistible (or difficult to resist) casts the threatening party as the responsible moral agent. This channels attention to what the *threatening party* might do differently — i.e., how the threat might be transformed or eliminated. The choice between these frames for counterfactual thinking is not a purely empirical question, since, as Hofstadter bluntly puts it, "there aren't degrees of 'didn't-happen-ness.'" Because "the 'almost' lies in the mind, not in the external facts," the choice between frames reflects human aims. Ultimately, therefore, the question of resistibility is normative, not factual: it is about whether we should hold an actor responsible for not resist-

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79. *See supra* text accompanying notes 68-70.

ing.[80]

Differing views about the resistibility of an effort to influence an HIV-infected woman's reproductive choices are likely to reflect myriad underlying normative concerns. A thorough analytic treatment of these concerns lies beyond the scope of this Article, but I will point to some, for purposes of illustration. To begin with, the belief that a particular means of influence is difficult or impossible to resist is likely to be tied to convictions about the moral legitimacy of the leverage it employs. Conditioning the provision of medical care upon reproductive abstinence, for example, will be troubling to those who view access to health care as a baseline moral entitlement, especially if other sources of care are not readily available. The use of clinical abandonment as leverage, after a therapeutic relationship has been established, will disturb those who believe that such abandonment constitutes a wrongful breach of patient faith.

Intuitions about the resistibility of an influence method also are likely to be linked to considerations of fairness and justice relating to the behavior that the influence agent wishes to elicit. Attempts to discourage childbearing by HIV-infected women implicate a host of such considerations. Some involve the sense that asking these women to sacrifice the fulfillment that comes with childbearing is unfair because of the injustice of their circumstances. To the extent that HIV transmission is seen as a product of poverty, racial discrimination, or other social ills, a clinical response that asks victims of these wrongs to endure further deprivation seems unfair.[81] This impression of unfairness is magnified by society's failure to offer other possibilities for fulfillment, e.g., educational and career opportunities to minority women who are at disproportionate risk for infection.[82] Awareness that many women contract HIV from

80. *Cf.* WERTHEIMER, *supra* note 19, at 267-73 (stating assertion that the recipient of a "coercive proposal" has "no choice" constitutes a claim that she is "entitled to succumb" to the proposal).

81. This intuition roughly tracks the Rawlsian difference principle, which allows inequities only when they benefit society's worst-off. JOHN RAWLS, A THEORY OF JUSTICE 75-78 (1971).

82. *See* Tedd V. Ellerbrock et al., *Epidemiology of Women with AIDS in the United States, 1981 Through 1990: A Comparison with Heterosexual Men with AIDS*, 265 JAMA 2971, 2972-73 (1991) (reporting that 72% of AIDS cases in women compiled by the U.S. Centers for Disease Control AIDS surveillance system before 1991 occurred in African Americans or Latinos). This

male sexual partners who decline to use condoms and, in some cases, impose their sexual will aggressively can add to this sense of unfairness. For some, painful memories of past infringements upon reproductive freedom[83] heighten sensitivities to present sources of unfairness.

On the other side of the moral ledger, concerns about burdening society with medical costs and burdening offspring with the tragedy of terminal, wasting illness invite the belief that discouraging childbirth is a legitimate aim. The prospect that many children of infected mothers will become orphans reinforces this view. More darkly, insensitivity toward the aspirations of HIV-infected women or to the deprivations that many have experienced may influence perceptions about reproductive abstinence as a clinical goal.

One might object that these factors (on both sides of the ledger) are relevant to the question of whether autonomy-negating influence *should* be exerted but unrelated to whether a particular influence is so difficult to resist that it precludes autonomous choice. There is something to this objection: we tend not to view our unanalyzed intuitions about resistibility as byproducts of our beliefs about fairness and justice. But if, as I have just argued, the concept of resistibility draws its content from implicit normative premises,[84] then ideas about fairness and justice are central to any analysis of resistibility that goes beyond boilerplate. The gap between this deeper analytic necessity and the common impression that resistibility is empirically measurable suggests that subterfuge[85] is involved when

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study's authors concluded that African-American and Latino women had cumulative AIDS incidence rates 8 and 13 times higher, respectively, than for Whites. *Id.* at 2972.

83. *See generally* THOMAS M. SHAPIRO, POPULATION CONTROL POLITICS: WOMEN, STERILIZATION, AND REPRODUCITVE FREEDOM (1985) (arguing that there is a discriminatory pattern in the use of sterilization with the poor and those on welfare); Sylvia Law, *Sterilization Comes Easier for the Disadvantaged*, 23 N.Y.U. L. BULL. 15 (1977). *See also* JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF A NATIONAL POLICY, 1800-1900 147-70 (1978) (interpreting advocacy of restrictive abortion laws by late nineteenth century physicians as part of an effort to promote their professional authority).

84. *See* text accompanying notes 71-80.

85. In employing the term "subterfuge," I do not mean to issue a categorical moral judgment, though the adverse connotations of this term plainly are suggestive in this regard. Rather, I mean merely to note that the concept of resistibility (and analogous constructs in the literature on autonomy and coercion) tends to obscure underlying normative choices. Such disingenuity, I suggest above, may have its advantages.

moral judgments are avowedly grounded on determinations of resistibility.

By obscuring deeper, substantive conflicts, this subterfuge may yield benefits. Judgments based avowedly on determinations of resistibility enable us to take hard moral decisions without openly affronting intensely felt values[86] and embittering their adherents. On the one hand, this mechanism may contribute to mutual respect and social peace.[87] It also may enable us to resolve value conflicts differently within separate spheres of activity without suffering the cost of explicit logical contradiction. On the other hand, by obscuring the sacrifice of some values, this subterfuge may make it harder for disregarded persons and groups to assert their concerns.

Another basis for disagreement about the meaning of resistibility merits brief mention. At a higher level of abstraction, proponents of broader and narrower understandings of resistibility may differ over whether human dignity is best served by broad conceptions of personal responsibility or by a preference against viewing victims of unjust circumstances as authors of their own actions. While the former perspective affirms human dignity by preserving the domain of the self in the face of myriad influences,[88] the latter does so by channeling attention to possibilities for averting the degradation of persons by alleviating injustice. Preferences for one or another of these perspectives may affect judgments about the resistibility of an influence method independently of normative considerations related to the particular leverage employed or behavior sought.

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86. *Cf.* CALABRESI & BOBBIT, *supra* note 22, at 149-50 (discussing the appeal of various decision-making procedures, ranging from juries to markets, that submerge the sacrifice of passionately held values).

87. If so, then analyses like the present work could have the ironic and disturbing effect of undermining mutual respect.

88. *Cf.* Meir Dan-Cohen, *Responsibility and the Boundaries of the Self*, 105 HARV. L. REV. 959 (1992) (linking alternative conceptions of individual responsibility to variations in the boundaries that we draw between the self and the external world).

### b. The Faden and Beauchamp Model and the Threat-Offer Distinction

The framing of contingent propositions presents further problems for the Faden and Beauchamp model. Faden and Beauchamp adhere to the classic view that threats coerce while offers do not.[89] Offers, they hold, are manipulative, not coercive.[90] They take the position, however, that not all offers permit autonomous choice. Some manipulations (including some offers), they say, preclude autonomous decision making. In short, threats (if "severe," "credible," and "irresistible"[91]) preclude autonomous action, but offers do not, unless they are "unwelcome" *and* cannot be "reasonably easily resisted."[92] This formulation makes the characterization of contingent propositions — as threats, "unwelcome" offers, or "welcome" offers — critical to whether they preclude autonomous decision making. But choices between these characterizations, like conclusions about resistibility, ultimately rest on moral judgments about the substance of the propositions at issue. With respect to the threat-offer distinction, this point has been made elsewhere, and I will touch upon it only briefly. I will say more about the difference between welcome and unwelcome offers, to which I turn first because it bears importantly on the role of the threat-offer distinction in the Faden and Beauchamp model.

What Faden and Beauchamp mean by "welcome" is less than clear. An offer is "welcome," they say, if it "is one the person influenced wants to *receive*, but not necessarily to *accept*." Conversely, they hold, an offer is unwelcome if its recipient would prefer not to receive it, whether or not she chooses to accept it. Beyond this, they do not elaborate, aver-

89. FADEN & BEAUCHAMP, *supra* note 55, at 340. *See also* WERTHEIMER, *supra* note 19, at 202 (characterizing this position as the "dominant philosophical view about coercion").

90. *See supra* note 69 and text accompanying notes 68-69.

91. *See supra* text accompanying note 57. Successful threats that are not "severe" (a standard that relies overtly on normative judgment about the leverage employed) qualify as "manipulation" within the Faden and Beauchamp model and thereby preclude autonomous choice when they cannot be "reasonably easily resisted." *See supra* text accompanying notes 68-70.

92. Decisions influenced by "welcome" offers are autonomous per se, Faden and Beauchamp say, without reference to a resistibility standard. *See* FADEN & BEAUCHAMP, *supra* note 55, at 357 (a choice influenced by a "welcome offer" is "entirely autonomous" because "it proceeds from the dictates of [the chooser's] will"). In contrast, decisions influenced by "unwelcome" offers are autonomous only when such offers can be "reasonably easily resisted."

ring that "the complex morass of human motivations that would *cause* such welcoming" is outside their scope.[93]

The idea of an unwelcome offer that a person decides to reject is easy to envision[94] but trivial for present purposes, since its resistibility, shown in retrospect by the act of rejection, renders it compatible with autonomous action. Much more important — and much more problematic — is the notion of an unwelcome offer that the recipient accepts. Faden and Beauchamp suggest just one example: an impoverished mother of five children is offered twenty-five dollars per day to participate in six day-long sessions of medical research involving painful and invasive procedures. Although she finds the prospect "horrifying" and "wishes desperately" that she had not received this offer, she nevertheless accepts it.[95]

The "unwelcomeness" of this offer is hardly self-evident, since in the end its recipient's fears are overcome by her desire for the twenty-five dollars per day. Although her acceptance seems motivated by a sense of duty, not joy, it constitutes an expressed *net* preference — a decision to endure pain in order to raise money for her children. Put in other terms, her acceptance of this grim offer is a Pareto-superior move, from her perspective, *given* her desperate, pre-offer starting point. She may have conflicting thoughts about making this move (including the waxing and waning wish never to have received such an offer), but in the end she opts to do so.

Once she accepts, characterization of the offer as one she would have preferred not to receive questions the validity of her own summation of preferences. By accepting, she announces that her own net calculus of preferences in the end *favors* the offer. To hold that the offer is nevertheless *unwelcome* to her accords privileged status to doubts that have lost out in her mind.[96] This privileging is an act of *interpretation* by outside

93. *Id.* (emphasis in original).

94. As an example, consider a physician's offer of free medical care to a happily married patient in return for sexual relations. This offer is both patently offensive and virtually certain to be rejected.

95. FADEN & BEAUCHAMP, *supra* note 55, at 358-59.

96. It is inconceivable (at least to me) that the recipient of an offer could at once *favor* its terms (in comparison with her alternatives) and find them *unwelcome.* Once the recipient has chosen the offer over its alternatives, the notion that it is unwelcome only can make sense (at least to me) as an expression of *observer discomfort* with her decision or with her limited set of

observers, not an unfiltered observation about the recipient's desires. As such, it is informed by the *observers'* normative beliefs about her preferences and about the choice situation. Such beliefs might arise from empathy with the recipient's situation, the belief that her life circumstances are unjust, or the sense that the researchers are unfairly exploiting her vulnerability.[97] Like the question of resistibility, the question of welcomeness cannot be answered without implicit reliance upon notions of fairness and justice.

The following example illustrates this point in the context of reproductive decision making by HIV-infected women:

> A thirty-eight-year-old woman without health insurance develops a fever, sore throat, and shortness of breath. She is childless but was married two months ago (for the first time), and she is looking forward to fulfilling her dream of motherhood within a committed relationship. She initially forgoes medical attention, but her symptoms become worse. After two weeks, she sees a doctor at her town's primary care center, the only clinic within a day's drive that provides free care to uninsured patients. After a thorough evaluation, including an HIV test, the doctor tells her that she is HIV-positive and has contracted an opportunistic infection. The doctor further advises her that the clinic will treat her only if she agrees not to become pregnant and consents to Norplant. She agonizes over this decision, telling her husband that she wishes she had not received this offer, but she accepts the clinic's terms.

By agreeing to the doctor's proposal, this patient indicates her net preference for its terms, as compared with the alternative scenario — reproductive freedom without access to treatment for her infections. One can characterize the doctor's offer as "unwelcome" only by privileging the patient's anguish about the childbearing possibilities she will forgo. A range of beliefs about fairness and justice might lead one to do this.[98] Exami-

options.

97. Faden and Beauchamp appear to reject the notion that such moral judgments inform determinations of "welcomeness." They cast exploitation of vulnerable persons and failure to ameliorate dire financial circumstances as "moral concerns" distinct from the question of welcomeness and from "problems of autonomy and control" more generally. FADEN & BEAUCHAMP, *supra* note 55, at 359.

98. The same moral premises that underlie perceptions that such propositions are difficult to resist, *see supra* text accompanying notes 80-88, can be expected to inform their characterization as unwelcome.

nation of her "complex morass of . . . motivations,"[99] uninformed by any normative vision, cannot.[100]

Since Faden and Beauchamp hold that welcome offers are compatible per se with autonomous decision making,[101] this choice between characterizations matters greatly within their model.[102] The threat-offer distinction is at least as important to their theory, since threats imply coercion,[103] which precludes autonomous action per se. Faden and Beauchamp do not propose an approach to the parsing of threats from offers, but they suggest that such distinctions can be made without reference to "[q]uestions of . . . moral justifiability."[104] A considerable body of recent work supports a different view.

To begin with, there is virtual unanimity about the proposition that threats and offers can be parsed only by reference to an extrinsic baseline. Wertheimer puts the point as follows:

> The crux of the distinction between threats and offers is quite simple: A *threatens* B by proposing to make B *worse* off relative to some baseline; A makes an *offer* to B by proposing to make B *better* off relative to some baseline.[105]

Selecting the appropriate baseline is thus central to distinguishing threats from offers. The making of this selection, moreover, is an inescapably moral enterprise. The role of moral judgment in setting baselines has been much-discussed by philoso-

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99. FADEN & BEAUCHAMP, *supra* note 55, at 357.

100. One might reconstruct the idea of an unwelcome offer by imagining a proposition that imposes on its recipient an emotional or moral cost-of-deciding (or cost involved in merely learning its dire terms) greater than the benefits yielded by accepting it. *Cf.* GUIDO CALABRESI, IDEAS, BELIEFS, ATTITUDES, AND THE LAW 69-86 (1985) (analyzing the problem of determining which kinds of emotional and moral costs should "count" for legal purposes). Costs-of-deciding are incurred upon receipt of an offer (or upon learning of its terms), whether or not the recipient accepts. Unless these costs are outweighed by the benefits of acceptance, a rational person will regret receiving such an offer, even if, once having received it, she chooses to accept it. This reconstruction relocates the task of normative judgment: underlying moral concerns inform the evaluation of both the costs-of-deciding and the benefits of acceptance.

101. Unwelcome offers, by contrast, must be subjected to a resistibility test to determine their compatibility with autonomous action. *See supra* note 92.

102. Because the same moral beliefs underlie both the inclination to view offers to persons in dire straits as unwelcome and the tendency to see such offers as difficult to resist, *see supra* note 98, the characterization of offers as unwelcome within the Faden and Beauchamp model is likely to be linked to the determination that they preclude autonomous decision making.

103. *See supra* text accompanying notes 89-92.

104. FADEN & BEAUCHAMP, *supra* note 55, at 341. They state that such questions are "separate matters" from the distinction between a "genuine offer" and a "veiled threat." *Id.*

105. WERTHEIMER, *supra* note 19, at 204 (emphasis in original). Faden and Beauchamp do not indicate disagreement with this view.

phers[106] and legal scholars.[107] Conceptions of fairness and justice, more often tacit than explicit, determine the baselines we employ.[108] The conditioning of medical care upon reproductive abstinence by HIV-infected women is illustrative. The premise that access to medical care is a right[109] (or that provision of care is a social obligation[110]) yields a baseline that includes the availability of health services. Measured by this baseline, the conditioning of care upon abstinence from childbearing plainly constitutes a threat, absent the availability of other sources of care.[111] By contrast, the belief that access to

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106. For a comprehensive review of this philosophical literature, see *id.* at 202-21. Robert Nozick generally is credited for the insight that moral premises inform the baselines tacitly employed to distinguish threats from offers. *See* Nozick, *Coercion, supra* note 40, at 447 (arguing that baselines incorporate both moral expectations and predictions of future behavior). Other important contributors include Martin Gunderson, *Threats and Coercion*, 9 CAN. J. PHIL. 247 (1979) and Vinit Haksar, *Coercive Proposals [Rawls and Gandhi]*, 4 POL. THEORY 65 (1976). Among philosophers writing on bioethics, Norman Daniels is perhaps the leading exponent of the view that choices between baselines are inescapably moralized. *See* NORMAN DANIELS, JUST HEALTH CARE 165-71 (1985) (criticizing derivation of baselines from the pre-offer status quo).

107. The problem of distinguishing threats (or illegitimate propositions) from offers (or legitimate proposals) arises in many legal contexts, including contract law (duress), constitutional law (the doctrine of unconstitutional conditions), corporate law (the coerciveness of tender offers that involve front-end premiums, followed by the use of condemnation authority to buy out naysayers at lower prices), and criminal law and procedure (blackmail, the defense of duress, coerced confessions, and plea bargaining). A diverse range of commentators holds to the position that threats cannot be parsed from offers in any of these contexts except by reliance on moral baselines. *See* FRIED, *supra* note 40, at 95-99 (arguing that distinctions between coercive and noncoercive contract terms rest on judgments about whether these terms are substantively wrongful, based on some normative theory); Anthony T. Kronman, *Contract Law and Distributive Justice*, 89 YALE L. J. 472, 485-91 (1980) (defining legitimate advantage-taking as that which *improves* the long-term prospects of those whom it disadvantages in the short run); Sullivan, *supra* note 38, at 1447-50 (arguing that distinctions between coercion and consent must rest on some normative theory); Kreimer, *supra* note 40, at 1363-71 (urging the role for equality as a moral baseline in distinguishing threats from offers); EPSTEIN, *supra* note 39, at 39-68 (arguing for setting of baselines on social welfare-maximizing grounds); Peter Westen, *"Freedom" and "Coercion" — Virtue Words and Vice Words*, 1985 DUKE L. J. 541, 576-77 (reviewing the role of moral baselines in identifying coercive proposals). Fried, Kronman, Sullivan, and Epstein hold that the setting of appropriate baselines is exclusively a moral question, while Kreimer and Westen argue for the relevance of both moral and non-moral criteria.

108. Sullivan, *supra* note 38, at 1449-50.

109. *See, e.g.*, THE PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION: BUILDING AMERICA'S HEALTH: FINDINGS AND RECOMMENDATIONS 3 (1953) (asserting that access to health care is a "basic human right").

110. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 22-25, 32-33 (1983) (concluding that society has an "ethical obligation" to ensure universal access to "adequate care" and distinguishing this position from the assertion of a universal right to health care).

111. If alternative sources of care are available, the threat-offer distinction becomes more

medical care is neither an individual right nor a social obligation, but rather a question of contractual arrangement,[112] implies a baseline that does not incorporate such access. Relative to this baseline, a proposal to render care contingent upon reproductive forbearance represents an offer.

Some commentators take the position that baselines also can be derived from nonmoral sources, including historical experience,[113] empirically grounded predictions,[114] and the subjective expectations of a proposal's recipients.[115] For example, a society's past failure to provide health care as of right establishes a historical baseline that does not include assured access to care. Relative to this standard, the contingent proposals I have been discussing constitute offers.[116] Alternatively, were the conditioning of medical care upon personal behavior a usual practice, one could characterize such proposals as predictable and thereby infer an empirical baseline that renders these propositions as offers.[117] The subjective expectations approach, by contrast, entails an inquiry into each recipient's *beliefs* about what is morally required. The belief that a health care provider is *entitled* to condition her services upon reproductive abstinence yields a baseline to this effect — and the conclusion that such propositions are offers.[118]

These seemingly nonmoral baselines invite the impression

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complicated, reflecting the need for a more richly developed baseline. Since my purpose is to point out the decisive role of moral baselines, rather than to offer a substantive theory of moral obligation in clinical work, I will not pursue the development of such a baseline here.

112. *See, e.g.*, Robert M. Sade, *Medical Care as a Right: A Refutation*, 285 NEW ENG. J. MED. 1288 (1971) (arguing that medical care is neither a right nor a privilege, but that it is a contractual service that is provided by doctors and others to those who wish to purchase it).

113. Kreimer, *supra* note 40, at 1359-63.

114. JOEL FEINBERG, THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO SELF 219-28 (1986) (discussing predictions in terms of norms of expectability); Westen, *supra* note 107, at 581 (using an empirically grounded prediction as a baseline); Kreimer, *supra* note 40, at 1371-74 (providing an example of an empirically grounded baseline); Nozick, *Coercion*, *supra* note 40, at 447 (arguing that baselines can also be derived from non-moral sources).

115. WERTHEIMER, *supra* note 19, at 207.

116. Conversely, a history of universal, unconditional access to medical care establishes a baseline that incorporates such access, yielding the conclusion that such proposals constitute threats.

117. Conversely, were the provision of care without such conditions the standard practice, such proposals would represent a downward departure from the empirical baseline. As such, they would constitute threats.

118. Conversely, a recipient's belief that she is entitled to care without this condition yields a subjective baseline that casts such proposals as threats.

that threats and offers can be distinguished without reliance upon normative premises. But this impression is illusory for two fundamental reasons. First, normative thinking is intrinsic to the formulation of the inquiries that these putative baselines demand. As has been widely recognized in recent years by philosophers of the natural and social sciences, observation and description are richly infused by normative imagination.[119] The claim that human observers can discern baselines from history, prediction, or accounts of intrapsychic experience without relying upon morally informed premises flies in the face of this realization. Second, the elaboration of *multiple* baselines — including some expressly moral standards and others derived from history, prediction, or subjective expectations — presents the challenge of selecting between baselines. Such selection is a necessary element in models of the threat-offer distinction that assert the possibility of both moral and nonmoral baselines.[120] That choosing between baselines entails normative judgment is tacitly acknowledged by commentators who propose reliance upon more than one baseline.[121] The relative import of history, prediction, and intrapsychic experience as grounds for distinguishing threats from offers is a moral question: the legitimacy of each rests on premises about the fairness and justice of the social phenomena upon which it purports to defer.[122]

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119. A vast amount of literature develops this theme. For a comprehensive, largely sympathetic discussion of this work, see RICHARD J. BERNSTEIN, BEYOND OBJECTIVISM AND RELATIVISM: SCIENCE, HERMANEUTICS, AND PRAXIS 1-169 (1988) (reviewing and synthesizing contributions by Thomas Kuhn, Peter Winch, Paul Feyerabend, Charles Taylor, Clifford Geertz, Richard Rorty, Hans-Georg Gadamer, Jurgen Habermas, and others).

120. *See, e.g.*, WERTHEIMER, *supra* note 19, at 212-13; Kreimer, *supra* note 40, at 1374-78; Nozick, *Coercion, supra* note 40, at 451.

121. Nozick, who contends that we derive baselines from predictions about the future and from moral expectations, suggests that when baselines from these sources differ, we ought to defer to the baseline accepted by the recipient of the proposal at issue. Nozick, *Coercion, supra* note 40, at 451. This decision rule elevates the ideal of personal freedom (interpreted within the liberal tradition, as deference to the individual's consciously experienced preferences) over competing moral claims — e.g., conceptions of distributive justice or welfare maximization. Wertheimer proposes a candidly result-oriented approach to the problem of baseline selection. Where the baselines yielded by moral reasoning, prediction, and/or subjective expectations diverge, he recommends selection should depend on the "moral force" behind the claim that a proposal coerces within a particular context. WERTHEIMER, *supra* note 19, at 212.

122. *See* Sullivan, *supra* note 38, at 1450 n.150 (observing, in the "unconstitutional conditions" context, that looking to history or prediction "assume[s] that reliance on continuation of the status quo or the statistically likely course of government action is justified").

c. "Advisory" and "Directive" Counseling

As defined herein,[123] neither "advisory" nor "directive" counseling of reproductive abstinence presents the listener with a proposal that changes her set of available choices. Such counseling thus entails neither a threat nor an offer. As such, it cannot coerce, within the Faden and Beauchamp paradigm or others that abide by the rule that only contingent propositions (threats or offers) can coerce. For the subset of such models that draw a simple dichotomy between coerced and autonomous action, this analysis suffices for the conclusion that "advisory" and "directive" counseling are compatible per se with autonomous choice.[124]

Within the Faden and Beauchamp model, however, further inquiry is necessary, since some influence attempts that do not constitute threats or offers are nonetheless not compatible with autonomous choice. In particular, influence attempts that "nonpersuasively alter" a person's "perception" of her choices[125] preclude autonomous action if they are not "easily resistible."[126] "Persuasion" is compatible per se with autonomous choice, but only "appeals to reason" can persuade.[127] Appeals to non-cognitive mental processes — to guilt, vanity, fear, or other emotions[128] — constitute efforts to "nonpersuasively alter" a listener's perceptions.

Faden and Beauchamp group influence attempts that "nonpersuasively" change perception into two classes: (1) "manipulation of information" upon which a person bases a decision; and (2) "psychological manipulation" via intentional acts that "caus[e] changes in mental processes other than those

123. *See supra* text accompanying notes 23-25.

124. I ignore here the problem of factual misrepresentation, which lies beyond the scope of this Article.

125. FADEN & BEAUCHAMP, *supra* note 55, at 354.

126. *Id.* at 367.

127. *See id.* at 347 (persuasion operates by inducing a person, "through appeals to reason, to freely accept . . . the beliefs, attitudes, values, intentions, or actions advocated by the persuader). To constitute an appeal to reason, a communication must target "some dominantly cognitive process" in the listener. *Id.* at 351. Appeals to "emotions or affect" — to "reactions and motivations such as hate, fear, disgust, or embarrassment" — represent manipulation, not persuasion. *Id.*

128. *Id.* at 351, 366.

involved in understanding," i.e., non-cognitive processes.[129] The former category encompasses a range of deceptive practices[130] that lie outside the scope of this Article.[131] Absent such deception, clinical counseling unaccompanied by offers or threats can interfere with autonomous choice only if it falls within the latter category *and* is not "easily resistible."

"Advisory" counseling, as defined herein, would appear to constitute persuasion within the Faden and Beauchamp model and thus would seem compatible with autonomous choice. A dispassionate recommendation against childbearing, accompanied by accurate statements about vertical HIV transmission, difficulties likely to confront mother and child, and even social costs, represents an "appeal to reason," as this term is typically understood.[132] Faden and Beauchamp acknowledge that their approach to advice given dispassionately entails a difficulty: imbalances of power in clinical relationships encourage patients to act in a passive, compliant manner.[133] This may diminish their ability to act autonomously, Faden and Beauchamp warn, especially when patients belong to "particularly vulnerable" groups like the poor and the uneducated.[134] Since HIV-infected women are disproportionately impoverished, African-American and Latino, and poorly educated, this concern applies with

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129. *Id.* at 355.

130. *Id.* at 363-65 (discussing lying, selective withholding of important facts, exaggeration, use of placebos, and exploitation of framing effects).

131. My analysis of "advisory" and "directive" statements departs from the assumption that they are not accompanied by factual misrepresentation. Such misrepresentation impinges upon autonomy, according to Faden and Beauchamp (and many other commentators) by interfering with a decision-maker's understanding of her choice situation. *Id.* at 362.

132. Faden and Beauchamp incorporate the modernist distinction between reason and passion, privileging the former, in Kantian fashion, as a basis for ascribing autonomy to actions. Shorn of Kantian metaphysics — in particular, Kant's proposition that the free and rational self exists "independent of determination by causes in the sensible world," IMMANUEL KANT, GROUNDWORK OF THE METAPHYSICS OF MORALS 120 (H. J. Paton trans. 1956) — ascription of autonomy based on this distinction reflects a preference for decision procedures that eschew overt reliance upon passion. This preference cannot rest on the implausible proposition that reason and passion differ in their dependence on "determination by causes in the sensible world." Rather, it stems from a view of the good life that distrusts the transforming (and potentially destabilizing) power of passion. *See* ROBERTO MANGABEIRA UNGER, PASSION: AN ESSAY ON PERSONALITY 256 (1984) (observing that many "social visions" eschew passionate influence out of concern that it could impede achievement of "more perfect forms of human association"). Whether this distrust is justified is a normative question that bioethics commentators by and large have not addressed.

133. FADEN & BEAUCHAMP, *supra* note 55, at 368-73.

134. *Id.* at 368-71.

special force to them.

Having acknowledged this problem, Faden and Beauchamp allow space for the conclusion that autonomous choice can nonetheless be safeguarded during "advisory" counseling. They posit that imbalances of power, or "role constraints," preclude autonomous choice only when people "do not act as they would *prefer* to act, and *would otherwise* act, were they not under the peculiarly intense and often oppressive pressures and constraints inherent in the dependent role."[135] This approach limits the autonomy-negating impact of such dependency to situations in which constraint is both consciously experienced[136] and sufficient to meet a variant of the non-resistibility test ("intense" and "oppressive" pressure). It thereby permits clinicians to counteract their own aura of authority by communicating clearly that their recommendations are not orders and that decisions contrary to professional advice will be treated with deference.[137] Even where such communication fails to eliminate the conscious experience of role-related constraint, Faden and Beauchamp leave room for the conclusion that advisory counseling is compatible with autonomous choice. In such situations, their reliance upon a resistibility test yields answers that rest on normative judgments external to their analytic scheme.[138]

"Directive" counseling, as I have defined it, would appear to present more possibilities for psychological manipulation via changes in mental processes other than those involved in understanding. Statements that take an imperative form and fail to acknowledge the patient's role as ultimate decision-maker pose the problem of role constraints more acutely than does the "advisory" counseling of reproductive abstinence. Such state-

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135. *Id.* at 369 (emphasis in original).

136. The use of the term "prefer" in this context implies that constraint must be consciously experienced. For Faden and Beauchamp, *unconscious* preferences and experiences of constraint are matters of authenticity and, as such, not germane to the task of identifying influences that preclude autonomous choice. *See id.* at 262-66 (arguing that authenticity is not a necessary condition for autonomous action).

137. *Id.* at 372. Faden and Beauchamp suggest additional strategies for dealing with the "role constraints" problem, including the involvement of family members, friends, clergy, and others who play supportive roles in patients' lives. *Id.*

138. *See* text accompanying notes 71-88 (reviewing wide range of normative concerns that inform answers to the question of resistibility).

ments seem almost designed to take advantage of the listener's sense of powerlessness, relative to the speaker. They draw much of their force from the speaker's aura of authority; indeed, declarations like "you should not become pregnant" or "do not have this child" appear to rely on little else.[139] Even if accompanied by a dispassionate explanation, e.g., remarks about disease transmission risks or social costs, these statements inject a non-cognitive element into the listener's decision making process. As such, they are strong candidates for characterization as psychological manipulation.[140] Whether such statements, once so characterized, should be deemed not "easily resistible" and thus incompatible with autonomous choice is a more open question. Like the question of resistibility in other contexts, it cannot be answered without reliance upon normative premises external to the Faden and Beauchamp framework.[141]

### 3. Summing Up: Autonomy-Negating Influence and the Normative Aims of Bioethics Theory

It would be wrong to read the work of Faden and Beauchamp as an authoritative statement of the bioethics understanding of coercion and autonomous action. Scholars within the main currents of American bioethics continue to struggle with these concepts, which are central to the field's aspirations for the empowerment of patients. Faden and Beauchamp, however, elaborate rigorously on some intuitions about the nature of autonomy-negating external influence that are widely shared within the bioethics movement and that play strategic roles in the movement's reformist vision. In particular, their model

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139. Such statements engender feelings of interpersonal and social duty, linked, perhaps, to irrational, often unconscious fantasies about the dangers of defying authority. *See* KATZ, *supra* note 11, at 114-21 (discussing the roles of irrational and unconscious mental processes in self-determination).

140. Absent any associated reason-giving, such statements as "you should not become pregnant" or "don't have this child" plainly constitute "psychological manipulation" within the Faden and Beauchamp model. The co-presence of such statements with "appeals to reason" may make the question of "psychological manipulation" versus "persuasion" into a difficult judgment call. Conversely, the co-presence of overtly emotional appeals — *e.g.*, condemnations of childbearing by HIV-infected women as self-indulgent or irresponsible — strengthens the case for characterization of such counseling as "psychological manipulation."

141. *See* text accompanying notes 71-88 and 138.

posits several prerequisites for the occurrence of influence incompatible with autonomous choice that are broadly accepted by commentators on bioethics. These include the presence of a human agent of influence, the existence (in this agent's mind) of conscious intent to exert influence, and the existence (in the mind of the chooser) of a conscious sense of constraint resulting from the influence attempt.[142]

Once these prerequisites are met, other questions take on decisive import with respect to the question of autonomy-negating external influence. These include the resistibility of an influence attempt, the threat-offer distinction, the difference between welcome and unwelcome proposals, and the distinction between appeals to reason and passion. The Faden and Beauchamp model's tacit reliance upon external normative reference points for answering these questions enables it to generate variable conclusions about the possibility of autonomous action in any given context, depending on the normative reference points chosen. But the threshold requirements that influence be consciously intended by a human agent and consciously experienced as constraining rule out lines of reasoning that might lead more directly to the conclusion that an influence precludes autonomous choice. Arguments about the constraining effects of social structure and/or unconscious experience are pushed to the margins by these prerequisites, which tacitly take patients' medical, social, and psychological circumstances as givens. This analytic strategy serves the bioethics movement's aim of advancing liberty in clinical settings within the parameters imposed by illness, personal character, and social structure.[143]

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142. These prerequisites are not universally accepted. Jay Katz's concern about the potential of unconscious mental processes to interfere with "psychological autonomy" represents one prominent, dissenting view from within the biomedical ethics mainstream. *See* KATZ, *supra* note 11, at 110-21. Norman Daniels' caveat about the autonomy-negating potential of unjust social practices in the absence of a deliberate influence attempt by a human agent, *see infra* text accompanying notes 145-57, represents another differing perspective.

143. Biomedical ethics scholarship tends to focus its reformist energies on the doctor-patient relationship while taking personal psychology and social structure as givens. A scholarly enterprise that instead emphasized possibilities for psychological or social change might be expected to conceptualize autonomy quite differently. *Cf.* Anita L. Allen, *Book Review*, 104 ETHICS 404, 404-05 (1994) (reviewing AFRICAN-AMERICAN PERSPECTIVES ON BIOMEDICAL ETHICS (HARLEY E. FLACK & EDMUND D. PELLEGRINO EDS., 1992).

Leonard Harris, *Autonomy Under Duress*, *in* AFRICAN-AMERICAN PERSPECTIVES ON

Viewed from this vantage point, the prerequisite that autonomy-negating influence must be both consciously intended and consciously experienced seems justified. Yet beyond the setting of sick patients seeking treatment, the case for this prerequisite is not so clear. Reproductive decision making by HIV-infected women may represent a clinical context within which differing normative aims merit another, perhaps broader, conception of autonomy-precluding influence.

## III. ALTERNATIVE ACCOUNTS OF AUTONOMY-NEGATING INFLUENCE

Outside the bioethics tradition, broader conceptions of autonomy-negating influence abound. The proposition that such influence must be both consciously intended and consciously experienced is open to dispute from diverse perspectives. In this section, I consider some of these challenges and their implications for our thinking about autonomous choice in clinical contexts. Seen from the normative vantage points that inspire these broader conceptions, each, I argue, is as persuasive as the prerequisite that autonomy-negating influence must be consciously intended and experienced.[144] As between this more restrictive position and broader conceptions, any preference must arise from some *extrinsic*, contextual perspective. The tight linkage between our opinions about the limits of autonomy-negating influence and our poorly articulated, context-based moral leanings is my focus in the next and final section. There, I argue for the need to dispense with subterfuge and to probe for underlying, often-hidden normative commitments when contrary visions of autonomous action collide.

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BIOMEDICAL ETHICS 133, 133-34 (Harley E. Flack & Edmund D. Pelligrino eds., 1992) (arguing that prevailing conceptions of autonomy and rational choice in American biomedical ethics fail to take account of fundamental distributional inequalities and thereby risk yielding morally perverse results).

144. I do not argue that *every* conception of autonomy-negating influence is equally persuasive when viewed from the normative vantage point that inspired it. Rather, I hold to the position (for reasons that are beyond the scope of this Article) that persuasive and implausible conceptions can be distinguished, even from the most sympathetic of normative vantage points, based on interpretive ideals of consistency and integrity. Each of the conceptions I discuss herein (including the Faden and Beauchamp framework) is persuasive, I contend, from some normative vantage point.

### A. Dispensing with the Intent Requirement: Coercion as Conscious Experience

Making the deliberate action of a human agent into a prerequisite for the presence of autonomy-negating influence fits poorly with our intuitions about the *experience* of being coerced. From the perspective of a person being influenced, as Norman Daniels observes, it is the "context of restricted choice" that engenders a sense of "diminished voluntariness."[145] The "blame" we might ascribe to someone "who plays an active role in creating the unfreedom"[146] is another matter. The experience of "diminished voluntariness" or "unfreedom"[147] in other words, is something apart from the actions, purposeful or otherwise, that bring about this experience.[148]

Intuitively, therefore, we often understand coercion as Lasswell and Kaplan define it,[149] in terms of the intensity of the constraining or inducing influence experienced by a chooser. To capture this intuition without discarding the requirement of a coercive purpose, Daniels constructs a parallel concept — "quasi-coercion" — that, he says, entails "diminished freedom of action of the same sort which is glaring in the central cases of coercion."[150] Restrictions on choice are "quasi-coercive," Daniels says, if they result from "unjust or unfair social practices and institutions."[151] For Daniels, autonomous choice is no more possible in the context of quasi-coercive restrictions than it is in the face of coercion as understood by Faden and

145. DANIELS, *supra* note 106, at 171. *Cf.* WERTHEIMER, *supra* note 19, at 243, 287 (referring to the belief that coercion has to do with the amount of "pressure" on an actor as the "preanalytic sense of coercion").

146. DANIELS, *supra* note 106, at 170.

147. Daniels employs the terms "voluntariness," "freedom," and "autonomy" in a more or less synonymous fashion, in contradistinction to scholars who ascribe divergent meanings to these three words.

148. On the other hand, the intentionality of influence efforts can affect the subjective experience of persons targeted by such efforts. Awareness that somebody else has deliberately restricted one's choices or otherwise concocted a pressure-filled situation in order to influence one's behavior can lead one to feel degraded and embittered. Such feelings may enlarge one's sense of "diminished voluntariness" or "unfreedom."

149. *See* LASSWELL & KAPLAN, *supra* note 61, at 97.

150. DANIELS, *supra* note 106, at 171.

151. *Id.* at 171-72.

Beauchamp or others who hold to the conscious intent requirement.

As Daniels acknowledges, his definition of "quasi-coercion" is question-begging: a theory of justice and/or fairness is needed to classify a restriction as quasi-coercive. But once joined to such a theory, the concept of quasi-coercion expands the scope of autonomy-negating influence beyond the boundaries imposed by the requirement of a coercive (or manipulative) purpose. All restrictions that are "socially caused," i.e., brought about by "act[s] or institution[s] of man, not God or nature," are quasi-coercive if "unjust or unfair."[152] This formulation allows immense flexibility. Not only is it open to many conceptions of justice and fairness, it also tacitly permits diverse approaches to the making of distinctions between restrictions on choice that are "socially caused" and those that are traceable to the doings of "God or nature." The broader our view of society's affirmative duty to alleviate pressure on personal choice, the more inclined we are to see failure to do so as a consequence of "act[s] or institution[s] of man."[153]

Daniels' notion of "quasi-coercion" preserves the classic Nozickian approach to coercion[154] in name only while in practice dispensing with the purposeful agent prerequisite. Were he expressly to enlarge the concept of coercion to encompass conditions he labels quasi-coercive, the implications for autonomous choice would be identical.[155] The practical significance of Daniels' de facto enlargement of the concept of coercion is potentially great, as the context of reproductive

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152. *Id.* at 172.

153. *Cf. id.* The distinction between "socially" and "naturally" caused pressures is thus thoroughly moralized, something that Daniels does not acknowledge in proposing his concept of "quasi-coercion."

154. Daniels professes fealty to the Nozickian requirement (which he refers to as part of all "standard analyses" of coercion) that a human agent act intentionally to alter the chooser's range of options. *Id.* at 165.

155. Such an enlargement could be achieved without abandoning the intent requirement entirely. This could be accomplished by interpreting intent less specifically — i.e., as mere knowledge of the consequences at issue. Were knowledge of the restrictions on choice that result from "unjust or unfair social practices and institutions" held to satisfy the intent requirement, then *society* could be charged with intentionally restricting choice by perpetuating such practices and institutions in the face of knowledge of their restrictive impact. Even if such knowledge is not widespread — e.g., if many Americans are unaware that some HIV-infected women lack access to health care — it might plausibly be imputed to society on the ground that a just society has a duty to identify and redress intrusions on its members' autonomy.

decision making by HIV-infected women illustrates. If justice entitles all persons to health care regardless of reproductive behavior or ability to pay, then society's failure to guarantee universal access to care forms a "quasi-coercive" backdrop for women's acceptance of proposals to provide care contingent upon reproductive abstinence. Assessed against this backdrop, agreement to such a proposal cannot be autonomous, even if a woman who otherwise would go without health care finds it welcome.[156] Alternatively, if access to medical care is seen justly as purely a matter of private contractual arrangement,[157] then such a proposal is not "quasi-coercive," absent some other moral precept that renders the recipient's choice situation unjust or unfair.

The implications of "quasi-coercion" for the "directive" and "advisory" counseling of reproductive abstinence depend in a different way on baseline beliefs about justice and fairness. The precept that justice requires universal access to health care does not in itself compel the judgment that such counseling is "quasi-coercive." Other moral input is needed to reach this conclusion. One might, for example, contend that the aura of authority around health professionals unjustly constrains women's sense of freedom when they hear clinical advice on reproductive matters.[158] One also could argue that poor people and members of marginalized social groups experience a pervasive and unjust sense of powerlessness in their transactions with participants in the dominant culture.[159] Either of

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156. *See* DANIELS, *supra* note 106, at 172-73 (performing a similar analysis for proposals to provide extra "hazard pay" to workers when the risks at issue are technologically reducible). Faden and Beauchamp, it should be noted, could arrive at the same conclusion (tacitly rooted in the moral premise that all people are entitled to medical care regardless of reproductive behavior or ability to pay) by characterizing the proposal as a threat or unwelcome offer that meets their relevant resistibility criteria. But such a descriptive move would be awkward indeed if the proposal's *recipient* insisted on characterizing it as welcome.

157. Sade, *supra* note 112.

158. Such an argument might roughly track Faden's and Beauchamp's concerns about "role constraints" in clinical settings. *See* text accompanying notes 133-38. Alternatively, it could take a radical turn, toward the notion that the perceived authority of health professionals is per se oppressive and unjust.

159. *Cf.* Charles R. Lawrence III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317, 326 (1987) (describing the argument that domination occurs when the ruling class gains the consent of the dominated classes through a system of ideals that reinforces the status quo); Peggy C. Davis, *Law As Microaggression*, 98 YALE L.J. 1559, 1567-68 (1989) (contending that minority people throughout the United States believe that the law

these positions can give rise to the conclusion that "directive" or even "advisory" counseling is "quasi-coercive" because its influence is amplified by unjust feelings of powerlessness.

The concept of "quasi-coercion" thus opens new analytic pathways toward the characterization of influence attempts as incompatible with autonomous choice. Yet this elastic concept does not fully capture the intuition that Daniels says inspired him to invent it. The conscious experience of the chooser is central to this intuition. From her perspective, as Daniels notes, restrictions on choice can diminish voluntariness (as perceived by the chooser) regardless of who, if anyone, might be to blame for imposing them. The notion of "quasi-coercion" reflects Daniels' intuition that the *intent* behind such restrictions is peripheral to the chooser's subjective experience of diminished voluntariness. But Daniels' prerequisites for characterizing restrictions as "quasi-coercive" — his requirements that they be both "socially caused" and "unfair or unjust" — seem no more relevant than intent to the chooser's subjective sense of voluntariness. Restrictions on choice traceable to natural causes, e.g., earthquakes or epidemics, can impinge upon a chooser's experience of voluntariness as much as can poverty or other constraints that are seen as socially mediated.[160] Likewise, constraints on choice can beget a sense of diminished voluntariness whether or not they are "unfair or unjust" as measured by one or another moral theory.[161]

Daniels' account of quasi-coercion is thus incomplete as an expression of the extent to which restrictions on choice can impinge upon a chooser's experience of voluntariness. His account has considerable appeal, however, as a pragmatic answer to the question of whether autonomous choice is possible

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will work to their disadvantage).

160. The line between social and natural causes is hardly as clear as Daniels seems to assume. Constraints on choice that result from natural phenomena invariably have a socially mediated component. For example, economic conditions and prior decisions about building safety play critical roles in the harm done (and constraints created) by earthquakes. The ascription of consequences to natural versus social causes is an inescapably moral question, tied to the problem of delineating duties to prevent harm. *See supra* note 153 and accompanying text.

161. It is true that the experience of diminished voluntariness often is linked to the *intuition* that a situation is unfair. But this pre-analytic intuition does not always reflect moral judgment. The occurrence of terminal cancer in a teenager, for example, evokes a sense of tragic unfairness in the absence of any conceivable moral agent.

in the circumstances that concern him. Daniels proposes the notion of quasi-coercion to cope with the question of whether laborers offered hazard pay for work that poses technologically reducible risks can assent autonomously. As Daniels notes, traditional bioethics understandings of coercion do not clearly encompass such proposals.[162] Yet the narrower one's range of employment options, the greater the pressure one is likely to feel to accept such a proposal. The concept of quasi-coercion enables such proposals to be dismissed as autonomy-negating when the offeree's range of options seems unduly restricted.

The prerequisite that restrictions be "socially caused" to be quasi-coercive reflects, in part, the liberal aspiration to preserve a measure of responsible human agency (and the dignity this carries with it) in the face of unavoidable, natural misfortune. The requirement that socially caused restrictions be "unfair or unjust" pursues a balance between respect for the agency and dignity of the chooser and paternalistic concern for the decency of the chooser's situation, as measured by our ideas about fairness and justice. Daniels' explicit deference to notions of fairness and justice permits boundaries to be drawn between autonomy-negating and autonomy-permitting circumstances on the basis of judgments about the *morality* of restrictions on choice. Intuitively, such judgments seem external to the chooser's subjective experience of voluntariness. Yet Daniels makes them central to the construction of domains of autonomous choice. In so doing, Daniels does candidly what we more typically do covertly, even unconsciously: he roots his conclusions about autonomy in his other moral beliefs.

To incorporate fully Daniels' intuition about the centrality of a subjective sense of "diminished voluntariness" to the experience of being coerced, one would have to define coercion as Lasswell and Kaplan do, in terms of the "degree of constraint and/or inducement" operating on the chooser.[163] However, this poses an obvious difficulty: the setting of a threshold level of "constraint and/or inducement" beyond which the influences operating on a chooser constitute coercion. Since the experience of constraint and inducement is ubiquitous in our con-

162. DANIELS, *supra* note 106, at 170.
163. LASSWELL & KAPLAN, *supra* note 61, at 97.

scious mental lives, the placement of this threshold is central to this account of coercion.[164] But this placement problem is no less thoroughly moralized than is the analogous question of resistibility, within the Faden and Beauchamp model.[165] Like the assessment of resistibility, the setting of coercion thresholds in particular cases of subjectively experienced constraint or inducement is dependent upon external moral reference points. This approach to coercion thus makes the delineation of autonomy-negating clinical influence[166] into a moral inquiry no less open-ended than that called for by the concept of "quasi-coercion." With respect to "directive" and "advisory" counseling or the conditioning of medical care on reproductive abstinence, this approach is therefore indeterminate, absent an accompanying vision of justice or fairness.

### B. Unconscious Coercion

The accounts of autonomy-negating outside influence that I have considered thus far share the premise that such influence must be experienced consciously by a chooser to be coercive or otherwise to preclude autonomous decision making. But some accounts of coercion incorporate the notion of unconsciously experienced, autonomy-negating outside influence. The most prominent such accounts have been offered by three groups of writers with very different normative aims: liberal philosophers concerned with authenticity, radical social theorists working within the Marxist and critical theory traditions, and psychoanalysts from the drive theory and object relations schools.

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164. Alternatively, all constraints and inducements could be considered coercive. *Cf.* ROBERT L. HALE, FREEDOM THROUGH LAW: PUBLIC CONTROL OF PRIVATE GOVERNING POWER 294-95 (1952) (asserting that every "[e]xaction of a price" in the marketplace "restricts freedom" and thereby coerces because the state limits the ability of "non-owners" to make "unauthorized use" of property). But this move toward global determinism would beg the question implicit in Daniels' intuition: how are we to identify prima facie morally problematic cases of "diminished voluntariness?" *See supra* text accompanying note 145.

165. *See supra* text accompanying notes 71-88.

166. I here presume an identity between coercion and all autonomy-negating external influence (and thus a simple dichotomy between coerced and autonomous choice). I omit (for simplicity's sake) the possibility of other categories of potentially autonomy-negating influence. I also ignore problems of misinformation (*e.g.*, deception and ignorance), which lie beyond the scope of this Article.

These accounts of unconsciously mediated *outside* influence need to be distinguished from the notion of unconscious *internal* influence. The latter is widely recognized in the law and in bioethics commentary as potentially autonomy-negating — but not as coercive — under the rubric of psychological incapacity. Mental illness, e.g., clinical depression accompanied by suicidal thinking, is the prototypical example.[167] Severe mental illness is conventionally seen as incapacitating its victims via an internally generated process, although environmental stimuli often are seen as playing a precipitating role.[168] Unconsciously mediated *external* influence, though, is not generally viewed by bioethics commentators or the law as potentially incompatible with autonomous choice.

#### 1. Liberal Theory and the Question of Authenticity

In liberal social theory (and in most bioethics commentary), the question of unconscious external influence typically is cast as part of the problem of authenticity. According to some liberal theorists, autonomous decision making must be the product of an authentic self, free from control by external forces. Strong models of authenticity require that a person's principles and preferences be self-consciously chosen, via a thought process free from unexamined influence by others.[169] Within such models, unconscious influences on choice tend to be seen as inconsistent with authenticity and therefore preclude autonomous action.[170] This vision of autonomy renders choic-

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167. *See, e.g.*, David L. Jackson & Stuart Youngner, *Patient Autonomy and "Death with Dignity": Some Clinical Caveats*, 301 NEW ENG. J. MED. 404 (1979) (using clinical examples to argue that depression and other psychiatric problems undermine autonomy in intensive care unit patients).

168. To the extent that environmental (external) stimuli play *any* role, the distinction between *internal* and *external* stimuli cannot be pure.

169. *See, e.g.*, S.I. Benn, *Freedom, Autonomy, and the Concept of a Person*, *in* PROCEEDINGS OF THE ARISTOTELIAN SOC'Y 109, 123-28 (Aristotelian Soc'y Series No. 76, 1976). *Cf.* Robert Young, *Autonomy and Socialization*, 89 MIND 565 (1980) (contending that unconscious mental activity undermines autonomy by coercing or manipulating, and that socialization thereby impairs autonomy unless it is made conscious); DIANA T. MEYERS, SELF, SOCIETY, AND PERSONAL CHOICE 187-88 (1989) (arguing that *some* unconscious forces are compatible with autonomy — indeed "constitutive of the uniqueness of persons" and protective of their integrity — while others "sabotage the use of autonomy skills to formulate life plans" or "splinter the personality").

170. This portrayal of unconscious mental processes casts them as *external* to the self and thus as *alien* influences. Alternatively, unconscious mental life might be characterized as *part* of

es about childbearing, health care, and other aspects of daily living non-autonomous unless they arise from thought processes far more introspective than those in which we usually engage. Assessed in this light, the reproductive decisions of HIV-infected women are typically non-autonomous whether or not clinical counselors employ any of the influence methods discussed herein.

This sets a high, arguably unreachable standard for autonomous action. If unconscious mental processes are a pervasive part of human decision making, yet are incompatible with authenticity, then autonomous choice, thus conceptualized, is rare or even mythic.[171] From the perspective of liberal social theory, the ideal of deliberative and dispassionate politics affirmed by this vision of self-determination is powerfully appealing. But from the standpoint of the bioethics movement's ability to employ the principle of respect for autonomy *pragmatically* as a safeguard against medical paternalism, the implication that autonomous action is atypical in daily life is troublesome.

Not surprisingly, then, bioethics commentators tend to eschew strong models of authenticity in favor of weaker models that allow considerable room for unconscious mental activity. Gerald Dworkin's model, for example, permits preferences to develop via such unconscious processes as identification with individuals and socialization into groups, so long as persons reflect on these preferences before espousing them as their own.[172] Unconscious external influence of this sort precludes

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the essential self and thus consistent with authenticity. Even models of authenticity that require the self-conscious embrace of principles and preferences leave conceptual room for underlying, unconscious concomitants of conscious choice. But theorists who equate authenticity with the conscious election of principles and preferences tend to be disinclined to incorporate unconscious mental life into their conceptions of the essential self.

171. Jay Katz, whose approach to autonomy demands a higher degree of reflection than that called for by many bioethics theorists, maneuvers around this problem by postulating that a "functional definition of psychological autonomy" must "take into account that an ideational system can exercise motivational force without being introspectively accessible." KATZ, *supra* note 11, at 115. Katz thereby allows for the possibility of autonomy in the presence of *some* unconscious motives even as he argues that more reflective clinical decision making, aimed in part at diminishing the influence of unconscious determinants, is needed to respect adequately the right to self-determination.

172. DWORKIN, *supra* note 32, at 15-20. Dworkin holds that such reflection need not be "a conscious, fully articulated, and explicit process," warning that otherwise "it will appear that it is mainly professors of philosophy who exercise autonomy." *Id.* at 17.

neither authenticity nor autonomy (or autonomous action), in Dworkin's view. Faden and Beauchamp go even further, suggesting, on frankly result-oriented grounds,[173] that authenticity be discarded as a condition for autonomous action. Their alternative to authenticity — expansion of their proposed "condition of noncontrol" by others to encompass noncontrol by "self-alienating psychiatric disorders"[174] — leaves no room for the notion that unconsciously experienced *external* influence can undermine autonomous action.[175]

2. Radical Social Theory

In sharp contrast, radical scholars within the Marxist and post-Marxist traditions find unconsciously experienced, autonomy-negating influences pervasive in daily life. For such theorists, coercion is much more commonly unconscious than overt: it permeates social relations between dominant and subordinated individuals and groups, and it usually goes unrecognized by its victims. Indeed, these theorists hold, the most potent forms of coercion succeed by remaining invisible to subordinated persons. Radical scholars have discerned hidden coercion in a broad range of power relations, including interaction between upper and lower socio-economic classes,[176] exchange between dominant and oppressed racial and ethnic groups,[177] and relationships between men and women.[178]

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173. Faden and Beauchamp explain: "If authenticity were made a necessary condition of autonomous actions, many familiar acts of consenting and refusing would fail to qualify as autonomous, and thus would not qualify for protection from interference by the principle of respect for autonomy." FADEN & BEAUCHAMP, *supra* note 55, at 265.

174. *Id.* at 268.

175. Faden and Beauchamp do not explicitly rule out the possibility that unconsciously mediated external influence might at times undermine autonomous choice. Rather, they eschew exploration of the problem of unconscious influence on the ground that "what really is or belongs to the self" and "the correct explanations of human behavior in terms of its causes and underlying reasons" are "unknowns." *Id.* In so doing, however, Faden and Beauchamp reject by default the idea that unconsciously experienced outside influence can preclude autonomous action. The only forms of external influence that Faden and Beauchamp explicitly find capable of negating autonomous choice are "coercion" and "manipulation," which, as Faden and Beauchamp define them, are consciously experienced.

176. *See generally* Jeffrey Reiman, *Exploitation, Force, and the Moral Assessment of Capitalism: Thoughts on Roemer and Cohen*, 16 PHIL. & PUB. AFF. 3 (1987); G. A. Cohen, *Robert Nozick and Wilt Chamberlain: How Patterns Preserve Liberty*, *in* JUSTICE AND ECONOMIC DISTRIBUTION 246 (John Arthur & William H. Shaw eds., 1978).

177. Kimberle Williams Crenshaw, *Race, Reform, and Retrenchment: Transformation and Legitimation in Antidiscrimination Law*, 101 HARV. L. REV. 1331, 1357 (1988). *See also* Law-

A comprehensive review of the mechanisms of influence by which choices are coerced, according to these radical models, lies beyond the reach of this Article. But the salient features shared by these theories of coercion deserve some attention, even at the risk of oversimplifying a large and heterogeneous body of scholarship. The central tenet in these models of unconscious coercion is that subordinated persons and groups internalize self-oppressing systems of belief. Such systems of belief enable subordinated individuals to tolerate — indeed consciously to accept — social structures and practices that benefit others at their expense. By so doing, subordinated persons avoid conscious confrontation with the bitter truth that their daily actions support the social arrangements that oppress them. The internalization of self-oppressing beliefs, these models hold, is a largely unconscious process for both the subordinated and the dominant. The potential of the powerful to impose their will on the oppressed by overtly posing a threat looms in the distance, but the psychological processes by which the powerless learn to comply remain invisible on the conscious surface of daily life.

This deeply skeptical portrayal of overtly cooperative relations between persons and groups in society renders autonomy largely illusory, especially as regards subordinated persons. For the radical scholars who subscribe to this deterministic picture, it is closely linked to one or another of two, sharply different normative visions. The darker of these two visions proceeds from the pervasiveness of determinism to the desirability of overt, state-sponsored compulsion. It holds that genuinely non-coercive social life, uncontrolled by internalized self-oppression and external compulsion, is impossible.[179] As a consequence, those who aspire to transform society on behalf of the oppressed need have little compunction about the use of state force to pursue their objectives.

On the contrary, in this Leninist view, the transformative

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rence, *supra* note 159, at 326.

178. *See, e.g.*, Catherine A. MacKinnon, *Feminism, Marxism, Method, and the State: Toward Feminist Jurisprudence*, 8 SIGNS: J. OF WOMEN IN CULTURE & SOC'Y 635 (1983).

179. *See, e.g.*, William Leon McBride, *Noncoercive Society: Some Doubts, Leninist and Contemporary*, *in* NOMOS XIV: COERCION 178, 185 (J. Roland Pennock & John W. Chapman eds., 1972) (critiquing Lenin's claim that a non-coercive society is not a real possibility).

vanguard of a society ought first to substitute its own dictatorial rule for the covert, internalized coercion embedded in daily life. Eventually, this model claims, the principles of human relations forcibly imposed by the revolutionary vanguard will be internalized by the people as habits of belief and behavior.[180] At this hypothetical late stage in social transformation, these habits will have become sufficiently ingrained to permit state compulsion to "wither away." But at this triumphant stage, coercion will remain ubiquitous, albeit internalized and therefore unseen.[181] The "liberation" this model pursues is the casting off of social and economic oppression, not the realization of personal autonomy. From this vantage point, the question of whether the methods of clinical influence discussed herein are compatible with autonomous choice is a pointless distraction. The possibility of autonomous therapeutic or reproductive decision making is illusory; all that matters is whether clinical influence operates as an instrument of class oppression or a tool for resisting it.[182]

Other radical scholars, in contrast, pursue a normative vision defined by the wide gap between the pervasiveness of unconscious coercion and their almost boundless optimism about the human capacity for autonomy. For such scholars, radical politics is a program for the liberation of people from deterministic interpersonal influences. The work of Jurgen Habermas offers perhaps the richest example. Habermas calls for the transformation of interpersonal relations so as to "extirpat[e] those relations of force that are inconspicuously set

180. *See* V.I. LENIN, THE STATE AND REVOLUTION 92 (Robert Service trans. & ed., 1992) (1918).

181. McBride, *supra* note 179, at 183 (arguing that in Lenin's Communist society, coercion would not be eliminated, but would be subtle and internalized). This deterministic vision was reflected in the Pavlovian model of human behavior adhered to by academic psychologists in the Soviet Union during Stalin's rule. The Pavlovian paradigm represented all human actions as the products of complex networks of environmentally conditioned reflexes. In theory, this paradigm predicted, these networks of conditioned reflexes could be engineered (by tight controls on environmental experience) to generate behavior consistent with Leninist political ideals. M. Gregg Bloche, *Law, Theory, and Politics: The Dilemma of Soviet Psychiatry*, 11 YALE J. INT'L L. 297, 308-11 (1986).

182. A committed Leninist would almost certainly view the influence strategies discussed here as falling into the former category under capitalist conditions. It seems equally likely that a Leninist would view these strategies as legitimate tools of class struggle if administered by the revolutionary vanguard. The treatment of women's reproductive freedom by the government of the Peoples Republic of China is, at the least, suggestive in this regard.

in the very structures of communication and that prevent conscious settlement of conflicts, and consensual regulation of conflicts, by means of intrapsychic as well as interpersonal communicative barriers."[183] Although Habermas aspires toward liberation that is largely intrapsychic, his transformative focus is primarily social and political. For Habermas, "relations of force" are embodied in material conditions and social institutions. "Emancipation" from "power constellations" that "constrain" and "distort" communication and understanding requires the reconstruction of social and political life.[184] The Critical Legal Studies movement pursues a parallel transformative agenda, emphasizing the exposure of myriad ways by which reigning legal categories and forms of argument conceal oppression, injustice, and possibilities for freedom.[185]

From the standpoint of this challenge to pervasive "relations of force" in social life, the methods of clinical influence considered here are poor candidates for compatibility with autonomous choice.[186] The conditioning of medical services upon abstinence from childbearing entails the naked use of material power as a substitute for "consensual regulation of conflicts." Moreover, to the extent that this manner of influence draws strength from patients' feelings of dependence upon particular clinicians (and consequent fears of vulnerability and loss), it employs human connectedness as an instrument of force. "Directive" counseling derives much of its influence from a different sort of "relation of force" — the directive speaker's aura of authority. By contrast with the liberal bioethics perspective, which focuses upon the non-cognitive qualities of clinical authority as an obstacle to autonomous choice,[187] the radical critique looks to social structures that create perceptions of authority and thereby distort under-

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183. JURGEN HABERMAS, COMMUNICATION AND THE EVOLUTION OF SOCIETY 119-20 (Thomas McCarthy trans., 1979).

184. *See generally id.*

185. *See generally* MARK KELMAN, A GUIDE TO CRITICAL LEGAL STUDIES 242-68 (1987).

186. The elaboration of a theory of autonomous clinical choice, from this radical perspective, is a project far beyond the scope of this paper. My comments in this paragraph are meant only to be suggestive about how scholars from this perspective might approach the question of autonomy-negating clinical influence.

187. *See* text accompanying notes 137-40.

standing. The daunting implication of this viewpoint is that the coerciveness of "directive" counseling cannot be altered without fundamental social change. A similar analysis applies to "advisory" counseling. However hard well-intentioned professionals work to imbue their counselees with a sense of empowerment, oppressive social structures will pervert clinical communication into a medium of force, radical critics could be expected to argue. Thus, the central normative thrust of this critique is away from an isolated focus on clinical relationships and toward an ambitious agenda of social transformation.

### 3. Psychoanalytic Models

In contrast, psychoanalytic understandings of unconsciously experienced external influence support an intensely personal transformative agenda that takes existing social conditions as givens. Psychoanalytic thinking about unconsciously experienced outside influence begins from a simple and powerful insight: because threats operate by evoking fear of future pain or loss, a threat cannot be effective unless it triggers some mental representation of the possibility of pain or loss.[188] Put more broadly, no threat or offer can work without evoking some perception of danger or opportunity growing out of the recipient's internal representation of the world.[189] To this basic idea, psychoanalysis adds the postulate that large portions of every person's mental representation of the world are unconscious. This opens the way to the perception of danger and the experience of threat in response to life situations that somehow evoke unconscious representations of the possibility of pain or loss. Indeed, life situations that seem benign to many people may be experienced as extremely threatening by others, since people's unconscious internal representations of the world vary greatly. Phobias offer a paradigmatic example: an object that seems harmless to most of us can evoke terror in a few, by

188. Willard Gaylin, *On the Borders of Persuasion: A Psychoanalytic Look at Coercion*, 37 PSYCHIATRY 1, 2-3 (1974).

189. Willard Gaylin offers a telling example: were one to threaten a primitive man with a small pistol, he would be less likely to respond compliantly than if threatened with a large stick. *Id.* at 3. Having never seen nor otherwise known gunfire, he would be unable to link the image of the pistol with the prospect of pain or loss. By contrast, his everyday knowledge of big sticks and their menacing uses would almost ensure the latter threat's ability to inspire fear.

activating unconscious representations of pain or loss.[190] But the influence of such representations is hardly limited to cases of clinically significant phobia — it extends to all life experiences that, by activating these representations, inspire fears that affect our choices.

When mobilized by life events, unconscious representations of pain or loss can exert the influencing force of overt, consciously experienced threats to life. Indeed, as Willard Gaylin observes, these representations derive their emotive power from their symbolization of our most primitive fears: abandonment and death. The infant's abject dependence upon its mother for survival, Gaylin argues, causes it to equate abandonment with death. In time, experiences of rejection, isolation, and humiliation come to symbolize abandonment and, therefore, death. These "symbolic equivalents of death,"[191] as Gaylin calls them, exercise extraordinary influence on our actions, often outside of our conscious awareness. If one is inclined toward an understanding of coercion in terms of the intensity of constraint or inducement, then this psychodynamic model of unconsciously mediated external influence invites the recognition of unconscious coercion.

Gaylin's central claim — that experiences of rejection, isolation, and humiliation derive coercive force from their symbolic equivalence to death — is consonant with diverse streams within the psychoanalytic tradition. Freudian theory, which postulates that instinctual drives propel all human action,[192] models the influence of external stimuli as the product of the ego's restraining effects upon the instincts. These restraining effects result from the ego's interpretation of external stimuli in terms of its previous experiences of trauma. Trauma, in the Freudian sense, derives from the frustration of instinctual cravings.[193] Instinctual frustration, in Freudian theory, evokes

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190. *Id.* (observing that each individual understands danger differently, in terms of his own knowledge, life experience, and perceptual distortions).

191. *Id.* at 3-4.

192. Although Freud repeatedly revised his account of instinctual life, he never deviated from his commitment to a model of human behavior as motivated by instinctual energy.

193. The theory of the link between instinctual frustration and traumatic experience is drawn largely from Sigmund Freud, *Inhibitions, Symptoms, and Anxiety, in* 20 THE STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 87 (James Strachey trans. & ed.,

unconscious fear of annihilation, dating back to the close link between infantile survival and instinctual gratification. Memories of instinctual frustration and fear of annihilation constitute our histories of traumatic experience. Such experience is minimized in the life of the well-adapted person as she learns to obtain instinctual gratification in socially accepted ways. But this ideal is never entirely achieved: we all experience instinctual frustration, and consequent trauma, during our psychosocial development.

When the ego senses a parallel between present experience and prior trauma, anxiety — and a sense of danger — ensues.[194] This anxiety and experience of danger may be conscious or unconscious. Either way, according to Freudian theory, it exerts immense influence on human behavior, in favor of actions that defend against the subjective sense of hazard. The range of life circumstances potentially able to evoke anxiety and a sense of danger is as broad as the diversity of traumatic experience. But what these circumstances have in common is the capacity to inspire fear of such things as isolation, humiliation, and abandonment — all symbolic of the possibility of annihilation.

From this psychodynamic perspective, myriad life situations thereby possess the hidden potential to coerce. Moreover, generalization about whether an influence method precludes autonomous action is futile. The presence of unconsciously mediated coercion can be assessed only on an individualized basis, via in-depth exploration of the affective experiences that are evoked by the influence at issue. Thus the clinical influence strategies considered here cannot be characterized as incompatible with autonomous choice, absent an individualized psychological inquiry. For example, a woman whose parents were unavailable for long periods during her early childhood might experience intense, unconscious fear of abandonment if told by her doctor to abstain from childbearing as a condition of continued care. Even if she had easy, unconditional access

1959).

194. Sigmund Freud, *Lecture XXXII: Anxiety and Instinctual Life*, *in* 22 THE STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 81 (James Strachey trans. & ed., 1964).

to alternative providers, she might feel (unconsciously) driven to accede to this prerequisite in order to maintain her current doctor-patient relationship. By contrast, a woman who never experienced such deprivation during early childhood might be less afraid to sacrifice this relationship and thus more inclined to change physicians.[195]

Along similar lines, a woman accustomed in early childhood to the conditioning of affection upon compliance with parental commands might tend unconsciously to experience a doctor's "directive" or "advisory" statements as orders to be obeyed. Even self-consciously non-directive remarks by a clinician seeking to remain neutral may be interpreted unconsciously by such a patient as imperatives to be heeded. On the other hand, a woman unburdened by unconscious associations between disobedience and abandonment might experience even "directive" statements as opinions to be weighed but not necessarily followed.

For the practicing psychoanalyst, deterministic accounts of this sort lend support to the intimate quest for self-determination via exposure of unconscious memories and fears. The normative import of such accounts for non-psychotherapeutic clinical relationships is less clear. The singularity of each person's unconscious experience augers against efforts to generalize about the possibility of autonomous action in the face of one or another influence. As Jay Katz has argued, however, psychoanalytic accounts of unconsciously mediated influence suggest possibilities for enhancing patient autonomy through more deeply reflective clinical conversation.[196]

Other psychoanalytic models of unconsciously experienced external influence are less heavily freighted by reliance on instinctual drives. Object relations theory emphasizes the central role of early interpersonal relationships in the development of a

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195. This hypothetical scenario glosses over the complexity of the inquiry that psychoanalysts deem necessary to develop an adequate portrayal of the links between a person's behavior, conscious motivations, and unconscious fears. For example, a woman who quickly rejects her doctor's reproductive abstinence condition might, in the alternative, be seen as acting autonomously, free from infantile fear of abandonment, *or* as *reacting* defensively (and non-autonomously) to such fear by assuming a defiant stance. The recurrence of such "onion-peeling" problems in psycho-dynamic interpretation presents its practitioners with pervasive uncertainty.

196. KATZ, *supra* note 11, at 121-28.

person's internal representation of the world.[197] According to object relations theory, this internal representation unconsciously structures a person's perceptions and expectations of the external world. The influence others exercise upon a person's choices is determined largely by the analogies the person unconsciously draws between present and prior human interactions. For example, at the risk of oversimplification, a woman whose parents were harsh and punitive might be more prone to experience a counselor's gently delivered advice as intimidating than would a woman raised by giving and tolerant parents. As a consequence, the woman with punitive parents might be more inclined to comply with the counselor's advice out of fear of the imagined consequences of defiance. Her experience of intimidation and expectation of punishment are unconscious, according to object relations theory, as is her understanding of the counseling relationship in terms shaped by her remembrances of her relationship with her parents.

At the conscious level, she may experience her compliance as her own, rational decision.[198] Indeed, if asked to explain her choice, she very well might respond with a plausible reason. But according to the object relations model, her choice in fact has been determined by the filtration of her conversation with the counselor through her internal, unconscious representation of the world. Like Freudian drive theory, the object relations model postulates that we wish to avoid unconsciously imagined danger situations — situations that portend, in our fantasies, rejection, humiliation, and abandonment — all symbolic of annihilation. But in contrast to the Freudian focus on frustration of instinctual drives as the source of unconscious fantasies of danger, object relations theory looks to our earliest interpersonal ties to understand our present perceptions of danger. For non-psychotherapeutic clinicians, this model invites attention to the possibility that even gentle advice can exert strong influence by evoking unconscious feelings tied to prior relationships, particularly those with early authority figures.[199]

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197. MELANIE KLEIN & JOAN RIVIERE, LOVE, HATE, AND REPARATION 57-119 (1964).

198. Her choice thus would be accepted by some liberal (and bioethics) theorists as autonomous, albeit perhaps not authentic. *See supra* text accompanying notes 172-75.

199. Such influence can flow from perceived similarities between a clinician's personality

The model suggests that such influence can be attenuated, or at least better appreciated by patients, if clinicians explore their counselees' affective reactions to advice with an eye toward discouraging unreflective compliance.

Recently, some psychoanalytic theorists have begun to reconceive unconsciously experienced danger as the product of personal narratives and myths. This emerging model stresses the substance of personal myths as opposed to their origins. These mostly repressed myths, the model holds, structure our perception and interpretation of present circumstances. Interpersonal differences in these narratives lead some of us to perceive great danger in situations that others experience as benign.[200] In the words of Roy Schafer, a leading exponent of narrative theory in psychoanalysis, unconscious perceptions of danger confine people "in bars and chains of their imaginings and behavior."[201] Within this inner world of "unconsciously developed meanings" — of "unrecognized symbols, concretized metaphors, reductive allegories, or repressed storylines of childhood" — reality is "reconstructed or retold as imprisonment."[202] The coercive power of such narratives of imprisonment typically operates beneath the conscious surface of mental life. It is often obscured, according to Schafer, by an illusory sense of autonomy — a "false freedom" that belies the truth of confinement.[203]

This narrative approach to psychological determinism implies enormous possibilities for personal liberation via the illumination of unconscious myth. It casts the psychotherapist as an interpretive guide to the patient's unconscious storylines, but it charges the patient with growing responsibility for her

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and that of a prior authority figure, or from conceptual parallels between the content of clinical advice and the beliefs of such an authority figure.

200. *See* ROY SCHAFER, THE ANALYTIC ATTITUDE 97-112 (1983).

201. *Id.* at 257. Schafer emphasizes that narrative imprisonment is the product of fantasy, not actual circumstance:

> [A]nything may serve as a prison. As we learn from that eloquent authority on imprisoning love, Juliet Capulet, even a silk thread will do. A job, a marriage, a tradition, a vow of vengeance, a stain of dishonor, a dream of glory, a promise made or a promise broken, a tense body or a beautiful face, a small town or the whole wide world; every one of them and many more are potential prisons.

*Id.*

202. *Id.*

203. *Id.* at 263.

actions as she becomes more conscious of the narratives that once constrained her.[204] She *becomes* responsible by "coauthoring" (with the therapist) a revised life narrative that self-consciously defines her identity and the possibilities and limitations it implies.[205] In non-psychotherapeutic clinical work, this model suggests, opportunities for such liberation are much-diminished, owing to the absence of a sustained search for unconscious narratives of constraint.

These three psychoanalytic models share a normative vision: each calls for the pursuit of personal insight and fulfillment via arduous therapeutic work.[206] For their adherents, such work holds out the promise of greater autonomy with respect to life's choices. However, these models suggest that prospects for achieving autonomous reproductive (or medical) decision making by proscribing clinical opinion-giving are modest without individualized, psychoanalytically oriented inquiry. Likewise, these paradigms imply, prohibition of efforts to condition medical care upon reproductive abstinence (or other behaviors) cannot by itself contribute greatly toward the goal of autonomous choice.

Understandably, this pessimistic view of the possibility for autonomous action without case-by-case psychodynamic inquiry makes these models unappealing to bioethics commentators and others concerned principally with empowering medical patients. The reluctance of many people to take on the difficult task of psychodynamic self-scrutiny, not to mention the prohibitive cost of such work, makes the ideal of autonomy to which these models aspire impractical as a prerequisite for patient self-determination. For similar reasons, this ideal is likely to

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204. *See id.* at 183-203.

205. *Id.* Schafer emphasizes that limitation is inevitable. Psychoanalysis, he holds, can enhance our autonomy by expanding our consciousness of narrative confinement, but "limitation is inherent in being anything at all." *Id.* at 263. He adds:

> To be something is to be different, to remain different reliably enough to be identified as who and what you are, to have an identity in the most general sense of that term .... Limitation is ... inherent in family and group belongingness, in having any kind of definable past and values, and in undergoing any kind of development one way rather than another.

*Id.*

206. There is an obvious parallel between this vision and the process of conscious identification with one's own preferences demanded by strong models of authenticity in liberal theory. *See supra* text accompanying notes 169-71.

prove unpersuasive as a standard for autonomous reproductive decision making.[207]

## C. Summing Up: Paradigms of Influence Without Intent

The diverse models of external influence just discussed share the premise that the intent of an influence agent is immaterial to whether an influence precludes autonomous choice. These models look to the experience of the chooser as the basis for making this determination, but their paradigms for understanding that experience differ greatly. This variation, as I noted above, reflects their divergent normative thrusts. Norman Daniels' notion of "quasi-coercion" candidly opens the question of autonomy-negating outside influence to arguments about the justice and fairness of the chooser's circumstances. Lasswell and Kaplan look to the chooser's conscious experience of constraint or inducement but, in so doing, must rely upon external normative input to identify influences incompatible with autonomous action. Liberal theories of authenticity concern themselves with unconsciously experienced influence as a threat to an ideal of deliberative, reflective public and personal life.

Psychoanalysts and radical social theorists mount a more basic challenge to the belief that our conscious sense of freedom is an apt measure of its actuality. There is an obvious parallel between the "false freedom" that psychoanalysts believe belies unconscious coercion and the "false consciousness" that radical theorists see as obscuring social relations of domination and subordination. Yet the normative aims of these enterprises differ sharply. Psychoanalytic practice pursues private liberation within existing social constraints,[208] while

207. An additional factor weighing against the appeal of psychoanalytic theory in this context may be the impact of feminist and other criticism of Freud. Although psychoanalysis has moved much beyond Freud, this criticism probably has undermined its cultural standing in recent years.

208. This preoccupation of psychoanalysts with the personal invites the frequent complaint that their clinical work ignores the moral significance of social and economic determinants and thereby reinforces injustice. Conversely, some critics warn that the tolerant intimacy of psychoanalytic work invites, in Alan Stone's words, "a kind of reflection in which the outside world shrinks and the self expands," encouraging too facile a disregard for moral duties to others. ALAN A. STONE, LAW, PSYCHIATRY, AND MORALITY: ESSAYS AND ANALYSIS 231 (1984).

radical critique aspires to liberation via the exposure and rejection of these constraints.[209]

Each of these paradigms is "true" in an important sense: there is conceptual integrity between it and associated aspirations for change in the self or the world. Recognition of these divergent "truths," I argue below, is a necessary starting point for conversation about the normative conflicts that underlie differences about the nature of autonomy-negating influence.

## IV. TOWARD A REINTERPRETATION OF CLINICAL AUTONOMY

### A. The Connotative Import of Autonomous Action

The claim that coercion is a thoroughly moralized concept, critically dependent on outside normative input, is highly counterintuitive.[210] Yet this proposition offers a compelling explanation for the persistence of differing understandings of coercion. More generally, distinct normative perspectives lie behind differing approaches to the question of whether a given influence is compatible with autonomous choice. Beliefs about justice, fairness, and the good life are linked to conceptions of autonomy-negating influence at multiple levels of model design and application.

The interplay between normative inputs at multiple levels is complex. The Faden and Beauchamp paradigm of autonomy-negating influence illustrates this. The prerequisites that influence be consciously intended by a human agent and consciously experienced as constraining marginalize concerns about social justice and focus attention upon prospects for empowering patients in clinical settings, once the influence of social

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209. Psychoanalytic theory, on the other hand, often has been employed as an analytic tool for radical critique, most notably by the philosophers of the Frankfurt School. *See generally* HERBERT MARCUSE, FIVE LECTURES: PSYCHOANALYSIS, POLITICS, AND UTOPIA (J. Shapiro & S. Weber trans., 1970); HERBERT MARCUSE, EROS AND CIVILIZATION (1966). *See generally* Lawrence, *supra* note 159, at 317 (arguing that unconscious racism in American cultural and social life imposes many constraints on members of minority groups); C. FRED ALFORD, MELANIE KLEIN AND CRITICAL SOCIAL THEORY: AN ACCOUNT OF POLITICS, ART, AND REASON BASED ON HER PSYCHOANALYTIC THEORY (1989).

210. As Wertheimer notes, this claim is contrary to the "preanalytic sense" that coercion has to do with the degree of pressure on a decision-maker. *See supra* note 145.

structure and biological misfortune is taken as given.[211] Yet the model's reliance upon resistibility tests, the threat-offer distinction, and a dichotomy between welcome and unwelcome offers permits the tacit entry of beliefs about social justice.

The insight that differing normative visions lie behind contrary understandings of coercion has led Alan Wertheimer to conclude that coercion "drop[s] out of the picture"[212] once its moral content has been exposed. Anticipating the charge of reductionism, he observes (relying upon Nozick): "[W]e tend to describe as reductionist only explanations which reduce what is thought to be more valuable (or interesting) to what is thought to be less valuable (or interesting) and do so in a way which is false."[213] Measured by these criteria, he asserts, it is not reductionistic to "disaggregat[e] coercion claims into more specific moral claims" because once this has been done, nothing else of interest remains. The same might be said about conceptions of autonomy-negating external influence more generally, since their underlying normative content plays a similarly determinative role.

Yet the case can be made that something interesting and valuable persists about the idea of coercion (and autonomy-negating influence more generally) even after all implicit normative propositions are parsed out. This interesting and valuable thing derives from the *evocative* power of respect for autonomy as an expression of our belief that persons should be treated as ends, worthy of non-instrumental deference and regard. Although this belief is identified most closely with Kant, it has been expressed in varying theoretical terms over time. Religious versions cast persons as specially worthy because of their ties to the divine, while Kantian and other Enlightenment iterations postulate a singular human capacity to reason.[214] Post-modernist writers rest their cases for such spe-

211. *See supra* text accompanying notes 142-43.

212. WERTHEIMER, *supra* note 19, at 310.

213. *Id.* (citing ROBERT NOZICK, PHILOSOPHICAL EXPLANATIONS 628 (1981)).

214. The quest for accounts of human rationality that distinguish us from other animals (and thus by implication single out persons for special regard) continues in our time with an empirical twist. Efforts by rational choice theorists to show that humans engage in distinctive strategic behaviors — e.g., waiting and indirection — represent one example. *See, e.g.*, JON ELSTER, ULYSSES AND THE SIRENS: STUDIES IN RATIONALITY AND IRRATIONALITY 9-28 (2d ed. 1984) (arguing that

cial regard on a variety of non-essentialist grounds.[215] However widely these accounts differ, their common implication that personhood merits deference and regard is powerfully *symbolized* within the liberal tradition by the idea that autonomous choice should be protected, at least to a point, and that coercion is prima facie wrong.

Yet, our shared sense that persons are worthy of non-instrumental regard contrasts awkwardly with our inconsistent answers to the question of *what* is to be regarded. As Wertheimer notes about the law's disposition of coercion claims and as I have observed here about conceptions of autonomy-negating influence in clinical settings, we treat constraints and inducements differently in varying normative contexts. Modes of influence that we tolerate or even encourage within some spheres of activity are thought to be problematic within others. A proposal that constitutes duress for contract law purposes might not invalidate a criminal confession. And a medical recommendation deemed by courts and bioethics commentators to be compatible with autonomous patient choice might nonetheless preclude autonomous action in the eyes of a patient's psychotherapist. Even within a given sphere of activity, we often argue over *which* aspects of personhood merit special deference and regard. Followers of Nozick and Habermas, for example, differ sharply about which personal choices deserve society's deference, although they share the sense that persons should be treated as ends.

Although these incompatibilities are explicable in terms of underlying normative differences, they present a problem for

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humans engage in "global maximization" while other animals are capable only of "local maximization" or "gradient-climbing"). A trace of Kantian metaphysics remains in Elster's work. *See, e.g., id.* at 16 (suggesting that "*in creating man natural selection has transcended itself*") (emphasis in original). Yet such efforts fit nicely with Rawls' call for the recasting of Kantian regard for persons as ends in terms of a "reasonable empiricism." John Rawls, *The Basic Structure as Subject*, 14 AM. PHIL. Q. 159, 165 (1977).

215. Richard Rorty's reconstruction of liberalism as the avoidance of cruelty represents one prominent example. Rorty builds his case for non-instrumental deference and regard upon our "feelings of solidarity" with other persons. Our "ability to think of people . . . different from ourselves as included in the range of 'us,'" Rorty argues, is evoked by narrative accounts of "particular varieties of pain and humiliation." RICHARD RORTY, CONTINGENCY, IRONY, AND SOLIDARITY 192 (1989). This ability, potentiated by the evocative power of such accounts, rests upon a myriad of historical contingencies and shapes the limits of our non-instrumental regard for others. *Id.* at 189-98.

the credibility of our commitment to persons as ends. They remind us of the distasteful truth that this commitment is neither absolute nor invariant. Different degrees of interference with personal choice are *prima facie* acceptable in different contexts. In so doing, they invite doubts about the seriousness of this commitment.[216] One might argue that such skepticism is a salutary thing — that the ideal of singular regard for individuals and their choices cannot stand up to the reality of mutual dependence and vulnerability, and that our culture ought to acknowledge this. Yet, it may be that the myth of singular regard for persons as ends reinforces, in a diffuse, *connotative* way, our discomfort over interference with individual choice. This could occur even as the limits of our *prima facie* tolerance for such interference are *denotatively* defined, via conceptions of autonomy-negating influence, by reference to externally derived norms.

To the extent that the ideal of special regard for persons (and their choices) operates in this connotative, even passionate manner,[217] it may inspire a measure of mutual respect beyond that implied by the moral premises that inform paradigms of autonomy-negating influence. This effect may be especially important when health professionals and patients encounter each other in impersonal, bureaucratic settings. Such settings are poorly suited to the development of empathic connection, making professional respect particularly important as an adjunct to feelings of care.

If the ideal of non-instrumental regard for persons accomplishes this much, then coercion, and autonomy-negating external influence more generally, are important apart from their

216. A loose analogy might be drawn to the insight that risking human life to pursue an economic opportunity endangers the myth that life is priceless. Unwilling to discard this myth (which itself expresses the sense that persons merit non-instrumental regard), we look for ways to hide the tension between it and our worldly aspirations. We fear, moreover, that visible affronts to the myth that life is priceless will erode our collective respect for life. Such concerns animate the law's attempts to construct subterfuges — doctrines and decision-making procedures that allow us to hold to conflicting aspirations. *See* CALABRESI, *supra* note 100, at 87-91. More generally, such concerns may inspire us to develop conceptual systems able to contain those contradictions most threatening to our deeply felt values.

217. *See* MARTHA C. NUSSBAUM, LOVE'S KNOWLEDGE: ESSAYS ON PHILOSOPHY AND LITERATURE 41-42 (1990) (arguing that emotions are "intelligent parts of our ethical agency" because they reflect our deeply held views about what is important).

component moral premises. They matter because this ideal is evocatively symbolized by the notion that autonomous choice should be protected and that coercion is presumptively wrong. Indeed, the symbolic power of these notions may protect the ideal of non-instrumental regard for persons from the corrosive effects of inconsistency in our tolerance for interferences with choice. Put in other terms, the connotative power of autonomous action as an ideal tends to obscure incompatibilities between conceptions of autonomy-negating influence. This helps us to maintain differing normative stances toward external constraints and inducements within separate spheres of life.

### B. When Conceptions of Autonomy-Negating Influence Collide

As a rule, we get along more than adequately with multiple, parallel conceptions of autonomy-negating external influence, each pertinent to different spheres of action. But at times, these conceptions collide. Then we must choose, or create anew, the conception that will govern. Such collisions occur most typically when we confront novel choice situations that implicate opposing, passionately felt normative concerns.[218] Current clinical examples include the debates over efforts to encourage use of long-acting contraceptives[219] and to promote reproductive abstinence by HIV-infected women. In the near future, the most prominent medical example may be the question of whether constraints upon patient choice imposed by managed care organizations are compatible with informed consent.

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218. Not surprisingly, the law presents multiple examples, since courts are principal mediators of such conflict. Unconstitutional conditions cases are perhaps the most prominent. The emergence of the welfare state against a constitutional backdrop of cherished negative rights created a myriad of novel possibilities for state influence over personal choice with respect to the exercise of these rights. One example (from the recent past) is the development of plea bargaining. *See generally* Albert W. Alschuler, *Plea Bargaining and Its History*, 79 COLUM. L. REV. 1 (1979). Another example is the advent of large business organizations which are able to gain contractual advantage through the use of vastly superior bargaining position. *See* John P. Dawson, *Economic Duress—An Essay in Perspective*, 45 MICH. L. REV. 253, 282-88 (1947) (observing that the doctrine of duress has evolved to incorporate unequal exchanges achieved through superior bargaining power).

219. *See* Bonnie Steinbock, *The Concept of Coercion and Long-Term Contraceptives* (1993) (unpublished manuscript on file with the author) (focusing on efforts to promote use of Norplant).

When conceptions of autonomy-negating influence collide, competing claims that fail to address, or even to acknowledge, the underlying normative questions at stake grate against each other without making analytic contact. At best, the makers of such claims sustain each other's disregard for the normative questions that must be settled to resolve the conflict. At worst, this mutual disregard degenerates into anger and bitterness as partisans to the conflict sense, quite accurately, that their cherished concerns (which have gone unexpressed) are being ignored. Thus the insulating capacity of claims about coercion and autonomy — the very quality that makes it easier for us to adhere to disparate models of coercion (informed by differing answers to normative questions) within *separate* spheres of life — presents a barrier to the resolution of conflict when disparate models collide.

To break through this barrier, a dialogue that pursues analytic connection is necessary. Such connection can be achieved only through candid discussion about the competing normative premises that animate conflict over whether an influence is compatible with autonomous choice. Candor of this sort carries risk: the suppression of visible conflict between intensely felt concerns may play an important role in the maintenance of public civility. But this risk can be reduced through mutual recognition that conceptions of autonomy-negating influence tend to make sense in terms of one or another plausible vision of human ends.[220] There are limits to the mutual recognition toward which we ought to aspire. We need not, for example, grant dialogic recognition to ideas about autonomy-negating influence that rest upon the racial preferences of an apartheid theorist or a Nazi.[221] Yet within such limits, we can accomplish much, in civil conversation, by opening ourselves to the plausibility of the competing normative visions at issue.[222]

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220. *See* text accompanying notes 209-10.

221. We might, on the other hand, aspire toward a better understanding of the fears and yearnings that might make such ugliness contagious, in the hope that by addressing them, we can prevent its spread to those not infected.

222. The conversational attitude I have in mind is nicely captured by Thomas S. Kuhn in a comment on intellectual engagement with claims that seem implausible:

> When reading the works of an important thinker, look first for the apparent absurdities in the text and ask yourself how a sensible person could have written them. When you

### C. Mediating Conflict Between Conceptions of Autonomy-Negating Influence: Clinical Counseling and the Reproductive Choices of HIV-Infected Women

How, then, might such a conversation proceed with respect to whether clinical efforts to dissuade HIV-infected women from bearing children are compatible with autonomous reproductive choice? I will not attempt to anticipate the entire course of such an interchange, nor will I advocate some single, preferred outcome. By their nature, such conversations are unpredictable. They take on direction and momentum of their own, animated by a dialogic rationality of mutual discovery that carries participants beyond their initial intentions.[223] I will, however, highlight some of the normative concerns that participants must engage if they are to achieve analytic connection. Moreover, I will suggest, without rigorously defending, some possibilities for the emergence of an accommodation.

#### 1. The Normative Issues at Stake

To begin with, any effort to achieve analytic contact must address the social justice concerns that inspired the claim that promotion of reproductive abstinence coerces HIV-infected women. For the most part, these concerns are tied to the fact that women who contract HIV are disproportionately poor and from disadvantaged minority groups. As noted earlier, the belief that these women's life circumstances are unjust lends force to the conclusion that it is unfair to expect them to give

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> find an answer, . . . when those passages make sense, then you may find that more central passages, ones you previously thought you understood, have changed their meaning.

THOMAS S. KUHN, THE ESSENTIAL TENSION: SELECTED STUDIES IN SCIENTIFIC TRADITION AND CHANGE xii (1977).

223. The idea of a distinctly dialogic rationality, unbound by the wills of isolated individuals, has been richly developed by Hans-Georg Gadamer. *See generally* HANS-GEORG GADAMER, DIALOGUE AND DIALECTIC: EIGHT HERMENEUTICAL STUDIES ON PLATO (P. Christopher Smith trans., 1980) In Gadamer's words:

> When one enters into dialogue with another person and then is carried along further by the dialogue, it is no longer the will of the individual person, holding itself back or exposing itself, that is determinative. Rather, the law of the subject matter is at issue in the dialogue and elicits statement and counterstatement and in the end plays them into each other.

HANS-GEORG GADAMER, PHILOSOPHICAL HERMENEUTICS 66 (David E. Linge trans. & ed., 1976).

up the fulfillment that comes with childbearing.[224] In particular, to the extent that HIV transmission is seen as a product of unjust personal or social circumstances, asking victims of these ills to endure further deprivation for public health purposes can seem wrong. Society's failure to offer educational and career opportunities to these women adds to the perception of unfairness by shutting the door to other possibilities for fulfillment. The key moral intuition here is a sense of inequitable sacrifice. Already having been victimized by a dread disease that strikes disproportionately at the disadvantaged, these women are asked to suffer further, for purported public health ends, while society provides them with little or nothing in return.

Analogous justice-related concerns arise from women's experience of socio-economic inequality and infringement upon reproductive and sexual choice. To the degree that women are seen as victims of economic and other discrimination, expecting HIV-infected women to sacrifice the joys of childbearing for the good of society may seem morally troubling. Likewise, awareness of past and present constraints upon procreative choice, such as restrictive abortion laws and low levels of public funding for family planning and abortion services, can nurture perceptions that the promotion of reproductive abstinence is unfair.

To make full analytic contact, conversation about whether strategies for discouraging reproduction are compatible with autonomous choice also must address concerns about the social costs of childbearing by HIV-infected women. To dismiss such concerns as stalking horses for sexism or racism is to deny the reality of two kinds of trade-offs — those between alternative uses of social resources and those between different experiences of pain and deprivation. Whether the satisfactions of childbearing justify the allocation of limited resources to medical care for HIV-infected children and public assistance for many whose mothers become unable to provide for them is a question that merits discussion. Likewise, how a woman's sacrifice of reproductive fulfillment compares to a child's experience of terminal, wasting illness or loss of her mother is a subject that

224. *See* text accompanying notes 81-83.

ought to be discussed. It may be that some who cite such concerns as reasons for the promotion of reproductive abstinence are swayed by covert racial or gender bias. But this ugly possibility does not diminish the costly and tragic realities that these concerns reflect. Moreover, frank discussion of the weight that these concerns should receive might expose underlying bias and/or embarrass those afflicted by it into retreating from views informed by prejudice.

The above-mentioned normative concerns bear on all of the influence methods discussed herein: "advisory" counseling, "directive" counseling, and the conditioning of health care upon reproductive abstinence. An additional question of social justice — whether access to medical care is a universal entitlement — is germane only to the latter. An affirmative answer mandates the conclusion that conditioning care upon reproductive abstinence is wrong when patients lack access to alternative sources of care. This moral baseline, in turn, invites the inference that such a condition precludes autonomous reproductive choice when care is not otherwise available. A negative answer leaves room for the judgment that such a condition is morally tolerable and thus compatible with autonomous action.

Another set of concerns relates to the Hippocratic ideal of undivided professional loyalty to patients. Proponents of clinical strategies for discouraging reproduction tacitly accept a measure of deviation from this ideal, at least insofar as the case for reproductive abstinence rests on social cost grounds.[225] That this ideal represents an ethical absolute is belied by the pervasiveness of clinical activities that compromise it. Physicians perform many clinical tasks in service of public health, forensic, and other social ends.[226] Far from condemning all such activity as an intolerable breach of Hippocratic fidelity, society expects its health professionals to perform such functions. These expectations exist in enduring con-

225. For purposes of delineating such deviation, I count as social costs not only monies spent for medical treatment or public assistance but also the suffering of children who endure the misery of terminal illness or the tragedy of maternal deterioration and death.

226. *See, e.g.*, M. Gregg Bloche, *Psychiatry, Capital Punishment, and the Purposes of Medicine*, 16 INT'L J. L. & PSYCHIATRY 301, 317-19 (1993) (addressing tensions between the ideal of undivided physician loyalty to patients and the reality that medicine serves many social, cultural, and political functions).

flict with the Hippocratic ideal of loyalty — and with medicine's therapeutic and caring purposes. Up to a point, we tolerate this conflict. Yet some uses of medicine for public purposes so undermine the apparent trustworthiness of clinical caretakers that we place them ethically off-limits. Such line-drawing, I have argued, requires case-by-case inquiry, sensitive to both the requisites of intimate trust and the weight of public necessity.[227] This inquiry bears on the moral assessment of each of the clinical influence strategies considered here.

This list of normative concerns surely is incomplete. Other considerations abound, such as, the more abstract question of whether human dignity is best served by broader or narrower conceptions of personal responsibility in the face of unjust circumstances.[228] Moreover, the issues I have raised can be framed in other ways; indeed, the problem of framing itself should be a subject of discussion. Nonetheless, the concerns I have cited can serve as a starting point for conversation about the normative questions at stake when conflicting claims are made about the possibility of autonomous action.

### 2. Toward an Accommodation

I will end with some suggestions about the outlines of an accommodation with respect to the autonomy-precluding effect of efforts to discourage childbearing by HIV-infected women. To begin, the widely shared premise that access to an "adequate" level of health care is a moral entitlement[229] should by itself suffice to support the conclusion that conditioning care upon reproductive abstinence is wrong when other providers are not readily accessible. The Hippocratic ideal of fidelity supports a more general objection to clinicians' use of their

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227. *Id.* at 327-28, 356-57.

228. *See* text accompanying note 88.

229. *See, e.g.*, 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 18 (1983) (setting forth, as an ethical standard, an adequate level of health care for everyone); G.A. Res. 200, U.N. GAOR, 21st Sess., Supp. No. 16, at 51, U.N. Doc. A/6316 (1966) (describing the International Covenant of Economic, Social, and Cultural Rights (to which the United States is not a party), assuring to all "medical service and medical attention in the event of sickness"). It is frequently pointed out that the U.S. is the only industrialized nation that has failed to guarantee, in its laws, universal access to medical care.

services as leverage to discourage childbearing. Whether or not alternative providers are accessible, conditioning one's willingness to treat upon a patient's compliance with public purposes constitutes a dramatic departure from this ideal. As such, it puts patient trust at risk, especially among poor people and members of minority groups already skeptical about the devotion of upper-middle class professionals. The above-noted social justice objections to reproductive abstinence as a public health measure only add to the case against conditioning care upon such abstinence. One need not deny the legitimacy of public health and social cost-avoidance concerns in order to infer from these moral difficulties that this method of influence is incompatible with autonomous reproductive choice.

The clinical counseling of reproductive abstinence presents a different configuration of normative concerns. The question of moral entitlement to medical care is not germane to the ethics of "advisory" or "directive" counseling, since neither entails a refusal to provide care in the event of non-compliance. Such counseling, however, breaks with the ideal of undivided loyalty to patients, insofar as the direction given is informed by social purposes. But especially for counseling that is only "advisory," this breach of fidelity seems less troublesome than does the total abandonment portended by a provider's declared unwillingness to serve unless her patients abstain from childbearing.[230]

More problematic, in my view, are the above-cited social justice concerns. The link between social deprivation and HIV infection risk, combined with the shortage of opportunities for poor and minority women to pursue non-procreative fulfillment, lends an aura of inequity to expectations that infected women forego childbearing for the good of the rest of society. This aura of inequity is heightened by past and present gender discrimination. Absent a serious effort to redress these concerns, the clinical counseling of reproductive abstinence calls upon HIV-infected women to bear a disproportionate burden of

230. As noted above, medical advice commonly serves public health ends, even at the expense of individual patients' interests. However, such counseling tends not to take a frankly "directive" form (at least as I defined this term earlier, *see supra* text accompanying note 25) unless linked to the actual or potential exercise of state compulsion, *e.g.*, in cases of mandatory treatment for psychiatric or infectious disease.

sacrifice for the benefit of a society that treats them with disregard.

This failure of reciprocity, I suspect, inspires the charge that even the advisory counseling of reproductive abstinence coerces. The claim that such counseling coerces gains moral force from the potential of other strategies to slow the spread of AIDS without imposing a singularly harsh burden upon infected women of childbearing age. Interventions targeted at the social conditions that engender high-risk sex and substance abuse, as well as toward opportunities for discouraging such behaviors once they become established, signal a concern for the lives of infected people that contrasts with the disregard conveyed by emphasis on reproductive abstinence. This disregard lends force to the claim that clinical advice to refrain from childbearing is incompatible with autonomous procreative choice.

On the other hand, if lack of reciprocity inspires the belief that the counseling of reproductive abstinence coerces, then efforts to ameliorate social deprivation could weaken the moral basis for this belief. Advice to abstain from childbearing might be less problematic in social justice terms if accompanied by programs to redress the conditions that promote HIV transmission and genuine attempts to provide poor and minority women with chances for non-procreative fulfillment. Such a melding of individual and social responsibility has the potential to transform the struggle against the spread of AIDS from a dividing practice into a community-affirming endeavor. To the extent that this potential is realized, it might become less objectionable to conclude that clinical advice to abstain from childbearing is compatible with autonomous choice.

These suggestions offer a starting point for conversation about how the boundaries of autonomy-precluding clinical influence should be drawn with respect to the reproductive choices of HIV-infected women. The subsequent course of such a conversation can be neither managed nor predicted. Its development is likely to be a recursive function of its participants' evolving perspectives with respect to many normative questions. What can be predicted is that after a set of boundaries is agreed upon, the normative judgments that inform them will recede behind the language of autonomy and

coercion. In turn, the connotative power of this language will engender respect for these boundaries and discourage persistent, corrosive criticism of their normative content.

## V. CONCLUSION

I have noted that judgments about whether particular influences are compatible with autonomous action rest upon tacit normative premises. Beliefs about justice, fairness, and the good life inform conceptions of autonomy-negating influence and guide their application in clinical and other settings. Within different spheres of activity, I also have noted, we live with contrary understandings of autonomy-negating influence, arising from conflicting normative visions. Usually, such contradiction presents no problem. As a rule, the understandings of autonomy-precluding influence to which we adhere in different spheres of life do not abrade against each other. Indeed, the notions of autonomy and coercion may help us to tolerate such conceptual dissonance by concealing the contradictory normative premises that inform these understandings.

But sometimes, conceptions of autonomy-negating influence collide within a single sphere of activity. Typically, such spheres are either newly emerging or rapidly changing. When this happens, we must choose — or construct — a governing conception. Reproductive decision making by HIV-infected women represents one such instance. In such circumstances, the otherwise appealing, even useful myth that autonomy and coercion are single, free-standing conceptions stands in the way of a solution. Competing claims about autonomy-negating influence that fail to pierce this myth by attending to underlying normative issues cannot achieve analytic contact. At best, those who make such claims reinforce each other's disregard for the normative questions at the heart of the conflict. At worst, mutual disregard evolves into anger as the conflict's participants sense that their deeply felt concerns are being neglected.

Accordingly, I have urged an approach to conversation about competing understandings of autonomy-negating influence that promises greater analytic engagement and reduced acrimony and bitterness. Recognition that many such under-

standings are possible and open discussion of the normative issues that undergird our choices between them are central to this approach. When the boundaries between influences that permit and preclude autonomous action are socially contested, a process of this sort has the potential to reach solutions marked by mutual respect, social reciprocity, and a deepened sense of community.[231]

231. Such solutions, it should be noted, leave us with an enigma. On the one hand, they are informed by normative conclusions about justice, fairness, and conceptions of the good. Yet on the other hand, the judgment that an influence precludes autonomous choice is not entirely equivalent to the conclusion that it is wrongful. At most, the former judgment establishes a default rule of wrongfulness: if an influence is deemed incompatible with autonomous action, then the burden of proof is on anyone who would nonetheless justify it. *See supra* note 35. Thus in practice, we sometimes separate the ultimate issue of wrongfulness from the question of whether an influence precludes autonomous action, though more typically we conflate these matters without evident ill effect. This curious inconsistency calls out for further exploration.