

The Value of Consciousness in Medicine

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Abstract

We generally accept that medicine's conceptual and ethical foundations are grounded in recognition of personhood. With patients in vegetative state, however, we've understood that the ethical implications of phenomenal consciousness are distinct from those of personhood. This suggests a need to reconsider medicine's foundations. What is the role for recognition of consciousness (rather than personhood) in grounding the moral value of medicine and the specific demands of clinical ethics? I suggest that, according to holism, the moral value of medicine is secured when conscious states are recognized in everyday medical science. Moreover, consciousness fully motivates traditional principles of clinical ethics if we understand respect for autonomy as respect for the dominion of an experiencer in the private, inescapable realm of bodily experience. When medicine's foundations are grounded in recognition of consciousness, we understand how patients fully command respect even when they lack capacity to exercise their bodily dominion through decision-making.

Introduction

It is arguably possible for patients to be phenomenally conscious without the complex cognitive capacities that meet standards for personhood. Independently of metaphysical debates about that distinction, patients in a minimally conscious state, those awakening from anesthesia, and those in advanced stages of Alzheimer's disease clearly do have experiential states despite lacking capacities that make medical decision-making possible. Moreover, there's been considerable philosophical discussion about the likelihood that consciousness, in the phenomenal sense, is actually isolated from personhood in some patients diagnosed as being in persistent vegetative state (VS) (Kahane and Savulescu 2009; Levy and Savulescu 2009; Shea and Bayne 2010). Regardless of how we interpret studies suggesting consciousness in VS

patients (Owen et al. 2006; Owen et al. 2007; Owen and Coleman 2008), it's been important to consider the distinct implications of consciousness when it comes to ethical questions about sustaining life.

The moral and ethical implications of consciousness should also be considered more broadly in medicine, particularly in its foundations as they've developed since the late twentieth century. Based on rejection of the so-called biomedical model (BMM), "humanism" and "holism" have driven a professional shift that's broadened the scope of medicine's focus from the limited realm of the body and its diseases to a broader realm where we recognize mind and its integration with the body in whole persons. This shift has had a profound impact on medical science and diagnostic practice. More than that, rejection of the BMM has typically been understood to clarify why medicine is a moral practice, broadly speaking, and why the specific demands of clinical ethics should be recognized as imperative. As we generally see things in bioethics, it is personhood that was overlooked by the BMM, and it is recognition of persons that brings medicine out of the realm of pure science into the realm of moral and ethical values. When we look more closely, however, particularly with respect to holism, we find that it is often not recognition of personhood that's driving medicine's current approach: it is recognition of consciousness.

There has been little effort, however, to clarify the specific role that consciousness has played in the turn away from the BMM, as distinct from the role of personhood. With this in mind, in this paper I address the following question: What is the role for recognition of consciousness in grounding the moral value of medicine and the concepts and principles of clinical ethics?

To address that question, I begin in Part 1 by pinning down the tenets of holism as they concern consciousness. Based on George Engel's suggestion that medicine's ethical demands are implicit in medical science properly understood, I discuss, in Part 2, three ways in which holism's recognition of consciousness changes medical science, and clarify how these force us to see the practice of medicine as a moral endeavor. In Part 3, I argue that the specific principles of clinical ethics are also grounded in recognition of consciousness, not recognition of personhood. In particular, I suggest that respect for autonomy in medical settings arises from respect for the inviolable boundary around bodily experience. Because bodily experience is both private and inescapable, conscious patients command respect for autonomy even in the absence of the cognitive capacities that make it possible for them to exercise their autonomy. I conclude that it is consciousness, rather than personhood, that compels us to pursue medical practice and defines the pursuit as moral, so it is consciousness that provides the foundation for clinical ethics.

My concern with consciousness in this paper is specifically focused on phenomenal consciousness – that is, conscious states with some kind of qualitative feel – and the capacity to have them. There is “something that it's like” (Nagel 1976) to be a conscious being in this sense, so the concern with consciousness in medical contexts is just a concern with the capacity of patients to have qualitative experiences. Consciousness in this sense is distinguished from “access consciousness” (Block 1995), which involves self-consciousness over time, along with the complex cognitive and motivational capacities that make it possible to set rational goals and act toward achieving them. I will follow Levy and Savulescu in considering access consciousness more central to personhood. As I will understand it, those who meet the standard of

personhood (as it's traditionally been construed) have "abilities that require access consciousness, not phenomenal consciousness" (Levy and Savulescu 2009, 367). Ultimately, though, I will defend the view that when holism is properly understood, it clarifies the sense in which conscious human beings are fully worthy of respect even when they do not meet the standard of personhood.

Part 1: Holism and Consciousness

Two Routes to Resolving Medicine's Crisis

The medical professions experienced a "quality-of-care crisis" (Marcum 2008, v) in the 1970s that only grew more pressing in the remaining decades of the twentieth century. Through the tradition of the BMM, medicine had centrally identified itself as a biological science that set out to improve the body and address its diseases.¹ Though there was no question that this approach had been profoundly successful in its goal, both the profession and the culture at large became concerned that something vital was missing. Ramsey (1970) suggested that patients should be recognized as persons, and that idea was then deepened, largely through Pellegrino's work, into the movement of "humanism".

Humanism insisted that because patients are persons rather than bodies, medical practitioners have clear obligations to them that go beyond the limited focus of biological

¹ It's important to acknowledge that medical ethics did exist before the late twentieth century (for example, in Gordon (1934)), so the profession's biological focus did not exclude the possibility of duties to persons. My distinction between the BMM and the holistic and humanistic alternatives follows the original writing that sharply defines those alternatives.

repair. Through the work of Beauchamp and Childress (1979), humanism pinned down those obligations in a way that codified the principles and concepts of clinical ethics as we now understand them. Humanism's impact on medicine can hardly be overstated. Through this movement, bioethics developed into a profession integrated with medicine and central to its success (Marcum 2008). Medical education evolved to include the humanities, and medical practice recalibrated to demand respect for the autonomy of persons through practices like informed consent and truthfulness.

But humanism is only half of the story when it comes to the turn away from the BMM. Not long after Ramsey's foundational book *The Patient as Person* (Ramsey 1970), psychiatrist George Engel wrote that "appeals to humanism" are "ephemeral and insubstantial...when not based on rational principles" (Engel 1977, 135):

I contend that all medicine is in crisis and, further, that medicine's crisis derives from...adherence to a model of disease no longer adequate for the scientific tasks and social responsibilities of either medicine or psychiatry (Engel 1977, 129).

As Engel saw it, "the proper boundaries of professional responsibility" (1977, 129) should be clarified through improved understanding of disease in medical science. The alternative Engel offered to the BMM was the "biopsychosocial model" (BPSM), which is "both a philosophy of clinical care and a practical clinical guide" (Borrell-Carrio et al. 2004, 576). Based on biological systems theory, the BPSM suggests that "clinicians must attend simultaneously to the biological, psychological, and social dimensions of illness" (Borell-Carrio 2004, 576). In doing so, they would reject the "biomedical dogma requir[ing] that all disease, including 'mental' disease, be conceptualized in terms of...underlying physical mechanisms"

(Engel 1977, 130).

As with humanism, it is hard to overstate the impact holism has had on medicine. The BPSM is implicit in the World Health Organization's continued commitment to a definition of health as "a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity" (WHO 2019). It has been described as "the official philosophy of the American Psychiatric Association and the Diagnostic and Statistical Manual, DSM-5" (Rease 2014, 1). Perhaps most importantly, the culture at large could not be more enthusiastic than it now is about "integrated mind-body medicine" and "whole person care", two ideas that have become essential for everyday medical marketing. There have been a great many criticisms of the BPSM in recent years, though most of these express frustration that failings in holism's original formulation have made it hard for the movement to achieve the dramatic change it originally aimed for (Bolton and Gillette 2019; Ghaemi 2010; Butler 2004).

The Philosophical Bottom Line

While the terms 'humanism' and 'holism' have had varied definitions, and they've often been used interchangeably, in Engel's writing holism provides the conceptual foundation we need to make sense of humanism's ethical demands. The central problem with the BMM, Engel suggests, is that it "embraces...reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle..." (Engel 1977, 129). More specifically:

The historical fact we have to face is that in modern Western society biomedicine not only has provided a basis for the scientific study of disease, it has also become our own culturally specific perspective about disease, that is, our folk model.... Biomedical

dogma requires that all disease, including “mental” disease, be conceptualized in terms of derangement of underlying physical mechanisms. This permits only two alternatives...the reductionist, which says that all behavioral phenomena of disease must be conceptualized in terms of physicochemical principles; and the exclusionist, which says that whatever is not capable of being so explained must be excluded from the category of disease (Engel 1977, 130).

Holism provides a middle way between these two alternatives, so it becomes possible for medical practitioners to address “the human experience of disease” (Engel 1977, 131), including mental illness, without reducing experience to biology and without threatening medicine’s claim to scientific practice.

Schillmeier recently suggested that the BPSM “protests against the manner by which only non-subjective qualities gain explanatory power” (2019, 141), and this echoes Borrell-Carrio and colleagues, who interpreted the model as “a way of understanding the patient’s subjective experience as an essential contributor to accurate diagnosis, health outcomes, and humane care” (Borrell-Carrio et al. 2004, 576):

Engel did not deny that the mainstream of biomedical research had fostered important advances in medicine, but he criticized its excessively narrow focus for leading clinicians to ...[ignore] the possibility that the subjective experience of the patient was amenable to scientific study (Borrell-Carrio et al. 2004, 576).

Though Engel himself never used these terms, his perspective is a form of non-reductive physicalism or property dualism (Marcum 2008, Woods 2015), aptly characterized by Borrell-Carrio and colleagues as the view that “subjective experience depends on but is not reducible

to laws of physiology” (2004, 576).² While it seems he was unaware of this, reductionism became untenable to Engel in medicine right around the time that it became untenable in philosophy. In both cases the challenge was (and is) to find a way of distinguishing experiences from the brain states with which they’re correlated, while still maintaining the causal closure that science requires. There are indications that Engel was aware of the philosophical enormity of this task: “We are now faced with the necessity and the challenge to broaden the approach to disease to include the psychosocial without sacrificing the enormous advantages of the biomedical approach” (Engel 1977, 131).

Part 2: From Recognition of Consciousness to the Morality of Medicine

Three Roles for Consciousness in Medical Science According to Holism

Working from the ground up, holism is committed to changing the scope of medicine’s scientific focus so that it can take stock of “the human experience of disease” (Engel 1977, 131). Unfortunately, neither Engel nor subsequent researchers working on holism have distinguished consciousness and personhood in this context. How exactly does the new model handle consciousness specifically, as distinct from the psychology of persons and the social parameters that impact the health of persons? I suggest that according to holism the scientific goal of improving the body requires that conscious states of bodily experience must be recognized in

² Engel repeatedly equates reductionism with dualism, so it’s clear he uses the term ‘dualism’ quite differently from the way philosophers understand it. This is not the place to address that confusion, so I accept Engel’s emphatic rejection of reductionism and, following Marcum and Woods, I take it to demand some form of property dualism.

three distinct ways. As we will see, on their own, the first two do not force medicine out of the realm of science into the realm of the values. The third, however, does.

(1) Conscious states are central to the success of diagnostic science. Gifford proposes that the BMM and the BPSM...

suggest different implications for the data one needs to collect in order to make decisions about diagnosis and patient management. From the BMM perspective, lab results etc. are seen as the most objective, as probing deeper into the medical reality, and thus as providing the most reliable and useful information. The BPSM perspective emphasizes more the reports from patients, including reports of subjective experiences (Gifford 2017, 446).

Engel certainly did not invent the idea that patients' experiences of their bodies are important to the diagnostic and treatment process. He did, however, bring this reality front and center in a way that posed a challenge for the BMM. Direct experience of the body is, essentially, the body's report on itself, so if your goal is to improve the body, information about experience will be scientifically crucial.

What's complicated about data of this kind – and this is the reason why the BMM would be inclined to minimize its scientific importance – is that experience of the body is epistemically private. That is to say that the doctor cannot get at this data except through patients' reports, and reports are not possible unless the patient has and employs the complex cognitive

capacities of personhood.³ In this sense, personhood intervenes between bodily experiences as they are and bodily experiences as a doctor can access them. Rogers has suggested that...

Medicine strives for objectivity; the purpose of the diagnostic interview and examination is to transform the initial chaos of the patient's presenting complaint into a series of symptoms and signs linked by reference to a pathophysiological disease state. This creates a need to standardise patients' signs and symptoms and to filter them through a medical sieve (Rogers 2002, 79).

Holism proposes that the epistemic complexity of this process in no way challenges the claim to scientific practice. The patient has conscious states of direct, private experience of the body, which she generally interprets and responds to with the complex capacities that characterize her as a person. As a person, then, she communicates to the doctor about her interpretations of, and responses to, her bodily experience. The doctor then works through a professional filtering process, which she hopes will isolate facts about bodily experience that can support accurate conclusions about disease.

The most essential skills of the physician involve the ability to elicit accurately and then analyze correctly the patient's verbal account of his illness experience. The biomedical model ignores both the rigor required to achieve reliability in the interview process and the necessity to analyze the meaning of the patient's report in psychological, social, and cultural as well as in anatomical, physiological, or biochemical terms (Engel 1977, 132).

³ There are substantial efforts in medicine to access the private data of bodily experience without the personhood-related complexities that arise with patients' reports. Pain measurement charts, for example, are meant to provide something like a numerical measure of pain experience purely through observation of patients' facial expressions. These measurements are deeply flawed, of course, because facial expressions of pain are generally mediated by person-level considerations that involve self-awareness and self-image in the social setting.

It's important to Engel that, as the language of the BPSM always points out, the doctor cannot develop an accurate picture of direct bodily experience if she only pays attention to patients' words about the body. Because a sad patient will report on pain differently from an anxious patient, for example, part of the doctor's clinical acumen involves assessing the patient's psychological and social experiences of herself as a person, and then using those assessments during the filtering process to improve the accuracy of data about conscious states of bodily experience. The doctor can, and should, also take stock of patients' psychological health and social frameworks through direct observation, independently of patients' reports about them. Sadness and anxiety are sometimes directly apparent, for example, as are the complex interactions of family. These considerations should play a role in doctors' interpretations of patients' reports about their bodily experiences.⁴

(2) Conscious states play a role in the biological development of disease, so they're central not just epistemically, but also metaphysically. Engel offered a case study that illustrates this, where a patient with history of heart attack has some initial cardiac symptoms, but then is triggered into actual heart attack by fear that arises in response to clinical investigations (Engel 1981). Whatever we might say about the challenges of that example, the point is important for a scientific understanding of disease. The body does not develop disease independently of conscious states. On the contrary, it seems clear that experiential states play an integral role in triggering, sustaining, and worsening disease.

⁴ Though my concern at this point is with the place for consciousness in holism's picture of biomedical science, holism does also centrally suggest that doctors should concern themselves with improving patients' experiences of themselves as persons, even when those improvements do not involve biological science.

Since Engel's time medicine has become far more informed about the impact of conscious states on the disease process. It is clear, for example, that stressful experiences delay wound healing and support the development of infection (Gouin and Kiecolt-Glaser 2012). Similarly, researchers have become much more precise about the neurochemistry of experiential states of distress, and this has made it possible to clarify how conscious states play a role in gut diseases (Sgambato et al. 2012). In both of these areas, research is focused on conscious experience of the self – that is, private experiences of psychological or social distress at a level that requires the cognitive capacities of personhood.

Other research in this area has considered the impact on the central nervous system when patients have bodily experience of pain for long periods of time. Research of this kind suggests it's possible for conscious states of bodily pain at a given moment to arise from the nervous system's response to sustained states of bodily pain in the past (Wallit et al. 2015). The distinction between consciousness and personhood in this area is complex and poorly considered. At times researchers seem to suggest the nervous system has responded directly to long-term bodily experience at the level of consciousness (Kaplan et al. 2019; Gracely 2002), while at other times the suggestion seems to be that the nervous system has responded to long-term experience at the level of personhood – that is, experience of the self as a person who suffers from pain (Budtz-Lily et al. 2015; Harte, Harris and Clauw 2018). Diagnosis and management would be improved with clarification on this point.

(3) Medical science must measure its success not in terms of the body's improvement, but in terms of improvement in conscious states. This is certainly the most powerful idea holism

introduced into medical practice, and its ramifications have been immense, both as a matter of science and as a matter of values. Engel wrote:

“Rational treatment”...directed only at the biochemical abnormality does not necessarily restore the patient to health even in the face of documented correction or major alleviation of the abnormality. (Engel 1978, 386)

Once diagnosis has been made and treatment has been provided, the doctor must evaluate the success of her interventions, and to do this she must again return to the private realm of experience, with all the epistemic complexity that involves. There are four reasons why this would be the case.

First, the diagnostic process is imperfect, so it's possible for doctors to identify and address problems in the body that are not actually responsible for patients' experiences of pain or illness. Error of this kind can only be rectified if the doctor returns to private experience of the body through the complex reports of persons.

Second, it's possible for diagnostic investigations to suggest disease when experience does not manifest disease:

...in terms of the human experience of illness, laboratory documentation may only indicate disease potential, not the actuality of the disease at the time. The abnormality may be present, yet the patient not be ill.... the biochemical defect constitutes but one factor among many, the complex interaction of which ultimately may culminate in active disease or manifest illness (Engel 1977, 131).

This point is particularly important in light of recent concerns about over-diagnosis and over-medicalization. It is true that much of medicine's power lies in its ability to notice and

address disease in its early stages, before experience of disease occurs. It is also possible, however, for biological abnormalities to be present that never actually threaten patients' lives or bodily experiences. We can recognize and incorporate this reality into the practice of medicine only because we recognize experience as the ultimate arbiter for medical success.

Third, it's possible for patients to have bodily experiences of pain or illness in the absence of biological abnormalities.

By evaluating all the factors contributing to both illness and patienthood, rather than giving primacy to biological factors alone, a biopsychosocial model would make it possible to explain why some individuals experience as "illness" conditions which others regard merely as "problems of living," be they emotional reactions to life circumstances or somatic symptoms (Engel 1977, 133).

The BMM would suggest that when patients experience illness in the absence of biological abnormalities, their problems lie outside the scope of doctors' concerns. But holism insists that medicine does not begin and end with biological abnormalities, because patients' experience of illness and disease does not begin and end in their biology. It is possible, holism proposes, for patients' experiences of themselves, at the level of personhood, to lead to experience of biological pain or disease when no biological abnormalities are present.⁵

Fourth, blind application of medical science is actually unproductive when it does not lead to experiential improvement. This has been a profoundly important revelation for

⁵ The idea of psychological causes for symptoms is a great deal more complicated than medicine, or philosophy, have appreciated. It remains unclear whether psychological distress can create an experience of bodily pain or illness, or what such a process would involve. Though practice guidelines now generally equate diagnostic uncertainty with psychological causes (O'Leary 2018a), bioethics has only just begun to examine ethical challenges that arise at the mind-body diagnostic line (O'Leary 2018b; O'Leary 2019).

medicine and for medical ethics, particularly in end of life care. While the BMM seems to encourage improvement of bodily abnormalities whenever it can be achieved, holism has made it clear that improvement is an experiential matter, and in many cases the blind application of biological science will not improve experience. We've gotten very good at medical interventions that won't actually improve conscious states for conscious patients, and we've gotten good at sustaining the body in various states of consciousness and personhood. These biological successes have forced us to recognize, through holism and through humanism, that we misunderstand the goal of medicine when we pursue biological interventions without weighing their value in experiential terms.

From the Scientific Importance of Consciousness to the Moral Character of Medicine

As long as we understand medical science to be initiated for biological reasons, to proceed based on biological data, and to succeed based on biological evaluations, the practice of medicine will not be intrinsically moral. We might insist that there should be ethical requirements for medical practitioners, and we might ground these in the idea that patients are persons rather than bodies, but if we construe medical science to begin and end with biology, those requirements will remain external to practice.

It is a scientific matter to insist that conscious states are central to the diagnostic process, and that they play a central role in the development of disease. It is also a scientific matter to insist that the success of medical interventions must be evaluated through improvements in conscious states – but this third scientific point forces us to recognize the moral implications of medicine as a practice that centrally attends to conscious states. As

Kahane and Savulescu put it, “the presence of consciousness, or of a capacity for consciousness...marks a crucial moral boundary separating conscious beings from other entities” (Kahane and Savulescu 2009, 9). Because holism demands attention to conscious states through every stage of the scientific process, and particularly in the goal of the process in every specific case, holistic medical practice is intrinsically moral from start to finish.

It is wrong-headed, then, to imagine that the doctor can go about the business of medical science as if values become involved only in ethicists’ external demands or in medicine’s big-picture goals. In reality, medical science is intrinsically wrapped up with conscious states, and it is driven at every moment by the moral goal of improving them. This tells us the moral shift does not occur because the doctor has recognized the body in the room as a person. It occurs because she has recognized the body in the room as conscious, and she has understood how its conscious states motivate and support the activities of medical science.

It’s helpful to compare medicine’s moral character as it arises from recognition of consciousness to the moral character of veterinary medicine. We understand veterinary medicine as medicine, rather than as veterinary mechanics, because we recognize that non-human animals are conscious. That is to say that we recognize the moral imperative to pursue veterinary medicine not because non-human animals might approach the standard of personhood, but purely because they meet the standard of consciousness. At the other end of the spectrum, if we imagine entities with the biological complexity of non-human animals that are not conscious – something like organic Roombas, for example – we will not imagine that repairing them will amount to Roomba medicine rather than Roomba mechanics. It is not the presence of biologically complex bodies, and it is not the presence of personhood, that compels

us to practice medicine and to understand the practice as moral. It is the presence of consciousness.

Part 3: From Medicine's Moral Character to the Classic Principles of Ethical Practice

Consciousness and the Principles of Clinical Ethics

It might seem like the route from medicine's general moral character to the specific demands of clinical ethics is easy enough to map out. The presence of consciousness is sufficient to motivate medicine and broadly define it as a moral enterprise, it might seem, but the development of clinical ethics has been driven by recognition of the capacities that define personhood. As we typically understand these things, "seeing patients as persons, who are rational, self-conscious beings" is "the backbone of Western medical ethics" (Tsai 2008, 172). I am going to argue against this simple explanation, suggesting that the principles of clinical ethics are fully motivated by recognition of consciousness in patients who lack the capacities we associate with personhood. Moreover, the principles would not be motivated by the presence of those capacities in the absence of consciousness.

The four principles of beneficence, non-maleficence, justice, and autonomy have been described as "four moral nucleotides that constitute the moral DNA" of medicine (Gillon 2003, p. 308). Introduced by Beauchamp and Childress in 1979, they have been vigorously criticized since that time, and vigorously defended through eight editions of the original text. Whatever we might say about their merits, the four principles have played a central role in the development of clinical ethics through holism and humanism, so it's important to understand

what they actually imply, and what they actually require, about the presence of consciousness versus the presence of personhood.

The first and most obvious step here has to do with beneficence and non-maleficence. While it's common to see these characterized in terms of personhood, what drives them both is the far simpler fact that patients are conscious. Debates about VS patients make this clear. We all do immediately recognize that "If PVS patients are sentient, then it matters what we do to them", because "phenomenal consciousness is sufficient to make its bearer a moral patient" (Levy and Savulescu 2009, 366). That is to say that the presence of consciousness in VS patients triggers the demand to beneficently improve conscious states through the practice of medicine. It should be equally clear – particularly given Kahane and Savulescu's suggestion that it's unethical to sustain the lives of VS patients – that it's consciousness, rather than personhood, driving the imperative not to do harm. The principles of beneficence and non-maleficence are fully motivated in conscious patients who do not meet the standard of personhood.

Broadly speaking, the principle of justice demands fair distribution of health resources, that is, equal access to medical care for those with equal need. In this sense it might seem that justice is best characterized as a social idea, an idea about how we should or must behave as persons in relation to other persons. In the context of VS patients, however, we automatically apply the principle of justice in spite of the absence of capacities that meet the standard of personhood. When patients are capable of conscious bodily suffering, that is to say, we do not debate their equal claim to pain relief, for example. Indeed, it seems morally reprehensible to propose that conscious suffering patients might have a lesser claim to health resources purely because they lack complex cognitive capacities.

There are many senses in which the medical principle of justice is applied that certainly do assume the status of personhood for those involved, and I do not mean to suggest that we should question the force of these kinds of considerations. I suggest, rather, that at the most basic level where we invoke clinical ethics, at the level where consciousness clearly does compel medical practitioners to act according to the principles of beneficence and non-maleficence, it also compels them to act according to the principle of justice.

That leaves us with the heftiest element of clinical ethics, the principle of autonomy and the practices that manifest respect for autonomy in medical settings, such as informed consent and truthfulness. Broadly speaking, traditional autonomy in clinical ethics is understood as a principle of patient self-rule or self-governance, in contrast with the more authoritarian practices that prevailed with the BMM. In a social or political context, autonomy requires the complex cognitive capacities of personhood – because if a being is not self-conscious, and does not have the capacity to set rational goals and act toward accomplishing them, she is not capable of making self-governing decisions. Within normative ethics generally (outside the context of medicine), Kant equates autonomy with entry into the realm where ethical duties apply. For all these reasons it appears that while consciousness is sufficient to ground the moral nature of medicine, and might even be sufficient to motivate beneficence, non-maleficence, and justice, when we reach the principle of respect for autonomy, it appears that it's personhood rather than consciousness that is more central. When we consider the prospect of a non-conscious being who meets the standard for personhood, however, this appearance is no longer convincing.

The Principles of Clinical Ethics for Zombified Patients

Based on the distinction between consciousness and personhood (or at least between phenomenal consciousness and access consciousness or “sapience”), Kahane and Savulescu (2009) present distinct considerations of values as they arise with all four combinations of consciousness and personhood in VS patients.. The most challenging of these combinations is personhood without consciousness, which they characterize as:

the presence of cognitive and motivational processes that are sufficiently extensive and systematic to merit not just ascription of local information processing in some area of the brain but ascription of genuine person-level mental states such as beliefs and desires. But this mental activity would take place without phenomenality – strictly speaking, there would be nothing it is like to be such a person (Kahane and Savulescu 2009, 16)..

The idea of personhood without consciousness is conceptually controversial. Kahane and Savulescu argue, however, that while “this possibility may ultimately prove to be incoherent...at this stage we certainly cannot just rule it out” (Kahane and Savulescu 2009, 16), and on that basis they propose that the ethical implications of personhood in the absence of consciousness should be more carefully considered. I suggest that regardless of our views on the empirical possibility of personhood without consciousness, and regardless of our views on its conceptual coherence, it is informative to consider the ethical implications of this combination of capacities. Siewert’s thought experiment about “zombification” or “phenolectomy” provides a particularly useful tool along these lines:

I ask...merely how you would respond to your options if you came to think it was possible for you to maintain as good as normal nonphenomenal capacities, after a total excision of relevant talents for phenomenal experience. To answer this question in a manner that reveals a commitment to valuing consciousness for its own sake, you need not actually believe that it is possible, in any sense, for this "zombification" to happen to you, or to anyone else (Siewert 2000, 23).

What intuitions do we find ourselves with when we imagine the possibility of zombification in the context of the four principles?

To begin, if a zombified patient and a conscious patient suffer an equivalent bodily abnormality, will we imagine that the duty to provide medical care applies equally, justly, for both patients? Levy suggests that access consciousness and self-consciousness might "underwrite a great deal of what we value...in our lives" (Levy 2014, 8) even in the absence of phenomenal consciousness. If this is the case, it would be important for clinicians to give equal weight in medical decision making to the nonexperiential interests of the zombified patient and the conscious patient. In the medical context, however, concerns about these kinds of interests cannot equal the demand to improve the experience of bodily suffering when it is present. When faced with a zombified patient and a conscious patient in a similar state of bodily abnormality, that is to say, the principle of justice will not apply.

Without a demand to provide medical care justly, moreover, as it applies to all conscious patients, the demands of beneficence and non-maleficence will also be weakened, if they will be present at all in their original sense. Because there's nothing that it's like to be the zombified patient, if we accept the goal of medicine as it's understood by holism, the sense in

which the doctor is compelled to beneficently improve the zombie's body, or to avoid harming it, will be strange and distinctly unmotivating.

Both holism and humanism were overtly concerned that the BMM had overlooked persons, but when we consider the zombified patient scenario we see that overlooking consciousness may have been the deeper problem. There is something quite grotesque about practicing medicine as if the bodies on which you practice are not conscious, even if you continue to pursue directives for preventing and alleviating pain. Things will be no less grotesque if you respect patients' personhood. The reason for this is the reason why holism swept through the medical professions with such immense power. We pursue medicine based on the moral significance of consciousness, so practicing as if patients are not, in fact, conscious, is morally grotesque. When we think of medicine in this way, as we do in the zombified patient scenario, the basic bioethical principles of justice, beneficence, and non-maleficence become skewed beyond recognition.

Would we recognize a demand to respect the autonomy of a zombified patient, one who has the cognitive capacities needed to make medical decisions, but lacks experience of the body? I suggest we would not. First, without the private character of the body's reports on itself in experience, it is hard to motivate the idea that the zombified patient has unique authority about her body in the medical setting. Second, we pursue the practice of medicine for the sake of the conscious patient because she cannot choose to escape her bodily suffering, because she is bound to experience the body even while experience is terrible. For this reason, the kind of stake that the conscious patient has in medical decision-making is deeper, more important, and more compelling than the stake of the zombified patient.

The zombified patient has non-experiential interests in the body, presumably having to do with her ability to use it, and there is no question that these are unique. On the basis of these interests the zombified patient does have a stronger stake in medical decision-making about her body than, say, her doctor does. At the same time, however, the zombified patient's stake in medical decision-making is quite different from the stake of the conscious patient across the hall, and that difference is vital to our understanding of medicine's moral motivation. The conscious patient commands respect for autonomy because her experience of the body is both private and inescapable, and she commands it even in the absence of the ability to act autonomously through medical decision-making.⁶

While the ability to make autonomous medical decisions does require the complex capacities of personhood, respect for autonomy in the medical setting does not arise from the presence of these capacities, and it does not arise from professional practices that manifest respect for the exercise of these capacities (like informed consent and truthfulness). It arises from the uniquely impenetrable character of phenomenal consciousness. While the zombified patient's claim to non-experiential interests would command respect from medical practitioners, autonomy in the medical setting is bodily autonomy. Without bodily experience we cannot make sense of respect for the patient's dominion in the realm of her own body.

When we equate respect for patient autonomy with respect for personhood we confuse the practices of medicine with the experiential realities that motivate them. Though this is not a paper where I can defend a position on the idea of personhood, my conclusions do suggest

⁶ Shea and Bayne (2010) raise important questions about what it might mean to suggest that VS patients have reportable experiences without the capacity to actually report. Though my concern is ethical, I am relying on a similar distinction.

that traditional notions of “personhood” and “respect for persons” are deeply misguided in the medical setting, that they arise from lack of attention to the differences between consciousness and personhood as they broadly pertain to the moral and ethical aspects of medicine.

Conclusions

Just as it’s been fruitful to track consciousness through philosophical discussion of VS patients, it is fruitful to track consciousness through philosophical discussion of the recent change in medicine’s identity. In the last fifty years, broadly speaking, we’ve seen medicine shift from a sense of itself as science-centered to a sense of itself as a moral endeavor with a very specific set of ethical constraints. This change has been understood in medicine, psychiatry, and bioethics to be grounded in recognition of personhood, but when we take a closer look we see it really was not personhood that drove the change, and it’s not personhood that sustains it today. Though humanism might rightly be characterized in terms of persons, holism (in spite of its language) is really about consciousness. It is a perspective that argues for recognition of conscious states in medical science, and for the idea that medicine’s moral character is grounded by this new scientific approach.

According to holism, properly understood, it is consciousness, rather than personhood, that compels us to pursue medical practice and defines the pursuit as moral, so it is consciousness, rather than personhood, that drives the principles of beneficence, non-maleficence, and justice. These principles apply for the VS patient just as they do for the everyday patient with a broken leg, because in both cases the doctor’s goal is to improve experience – and that goal is recognized, pursued, and achieved when conscious patients lack

the capacities we associate with personhood. Most importantly, the authority and inescapability of bodily experience command respect even when patients lack the capacity to exercise bodily authority through medical decision-making. Respect for patient autonomy is respect for the dominion of an experiencer in the private, inescapable realm of bodily experience – so even when experiencers lack the capacities needed to exercise their dominion through medical decision-making, they nevertheless command respect for autonomy.

Qualitative facts about the bodily suffering of one being are inaccessible to others. At the same time, experience of bodily suffering forces all conscious beings to need relief – but it does not give conscious beings the power to bring relief upon themselves. It is for these reasons that human beings cooperate in the social endeavor that is the medical profession, and it is for these reasons that we all share the sensibility that this endeavor is a collective human duty. The impenetrable boundary around bodily experience characterizes the human condition, and medicine is defined by its deep engagement with that reality.

Finally, while medicine provides fertile ground for philosophical understanding of the ties between consciousness and value, understanding of this kind is actually more important in reverse. That is to say that while it's philosophically useful to consider the implications of medicine in this area, it's more important to consider the medical usefulness of these kinds of philosophical conclusions. I'm not suggesting that medical practitioners need to engage in high-level philosophical debates about consciousness, or even that these kinds of debates should be incorporated into medical education (though I'd certainly approve of that). I'm suggesting that, because holism is right that medicine is improved when its scope includes consciousness, medical practice would be more successful if practitioners were trained to understand how

private bodily experience figures into medical science. More than that, medicine would be more successful if practitioners had a sense of how medicine's moral identity, and its specific ethical constraints, arise not from the extraneous demands of ethics professionals but from the nature of bodily experience.

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