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The Autonomous Relational Self- Confucius and Beyond

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Abstract

The Autonomous Relational Self- Confucius and Beyond

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Through this thesis I will posit an abstracted Confucian model of relationships to help frame the influences that impact a patient during end-of-life decision making. The clinical ethics surrounding decision making in medicine are complicated, and get increasingly more so in end-of-life care contexts. First I will evaluate a facet of Western clinical ethics, autonomy- its importance, its current formulation, and its pitfalls. To resolve the issues raised I will employ scholarship from the fields of Relational autonomy. To further the understanding of the self and one's relationship in the context of autonomy, I will employ the five Confucian relationships and concepts of self-cultivation, and benevolence. Finally, I will rework concepts from the above disciplines to create a model that is inclusive and applicable for modern day clinical practice.

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Table of Contents

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1. On Autonomy

Autonomy is one of the four seminal principles of clinical bioethics. Our current understanding of the practice of autonomy in clinical settings is posited and to this day greatly shaped by Beauchamp and Childress work in 1979. Scholars have often cited the inclusion of autonomy as one of the main principles as a pushback against paternalism that was rampant in the medical field (Genius, 2021). Furthermore, it protects the individual's right to choose and is grounded in modern day prioritization of liberty.

The concept of autonomy can be traced far further back than 1979. While there is evidence of examples of autonomous decisions in antiquity it was not posited as a principle (Saad, 2017). During the

enlightenment, Rousseau and Kant begin to develop a new bedrock for morality, one that isn't tied to appeal to the divine. Autonomy as a personal and political idea starts to take root.

Rosseau's autonomy asks that the individual be free from a coercion and external influence. Neuhouser (2011) details that Rosseau's conception aimed to center the individual in decision making process, making the individual his own master assuring his liberty. However, Rosseau was careful to balance the idea of individual liberty with equality of citizens, to ensure that society did not fall into anarchy. His goal was to ensure that while an individual retained dominion over themselves, they did not attain their wants through harming others. Rosseau adopts a pragmatic approach in hopes of redistributing power to the individual and still allows for collectivist contractualism (Saad, 2017).

Kant's conception of autonomy differed from Rosseau's, favoring a rational construction in lieu of pragmatism. Kant posits in *Groundwork of the Metaphysics of Morals,* "the idea of the will of every rational being as a will giving universal law". Tauber synthesizes this view stating that human will is autonomous because it possesses the ability capable of self-determination in line with moral law. Kant believed that humans had the ability to abstract from their own perspective to better align their desires to the universalizable moral principles that he posited (Elsner & Rampton, 2022). There are many criticisms for Kantian conceptions of autonomy [1], with the two most prevalent being in relation to its lack of practical applicability as well as this conception being highly individualistic.

Rousseau and Kant developed the basis for autonomy in political theory, but this principle meets mainstream medical contexts in the middle of the 20th century during the Nuremberg trials. The justification of furthering of science was used by the Third Reich to conduct horrific scientific

1. Saad, 2017. Distinguishes further between practical reason versus pure reason and how the former is a more realistic conception of autonomy

experiments on the people held in concertation camps. The Nuremberg Code posited thereafter, includes a condition for consent of the participant when participating in research. However, this principle doesn't carry over into the practical world. It does not prevent gross misconduct in the American medical research space over the next few decades (Operation Sea Spray, Project Shipboard Hazard and Defense, United State Public Health Service Untreated Syphilis Study as Tuskegee to name a few).

American autonomy in the medical space began to take root due to the changing political landscape. The Nixon administration pushed forth ideas of reproductive freedom, civil rights, as well as a bill entitled the National Research Act (a direct response to the outcry at the reveal of the USPH Tuskegee study) (Gilbert.S, 2024). Additionally, the establishment of academic groups, like the Hastings Center and the Kennedy Institute, and prominent academics, like Paul Ramsey, brought the idea of consent to the forefront of the collective conscious.

Beauchamp and Childress publish the first edition of the *Principle of Biomedical Ethics* against this backdrop (Gilbert, 2024). While many contributed to the development of autonomy and other key principles, Beauchamp and Childress codified principles comprehensively and simultaneously resolved a lot of the issues present in earlier iterations. Their goal was to generate a system that was descriptive and did not "fetishize a single type of theory or promote a single principle over all others" (Beuachamp & Childress, 2019). This book was the first to address the medical field, instead of focusing on specialized issues, and one that was rooted in a secular conception of morality and is thus widely considered the starting point of clinical bioethics. It is still used as a part of medical education curriculum to this day. This seminal text is where I will begin my evaluation of the conception of autonomy in clinical settings.

Beauchamp and Childress define autonomous individuals as those who "act freely in accordance with a self-chosen plan, analogous to the way an autonomous government manages its territories and

sets its policies" (Beauchamp & Childress, 2021). Of the four bioethics principles, more often than not, autonomy emerges as paramount (even though Beauchamp and Childress insist it does not have "moral priority over the others"), laying the foundation for the protection of the other three principles- beneficence, non-maleficence, and justice. Grounded in Kantian philosophy that asserts people have intrinsic and unconditional worth, western autonomy seeks to protect the power of the patient to make decisions for oneself and exercise one's capacity for self-determination. (Varkey, 2020).

In evaluating the metrics used to gauge whether an individual possesses autonomy versus the ability of a capable individual to practice autonomy, this argument will focus on the former. The latter is a question that can be better answered using scientific data, a question that relies on evaluation of cognition primarily. That is beyond the scope of this paper. In assuming that an individual has the ability to practice autonomy, the former question takes center stage- how do we ascertain whether an individual is free from outside influence and coercion. This is the question that Beauchamp and Childress aim to answer as well.

Autonomy in the medical setting asks of three conditions from actors: to be intentional, to act with understanding, and to make decisions voluntarily. To be intentional, an action must correspond to the patient's perception of the act. For a patient to act with understanding they must have comprehension about the situation and be able to rationally gauge the merits and demerits of the choices presented. For the patient to be voluntary, they must be able to act free from controlling influences that modify their actions (that is "free of an external or internal state that robs them of self-directedness") (Beauchamp and Childress, 2021).

Earliest conditions of autonomy have posited that autonomy requires freedom from controlling influences. One might think of abusive partners, restrictive laws, religious constraints; but this list is non-exhaustive and highly subjective. The key distinction in understanding influence from individuals as

impeding autonomy is to determine whether the influence is controlling in nature or not. First, we must characterize ‘influence’. According to Beauchamp and Childress external influence (which is the scope of their argument) can be categorized into three buckets- coercion, persuasion, and manipulation. Coercion is characterized by an intentional credible threat that displaces a person's intended course of action. Persuasion is characterized as an appeal to rational reasoning, merit as opposed to an appeal to emotion. Manipulation, a “generic” term, is defined as “swaying people to do what the manipulator wants” such that the tactics used aren’t persuasive or coercive. Withholding of information, lying and exaggeration are intuitive examples posited.

Not all influence infringes on autonomy. Controlling influences however are incompatible with the condition of ‘voluntariness’. However, the model fails to note which kinds of influences are controlling in nature. One can extrapolate that coercion would be considered controlling, and perhaps some forms of manipulation but the specifics of how to discern on a case by case basis is never posited. To answer the question of ‘control’ Beauchamp and Childress state that ‘resistance’ is the key - can this form of influence be rejected or is it welcomed? This characterization is not further explained.

While the aim of Beauchamp and Childress seems to be to allow for positive influences while protecting patients from negative influences, they do not tackle the gray area of ‘control’, leaving the reader with a model that cannot be easily applied to a real life scenario.

Consider, for example, a patient who is being treated for a debilitating terminal illness and is hesitant to seek treatment. Their primary caregiver, the insurance holder, is also the only stream of income for this patient and thus the primary financial support. In case one, an expensive treatment option is put forth to the patient. The treatment has a high copay and the caregiver is worried about the financial burden that it would pose. Should the caregiver state that they will not continue to provide

support, both financial and emotional, should the patient pursue this option we would feel confident in our characterization of this being a coercive influence as a threat is being utilized.

However, consider the far more likely scenario that the patient informs the provider that they intend to decline the treatment that they want because they believe the caregiver simply cannot be an emotional and financial aid simultaneously. It is not clear right away whether this decision is autonomous. Under the model we do not understand how to categorize fiscal constraints or rather the influence they exert as controlling or not. To apply the Beauchamp and Childress model to test for control is it clear that there is no threat being made so it cannot be coercive; it isn't persuasive for logical reasoning isn't being employed. That leaves us with the catch- all 'manipulative' bucket. It is uncertain whether the insurance company should be deemed 'controlling,' and whether this version of 'control' should be considered a negative influence. A surface level answer might posit that the patient is making a simple trade off- treatment for finances, a tale as old as ~~time~~ capitalism.

However, on looking further, there is the question of the caregiver. We must determine whether the caregiver's emotional and financial bandwidth a factor that influences the patient. It wouldn't be fair to categorize these constraints that lie outside the patient as internal (that is based on the patient's *perception* of the situation) for the constraints are rooted in measurable data- a cap on insurance, the money in one's bank account, the number of hours in the day, the time it requires to be a full time caregiver. It wouldn't be fair to categorize this consideration as anything but an influence- after all the caregiver is an individual impacting the patient's decision, even if they aren't explicitly voicing an opinion. The caregiver isn't manipulating the patient, nor are they engaging in coercion or persuasion. When evaluating 'control', the caregiver's realistic emotional and financial capacity isn't a factor that a patient can 'resist'. Is the caregiver infringing on the patient's autonomy?

There are two key problems with Beauchamp and Childress' model as shown above.

1. While there is an acknowledgement that influences aren't all bad the qualities of positive influences are never highlighted. Persuasion, which is the only category of influence that is not negative, rests on belief being brought about by "the merit of the reasons another person advances". What do we make of influences that are not explicit statements but acts of care and love (an example that Beauchamp acknowledges is a kind of influence)? Furthermore, how do positive influences factor into the intentional-understanding-voluntary model?
2. The lack of a robust definition of control further complicates parsing through influences that infringe on autonomy, and influences that don't. As Marceta (2019) states human beings are social creatures and there exists no state in which humans are free of controlling influences. Marceta argues by the reality of living in a society with constraints humans are constantly subject to controlling influences, so our conception of autonomy cannot rely on the negation of controlling influences. It calls for an "ideal" version of autonomy that cannot be realized.

    This statement is well exemplified in the hypothetical case laid out above. The caregiver does not explicitly state an opinion, but by virtue of their proximity to the patient they are a source of influence. If one can act in a patient's best interest, and still be infringing on a patient's autonomy through the 'control' they exert on a patient's life perhaps the definition of 'control' is not comprehensive in evaluating if an influence is infringing on autonomy.

Even if we were to waive the financial constraints in the above mentioned example, a patient making a decision based on the emotional state of any individual to account for an existing bond would render virtually every decision non-autonomous. Individuals do not exist in a vacuum, any individual in a healthcare setting is interacting with a slew of individuals- loved ones, providers, other patients, insurance representatives, the government representatives (who by extension control the laws that

control the patients care) to name a few. There are factors that exist outside of the patient that influence, either overtly or covertly, their decision making.

If a doctor decides to operate in the morning instead of the afternoon as they have other commitments, even if the patient strongly prefers to be operated on in the afternoon it is ambiguous whether we would categorize that constraint as a controlling influence. If a patient chooses to forgo care to spend the last few months of their life with their child, it is unclear whether the child's emotional dependence is a controlling influence. After all, the child is an external influence that is robbing the patient of their "self-directedness" by this measure. Intuitively this statement makes little sense. One could argue that the bond between the patient and the child not an integral part of the patient's 'self', and to factor in this relationship is to make a decision that prioritizes the 'self'.

To truly fulfill the western conception of autonomous decisions would have to be made independent of all people and structures. Short of an individual that exists in a vacuum this would be impossible, individuals that live in a society are influenced greatly by their circumstances. The discernment of influences as 'good' and 'bad', or 'controlling' and not becomes tiresome quickly and doesn't provide a clear path forward. Through this characterization of autonomy, one that is individualistic and arbitrary separates the 'self' from their surroundings, Beauchamp and Childress' model provides little navigation for the realities of end-of-life care.

2. On relational autonomy

Unlike Beauchamp's model of autonomy that emphasizes the hyper-individualistic conception of the self, relational autonomy recognizes the importance of intimate relationships during one's decision-making process. Relational autonomy aims to "maintain the essential aspect of autonomy, namely

control over one's life, while at the same time, incorporate insights of a socially embedded notion" (Virseda, Gastmans, BCM ethics, 2019). The incorporation of socially embedded notions allows for the patient to hear other perspectives, use them as a tool in the decision-making processes, but ultimately retain the ability to veto decisions. Donchin too states, "Crucial to the reformulation of autonomy is a positive conception of human agency that recognizes relational experiences as an integral dimension of individuality" (Donchin, 2000). In formalizing the role of relationships of the individual, relational autonomy bridges the gap between atomized autonomy and the existence of the self in the context of relationships.

Viewing the 'self' in the context of relationships becomes increasingly important when looking at end of life care settings. Dove et al. (2017) maintains, "relationships (with family, community and society), responsibility, care and interdependence are key attributes of relational autonomy: people develop their sense of self and form capacities and life plans through the relationships they forge on a daily and long- term basis" (Delgado, 2019). By virtue of proximity and/or shared values relatives often share their perspectives with the patient. Donchin points out that for an ailing patient, who is often faced with feelings of inadequacy brought about by the inability to be self-sufficient, separating out relations and stressing the atomized isolated view of the individual can be psychologically taxing. Additionally, these feelings of isolation are exacerbated for disadvantaged populations as patients with intersectional identities often face hurdles when advocating for themselves in the health care system. Patients might be dependent on their caregivers, especially when terminal, even while preserving mental and cognitive functioning.

Furthermore, relational autonomy has been posited to help alleviate conflict in clinical settings, with mediation not only helping the patient physician relationship but also helping the patient and their relatives communicate with each other. A study conducted by Laryionava (2021) showed that in high-

stress settings, a patient's family played a significant role in the ease of treatment. A supportive family, whose goals align with the healthcare unit and patient, could go on to facilitate discussions and help manage treatment decisions. For patients whose families didn't agree with the course of treatment there was additional psychological burden experienced by the care team, the family themselves, and the patients. Respecting relational autonomy requires physicians to broaden their perception of respect for the patient, to include their networks and social connections (Delgado, 2019) but seems to have many benefits for the patient and healthcare team as a whole.

The theoretical appeal of relational autonomy is strong, but a push back is often the inability to adequately implement it in clinical settings. We see foundations that support its inclusion in a limited scope at present, and new models emerging that suggest it might not be as far-fetched to incorporate in end-of-life care settings. The substitution of kin in lieu of an individual for example is already present in current western autonomy practice; it is simply employed in very specific scenarios. If a patient is declared unfit due to cognitive decline, their loved ones are charged with medical decision-making power. If their kin are declared unfit, the state is given the ability to make decisions on their behalf. We see how decision-making power is given to kin, should an individual be unable to do so. This is done as we believe that these individuals would be best able to make decisions for the patient- be it because of familiarity, a shared set of values, or the patient choosing to have them in their lives. Relational autonomy posits that decision making can be supported by kin before the loss of cognition, pushing for a set up that is closer to an inclusion of the kin unit instead of merely a substitution.

There are current models that put forth broader structures that would allow for a greater stress on communication that could be utilized to build towards more widespread relational autonomy. One example is the Collaborative Care Model (CCM). This framework, developed for the mental health space by Thota, functions around five keystones: patient-centered care, population-based care, measurement-

based care, evidence-based care, and accountable care with continuous quality improvement. A team of healthcare providers, from multiple disciplines, work together with the patient to achieve a shared goal. While this might not sound novel, the set up prioritizes explicit communication and prevents clinical siloing- where interests and beliefs of each party (physicians, nurses, researchers, counselors) reduce effective communication. This system acknowledges the importance of weighing the perspectives of numerous healthcare providers and allows for negotiation to occur with the patient centered and an active part of the discussion. Facilitating communication in this vein tackles an aspect of relational autonomy, by recognizing and incorporating systems to ensure the patient-provider relationships are in alignment. However, while this model like many others allows for the balancing of interests between the healthcare unit, there isn't one to balance the interests of the patient alongside their close relationships, or kin unit which is key to a model that truly embodies relational autonomy.

Michael Rubin's model builds on the patient provider relationship. He proposed the Collaborative Autonomy Model that provides a step-by-step model to facilitate shared decision making between the physician and patient. This model serves as an alternative to a paternalistic model or an isolated autonomy model, by acknowledging the role a patient plays in their own kin unit. The role of a patient is not static- while they are a patient, they continue to be someone's partner, someone's parent, someone's child. By acknowledging this aspect of the patient, their chosen responsibility to their kin, healthcare teams can help better serve the patient. While this model can vary depending on the medical intervention, Rubin posited that there are three 'first' steps involved in any shared decision making: 1. A purpose statement and introductions regarding the relationship to the patient 2. A shared understanding by all members of the medical diagnosis 3. A description of all viable care options, including but not limited to standard of care.

For example, for a patient with a terminal illness their healthcare team would typically entail physicians from different specialties, nurses, social workers and/or religious figures, pain management specialists, physiotherapists/occupational therapists. Each of these providers is assisting the patient in an aspect of their treatment, but they all have vastly different trainings, and different durations of time with the patient. Not every provider will know 1. The patient's goals for their overall wellbeing and 2. The way other providers are realizing the patient's goal. Through this model the patient would be able to define their goals and considerations to the providers, and the providers would be able to do the same for the patient. Providers would also be able to better understand how their goals are similar or different than their colleagues. Following the establishment of the patient's goals, different treatment options from different providers can be proposed and negotiated. Considerations proposed by a surgeon can be reconciled with considerations proposed by a Chaplin. This framework allows for the patient's goals to be the overarching driver that all the providers then work to realize. Furthermore through these negotiations each provider will get a better understanding of how each member of the team is contributing to the treatment plan and how they contribute to the shared goals of the team.

There are many benefits to the collaborative autonomy mode. It builds on the collaborative care model by providing structural guidelines that would aid a team tackling negotiations. Sudgen's model of team reasoning (2003) can be used to reinforce the benefit of the structural guidelines provided by Rubin's model. Sudgen states that when 2 or more parties are engaged in negotiations the question of "what should we do" is far more beneficial than an individual conception ("what should I do, given my beliefs of what others will do?"). Using game theory, Sudgen shows that assessing consequences of a strategy for the team as a whole proves to be far more beneficial for all the players; they engage in a 'cooperative' dominant strategy to maximize their good outcomes. Additionally, Sudgen notes team reasoning is only successful when an individual identifies with the team and the common goal. Serendipitously Rubin's model stresses the need for a shared understanding of the team's goal.

The collaborative autonomy model shows us that a version of relational autonomy is already being conceptualized in current clinical ethics. However, there are two pitfalls with this model. The first is contained into the model itself- the kin unit negotiation method has still not been set up as a part of the communication process. While honing the communication of patient-provider relationships accounts for a percentage of the relationships that a patient is encountering, it doesn't address significant relationships of the kin unit. This model doesn't explain what role the patient's kin plays and how their expertise (on the patient!) figures into decision making.

The second issue with the model is one that extends to the conception of relational autonomy as a whole. It is quite possible that in the healthcare unit or the kin unit there are individuals who are negatively influencing the patient. Beauchamp and Childress' model discussed at length the impact of negative influences, and relational autonomy discussed the positive influences. However, we are yet to come across a model that allows us to separate the negative influences from the positive influences.

While relational autonomy elucidates key principles of shared decision making it fails to explain how one can parse through the different influences and prioritize them. While a patient is relational, not all relationships are 1. Beneficial and 2. Equal. The weight given to a partner's opinion might be different from that of one's grandparent. The reality of moving away from cis het relationship structures as the default (moving away from paternalistic structures that emphasized ownership and thus impacted who could make decisions and whose opinions mattered) means that one must be able to decide which relationships are truly helping reinforce their autonomy and which one's aren't. This is no small task and requires us to have a better understanding of how we view relationships, and how they factor into our conception of self.

3. **The Confucian self**

The reality of being a human in society is that we exist in relation to those around us- that is we only develop a sense of 'I' through our interactions with influences outside of 'I' (Herbert Mead). Mead details how behavioral acquisition is greatly impacted by social conditions that in turn impacts the self. There is a two-pronged exchange of information occurring throughout this process of acquisition- 1. where an 'attitude' is communicated to an individual by another, 2. while simultaneously the individual is communicating attitudes within themselves. The first process leads to, as Mead says, 'the attitude of the other', another person's behavior being incorporated into the individual's repertoire. Mead concludes that in the second process, the internal communication is used to fine tune information received through the first process. That is to say all attitudes are founded on the bedrock of the 'attitude of the other'. There is no 'I' without the social interactions that we experience. (Northrup, 1995, Autonomy of Otherness).

The Confucian conception of the self differs from the western autonomous conception of the self, and is more in line with Mead's attitudes. Confucian philosophy at its core is a relationship oriented system, as opposed to the western conception that "views human beings as abstract, individual selves" (Wang, 2002). The Confucian self is intertwined and inseparable from the five relationships, the core social relationship that forms the basis of civilized society (*wu lun).* There is no 'self' described in this system independent of these relationships: ruler-subject, father-son (parental), husband-wife (marital), elder sibling-younger sibling and friend-friend.

These relationships are a key part of ritual (*li)*, duties that an individual must partake in to engage in the act of self- cultivation (*xiushen)* or the betterment of oneself. Rituals are acts that help set an individual on the path of self-cultivation, which allows an individual to "become receptive to the symbolic resources of one's own culture and responsive to the sharable values of one's own society" (Tu, 1985). Without engaging in one's ritual duties, a person fails to engage in the act of self-cultivation which is crucial to being a 'distinguished moral person' (*junzi)* . Confucian thought acknowledges that the importance of relationships to one's own morality is crucial as one's humanness stems and sustains from the cooperation from one's family, community, and state.

Additionally, to reap the true benefit of the mutually beneficial relationships, both parties must fulfill their duties (Herbert, 1987). The two main reasons for this principle lay rooted in the push for interdependence and a sense of reciprocity posited by both Confucius and Mencius, as well as the inclination of man to be benevolent towards his fellow men *(ren)* (Herbert, 1987). In behaving righteously, with respect for the relationships, the accountability would motivate individuals to continue their own moral self-cultivation. This self-cultivation incorporates principles of care for community and relationship into its framework. For if a ruler isn't fulfilling his duties and his obligations as a ruler, he will not contribute his best to the relationship preventing the subject from reaping the benefit. For the subject's identity as a subject, is tied to the necessary existence of the ruler. Without the ruler, there is no subject and vice versa. To paraphrase Fingarette, without engaging in ritual there is no self. The five relationships thus are crucial to the realization of the self-according to Confucian thought, an

idea diametrically opposed to Beauchamp's conception of the autonomous self yet well supported by Mead.

The link between the self and ritual is further reiterated by the relationship between ren and the cultivation of the moral person. Ren, that is humanity or benevolence, asks the 'moral person' to cultivate the self through harmonious relations with community, and with nature' (Gardner, 2014). The reason behind this is that benevolence is a necessary component in recognizing, understanding, and growing one's own morality. Benevolence nor humans can sustain in an isolated vacuum. Confucian thought acknowledges not only 1. The reality that our own sense of self is cultivated by our surroundings and our community but also 2. Morality is a practice, not a theory- the ability to live a life in line with one's belief, in this case benevolence, can only be gauged when one interacts with society. At its core Confucian thought stresses that the moral self is tied to its relationships.

There is a discourse surrounding the negatives of the relational self, that is the self obligated to play a certain role to maintain the harmony. Wei-Ming Tu argues that while these relationships are rightly criticized for their underlying patriarchal and authoritarian bend there is benefit to viewing the self as "an open dynamic process..an ever expanding network of human relationships."[5] Of the twelve basic virtues detailed in Confucian thought, the rigidity of ritual *(li)* is balanced out by benevolence *(ren*), loyalty (*zhong*), affection *(ai*), xin (t*rustworthiness*) and he (*harmony*). Collective societies are often said to prioritize the good of the community over the good of the individual, but I believe that the good of the individual and the good of the community are intertwined and inseparable in Confucian thought. I believe that when there is adequate self-cultivation from all members of a social group support and

strengthen one's own morality but the relationships themselves as they are currently detailed in this millennia old text are outdated. By emphasizing the importance of social bonds and harmony (he), we are invited to consider a system that allows one to lean on friends and family in times of crisis- be it a crisis of faith, an economic crisis, or even a crisis in one's health.

4. The proposed model

To abstract the main principles posited by Confucius to account for a multitude of relationship structures and do away with the prescriptive bend in the *Analects,* I propose we categorize relationships using two factors 1. The degree of integration between the participants 2. The power dynamic between the participants. These two axes intersect to allow for relationships to shift between the quadrants to account for the subjective nature of each individual's relationship.

The integration of participants refers to the degree of dependency between participants, and how that shapes one's constitution of self. The degree of dependency can be influenced by many factors- proximity, alignment of moral values, effective communication, to name a few. On a spectrum of 'Me and You' to 'We', participants might be between one extreme of separate entities that share experiences and perspectives but do not feel their personhood connected to each other as opposed to the other extreme of having

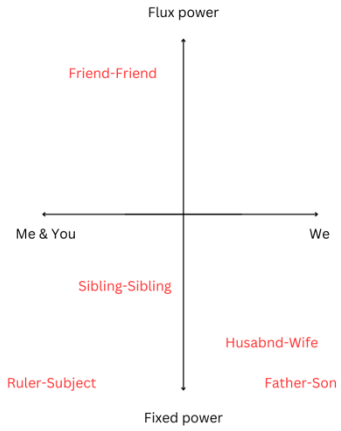

Figure1. The following figure posits the new model proposed overlayed with the Confucian relationships (in red). The axes represent a continum of power and relational integration. The Confucian relationships are placed to exhibit how the power hierarchy in the Confucian model is enforced more stringently- a facet the new model seeks to revise.

one's identity shaped and defined in part by this relationship. 'We' is a relationship that influences the constitution of the self greatly, be it through value formation (a person you consult in times of moral crisis), through decision making (a person you factor in as your decision will impact their lives drastically), etc. A 'We' configuration might mean that the absence of this person in your life would fundamentally change the way you perceive the world and yourself. A 'Me and You' formation is where a majority of relationships lie- though the degree of intensity, the influence, would change depending on the involvement of this person in your life. A casual interaction you have with a stranger would be 'Me and You'- two individuals interacting in a specific state (a place and time) with the sharing of information underway. The individual's sense of self is not deeply connected to the other. A 'Me and You' formation can be more intense, two individuals who choose to meet every week for a few hours. Their relationship might be deeper than the first scenario (though not necessarily), but their conception of the self is not greatly dependent on this dynamic.

I shall refrain from firmly planting any relationship on any extreme for each relationship is deeply personal. As an example, for an individual John Doe, who is estranged from their parents and has lived with their partner for 15 years, their partner relationship is a 'We' and their parents are a 'Me & You' and their friends as somewhere in between. Another example might be an individual who is working towards a specific professional goal with the help of a mentor, their identity formation is so intertwined with this goal that their mentor inhabits a 'We' space whereas their partner might be closer to a 'Me and You'.

The power dynamic of participants refers to whether there is an ever-present hierarchy in a relationship or a relationship where the power fluctuates but tends to net neutral. This is an

important factor to consider when evaluating the way a relationship impacts our constitution of self. A relationship that has both individuals on a net neutral playing field (that is power might fluctuate in interactions but tends to a fairly equal state) will lead to a very different relationship dynamic- be it through communication, the ideas shared, the actions one might take, the constraints- than a relationship that is hierarchical with one party holding the ability to exert considerable influence over the other. On a scale of 'fixed' to 'flux', we would typically think of institutional relationships on one end (state and the individual) as opposed to relationships that are constituted of a give and take or power sharing.

These two categories are important to help understand our own self in the context of our relationships. By understanding the power dynamic and integration relationships possess we protect our own place in these dynamics. By acknowledging the nature of the relationship, we can better account for the importance and priority we ascribe to these relationships. This can help make meaning of relevant influences (for examples ones that reaffirm a 'We' or ones that are hierarchical in ways that they constrain our options) and ones that are not as relevant in the context of end-of-life care decision making.

To help categorize relationships into 'We' or 'Me+You' and 'Power' or 'Flux' I posit six (non-exhaustive) categories or metrics to evaluate relationships- care, investment, depth of knowledge, communication, ability to deal with friction, and flexibility of hierarchy. The goal of the categories is to abstract commonly observed facets of relationships that would distinguish casual relationships from foundational identity affirming relationships. These categories can help one determine where one's relationship falls on the axis of integration and the axis of power.

1. On Care: this factor refers to the amount of patient-centered emotional reaction an outside party might have in the patient well-being. For example, a person who feels deeply unsettled or deeply joyful regarding the patient might hold more importance than someone who doesn't feel as much emotional involvement. An individual in a Me and You configuration might feel sadness, or even great sadness depending on the proximity of the connection at an individual's diagnosis. However, that is distinctly different from a patient's diagnosis shaking the foundation of the way one views the world and their place in it, as a direct result of the patient being in crisis. In an intimate relationship care might show up as being shaken at the perception of the patient's diagnosis, whereas a causal relationship might experience distress rooted primarily in the unpredictability or uncertainty of life.

   While these emotional states do not have to be explicitly communicated to the patient, the patient's perception of the care in the relationship would impact their own categorization of a relationship as 'Me and You' versus 'We'.

2. On investment: this factor refers to the idea of joint projects that the party might have with the patient that might be abstract or concrete in nature. For example, a patient who has shared goals or ideas that require both the patient and participant would factor into a decision more than a person who doesn't have a shared investment with the patient. An abstract project might be in the form of commitments-to spend a lifetime together, to aid someone in their learning process. A concrete project is rooted in the

material- a mortgage on a house, a small business, a community garden. The abstract and the concrete projects can coexist in the same relationship. The importance of the project, or the number of projects, or both, might influence the investment an individual and patient feel with each other.

3. On depth of knowledge: How much does the party know about the patient, and how does this interact with the patient's needs. For example, a patient might value a person who understands or predicts their emotional states over a person who has mere factual knowledge of a patient. Typically, depth of knowledge is a result of repeated interaction, or at the very least substantial time spent together. This recognition and anticipation of a patient's needs by the individual can help discern intimate relationships from surface level relationships.

4. On communication: the extent to which both parties can express their ideas freely might influence the relationship categorization. For example, a person might have a closer relationship in a dynamic where they can express themselves freely. This category heavily favors relationships that have a flexible power hierarchy as opposed to one's that are more rigid. That is not to say that relationships that have less free communication are less intimate, or less important to identity formation. However, in combination with other categories, that might be the case, as much as it might not.

5. On ability to deal with friction: relationships that allow for the ability to deal with disagreement and mutually carving paths forward as opposed to relationships where one party has the ability to shut down disagreements with a trump card. Additionally, this category accounts for the space in the relationship for differing opinions and how that impacts the relationship itself. A relationship that is more intimate would probably have a higher tolerance for disagreements and conflicts than a relationship that is casual in nature, because of a higher presence of other factors, like care, understanding, investment, etc.

6. On flexibility of power hierarchy: the degree to which power is shared in a relationship, such that both parties are able to occupy a role of equalness as opposed to one party always having the upper hand can impact the dynamic of the relationship greatly.

These categories are not meant to be dichotomous in nature- they are a continuum to allow for the complex nature of a relational dynamic. Furthermore, a relationship need not satisfy every category. It is quite possible that an intimate relationship might not have a vast depth of knowledge, or explicit communication. People might prioritize these categories differently based on their own moral values and emotional needs. The goal here is to provide a framework that can aid in evaluation of the nature of one's relationships.

An example of categorization of relationships might follow as such. Take a patient who is suffering from a terminal illness. Their relationship with their older sibling is the most seminal relationship in their life. They live in the same city and have endured a lot of hardships in their

childhood together. The patient has often said that there is no one in the world who understands her better than her sister. This patient has a partner whom she has been married to for two years. They met in their mid 30's and have a happy marriage. In a current medical system, we would see that the partner relationship would take precedence over the sibling relationship. The partner would be the person to make decisions should the patient be incapacitated. However, the patient is better understood by her sister, and has had her identity formation tied more deeply to the sibling relationship. The depth of knowledge between the two relationships will always be unequal by virtue of the circumstances the siblings grew up in. To this patient, this might elevate her sibling's opinion above her partner's. When engaging in decision making the sibling relationship might be further on the 'We' configuration (more to the right) than the partner relationship.

This experience might be more common than we realize. In the current medical system and patriarchal set up of relationships, romantic love takes precedence over other relationships. Should there not be a romantic partner in the patient's life decision making power might revert to the parents, no matter the state of the relationship. This framework asks that we do not default to a relationship status quo but instead evaluate each individual's circumstance more closely to truly discern the key relationships in one's life.

This framework does not posit when this evaluation must occur in a clinical context. The goal is two-fold. 1. To allow patients to revaluate the relationships that they want to prioritize when consulting and leaning on the kin unit during terminal illnesses and 2. To allow providers to dispel preconceived notions of relationships and incorporate each individual's relationship with their kin unit as an integral part of the treatment plan. This model might provide a medium

to allow the patient to determine the relationships that are crucial during a clinical crisis and help providers better understand the patient's kin structure.

Conclusion

Autonomy is the bedrock of patient decision making. It is crucial in centering the patient's will above paternalistic medical considerations. The way we talk about patient autonomy, and characterize influence can greatly impact a patient's mental state and their decision making during end-of-life care settings. Through this paper I have aimed to show that a framework that allows for the influence of relationships is not counterintuitive to autonomy. In fact it can be helpful and reinforce autonomy. The framework is a stepping stone that bridges modern day values with Confucian ideals, to allows for end-of-life care decision making that prioritizes the self.

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