National Collaborating Centre for Healthy Public Policy

AUTONOMY PROMOTION IN A PLURIETHNIC CONTEXT: REFLECTIONS ON SOME NORMATIVE ISSUES

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LAYOUT

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The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. It is one of six centres funded by the Public Health Agency of Canada located across Canada, each with a mandate for knowledge synthesis, translation and exchange in a different area of public health.

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EDITOR'S INTRODUCTION

This paper is part of a series of essays developed for the **National Collaborating Centre for Healthy Public Policy** by researchers associated with the Centre de recherche en éthique de l'Université de Montréal (Université de Montréal Research Centre in Ethics).

The essays are designed to present public health actors with a synthetic analysis of some of the most important contemporary ethical issues associated with various dimensions of public policy that can affect population health. The essays are also designed to encourage reflection on these issues.

The present text, developed by Michel Désy, concerns the promotion of autonomy in a pluriethnic context. Autonomy promotion has become a widely-practiced activity in the field of public health, since studies have emerged showing the close relationship between individuals' state of health and their ability to exercise control over their life and their living conditions. Many vigorous ethical debates have taken place and continue to take place surrounding the general subject of this activity. However, significant changes in the ethnocultural composition of the Canadian population have generated debates more specifically focused on the implications of these changes for autonomy promotion practices. The impetus for these particular debates is the idea that autonomy is a culturally determined product (historically, socially and politically speaking).

In this text, the author first discusses the subtleties of the complex relationship between health and autonomy, situating this relationship historically within a public health context. Next, a distinction is made between two separate meanings of autonomy (substantive and procedural) in order to advance the author's proposition that health promotion should focus more specifically on procedural autonomy. Finally, four types of paternalism are identified (narrow and broad; weak and strong) in support of the idea that autonomy promotion should be guided by the principles of weak, broad paternalism, when applied to groups within which individual autonomy does not constitute as central a value as within the Canadian ethnocultural majority.

The production of these essays is intended as an exercise in reflecting on practical ethical issues in the area of contemporary public health. Productions such as these invite commentary.

Thus, in order to extend debate, the following questions may be asked with respect to this text:

Can this problem be understood differently, particularly as it relates to religious belonging, without reference to ethnic belonging?

The author chose to address the ethical issues raised exclusively through reference to the question of religious belonging. Can they be analyzed with reference to other dimensions of social belonging?

Finally, the author argues, with few concessions, for the general adoption of the principles of weak and broad paternalism. Do you think it should also be stressed that an approach based on strong paternalism can be equally well defended in ethical terms, for certain specific situations?

Use the space provided for comments on the right of the page: we will publish comments on an ongoing basis as they are received.

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INTRODUCTION

The field of action specific to public health has broadened considerably over the last century. The reasons for this expansion are complex and multiple. One of the main reasons is that the range of problems we seek to eradicate through such action is no longer—at least in what is referred to as the Western World—solely composed of infectious diseases and parasitic infections whose causes were relatively easy to identify and treat with the help of scientific breakthroughs. Today, a substantial portion of the problems being addressed by public health workers stem from people's living habits, specifically those habits considered to be harmful to people; we have only to think of obesity and smoking, for example. At the same time, measures undertaken by public health authorities to improve population health now go beyond simple prevention of the problems being addressed to include actions aimed at promoting good health. We understand well enough, for example, what causes heart diseases (inactivity, among other things), but we have very little grasp of how to remedy such problems because they are largely caused by multiple distal factors (including social and environmental factors) that influence our living habits, and these factors seem too far removed causally from said problems to be clearly isolated as *the* cause of the diseases in question. Moreover, these problems are, for the most part, the harmful consequences of activities freely engaged in by the persons concerned. This is why public health authorities are now trying, among other things, to convince such persons to reconsider their habits and adopt others that are less damaging to their health. In order to meet these challenges, health promotion is thus inclining towards an interdisciplinary approach aimed, among other things, at identifying and modifying—if necessary—the proximal and distal factors that influence people's behaviours[1].

[1] For an introduction to the concept of health promotion, see, for example, Crosby, Kegler & DiClemente (2002).

1 HEALTH AND AUTONOMY

Given this context, a clearer conception of what health promotion seeks to promote is required. At the same time, the redefinition of the very notion of what it means to "be healthy" can be seen as evidence of a shift in the paradigm defining the factors that can potentially influence people's health. Indeed, this shift was recently given concrete expression in the Ottawa Charter, whose proposed definition of health extends far beyond the classic—negative—conception of health (i.e., health defined as the absence of pathologies). The Charter stipulates that:

> "Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing." (World Health Organisation, 1986)

Health is seen here as a state of wellbeing that is at once physical, psychological and social. Moreover, according to the Charter, the preferred means of achieving this state of wellbeing and, therefore, the goal of much health promotion action, is to ensure the capacity of individuals to exercise control over their lives, to direct their own lives; in short, to be autonomous. In fact, many studies have demonstrated that individuals who have little or no control over their lives are generally less healthy than others (Cf. Rissel, 1994). Autonomy is thus seen as crucial to an individual's health. Of course, the importance of autonomy is not limited to the area of health: it is one of the central political values of liberal democracies, for quite evident reasons. Its development is also one of the primary objectives of public education. Nevertheless, it is mainly its place within a certain conception of health and its promotion that I wish to consider.

Cleary, the movement from a narrow to a broad conception of health can pose problems on many levels (Seedhouse, 1995). Among other things, a broad definition of what constitutes health is morally charged; it is clearly not neutral (see, for example, Holland's remarks, 2007, pp. 92–93). It is intuitively obvious that if, for example, the quality of our relationships with others is considered when our state of health, in the broad sense of the term, is being determined, then, inevitably, moral values come to play a fundamental role. If we focus more specifically on the central role assigned to autonomy in the broad conception of health, are we led to conclude that the health of persons who do not appear to live autonomously is therefore inevitably *diminished* as compared to that of those around them?

This is one facet of the problem I would like to examine. This problem derives from the fact that there seems to be a good number of people for whom a life in which autonomy does not occupy a central place is desirable *and* for whom this does not seem to produce harmful health effects. This is particularly true for persons who belong to conservative religious groups. In fact, there are people for whom obedience and self-denial are central values; for such people, the promotion of autonomy by public institutions may very well unduly conflict with their lifestyle. If this is true, as I maintain, then the perspective that positions autonomy

as the cornerstone[2] of health promotion must at the very least be clarified, if not substantially modified to accommodate such situations. The purpose of this text is to offer such clarification and to explore the consequences for any policy that intends—mainly or in part—to promote autonomy.

2 TWO MEANINGS OF THE CONCEPT OF AUTONOMY

How can the concept of autonomy be clarified? Part of the difficulty surrounding its elucidation stems from the fact that it has two distinct meanings (regarding this distinction, see Christman, 2003). Firstly, there is procedural autonomy, which refers to an individual's effective *capacity* to make choices, independently of the influence of others. The formulation of this definition is somewhat inadequate given the large degree to which our choices are causally (directly or indirectly) influenced by our social environment, but we nevertheless consider individuals who have ostensibly exercised this capacity to be independent, even if their choices resemble those of their peers. Thus, we generally consider that procedural autonomy may be fully exercised in the absence of undue external constraint. The second meaning refers to substantive autonomy, which is not the capacity of individuals to make choices, but rather the *quality* of the choices made. The substantive conception of autonomy is linked to the idea that there are values that *should* be upheld by individuals if they are to be considered healthy in the broad sense of the term. [3] Thus, substantively autonomous individuals make the *right* choices with respect to their lives, the choices that correctly embody what it means to be autonomous. Indeed, from this perspective, there are particular lifestyles or values that concretely express what it means to live autonomously.[4]

Let us return to the counter-example presented above. It seems quite plausible that there are deeply religious persons who choose autonomously, in the procedural sense of the word, to live lives that do not assign a central role to autonomy. Indeed, the fact that one leads a life of obedience and self-denial does not mean that one has lost the *capacity* to make choices. One might object, however, that such persons cannot choose other than to lead a religious life because they are constrained simply by belonging to a particular group, that their *culture* does not allow them to choose otherwise.

3 AUTONOMY AND CULTURAL BELONGING

In my view, this objection rests on a false conception of the nature of cultural belonging. It presupposes that belonging culturally to a particular group implies exclusivity and inexorability. However, to begin with, the idea that a culture is composed of a group of consistent and stable characteristics that *determine* its members is clearly doubtful. In fact,

[2] Not to say the *Holy Grail* of health promotion, to quote Rissel.

[3] It should, however, be understood here that substantive autonomy is necessary, but not sufficient for a person to be healthy.

[4] It should be pointed out that the distinction between substantive autonomy and procedural autonomy finds its parallel in more sophisticated definitions of health, in the broad sense. In fact, it can be maintained that health derives from a combination of factors, including the basic capacities of individuals (their procedural autonomy) and the objective manifestations associated with good health that stem from these capacities (their substantive autonomy). See, for example, the respective positions of Brülde (2000) and Tengland (2006).

as noted by Tariq Modood (1998), among others, hardly anyone can be found who still defends an essentialist conception of culture. Thus, cultural belonging does not imply inexorable conformity. Next, the idea that the cultural options available in a liberal community, for example, cannot be conceived of as accessible to members of a religious group is doubtful as well. In fact, it is clear, for example, that the members of the congregation of Grey Nuns of Montreal are aware of what life is like outside their convent. It cannot be said, therefore, that this choice is inaccessible to them, strictly speaking.

It must also be noted that, if one considers the mental health of those in religious groups, the relationship between autonomy and health does not appear to be as direct as one might have been led to believe. In fact, certain studies have demonstrated that depression rates among the Amish in the United States are half as high as those recorded for the rest of Americans (some of these can be found in Schwartz, 2000). As noted by Schwartz, American citizens have never in their history had so much choice and, paradoxically, they do not seem to benefit psychologically, but rather the contrary (Schwartz, 2004). This is another facet of the idea put forth by Jeff Spinner-Halev, who notes that conservative religious communities may offer fewer choices to their members, but that these choices may be perceived as being more significant than those available in a liberal community (Spinner-Halev, 2000).

It should not be understood by this that we should all join closed religious communities to improve our mental health—after all, the data on the prevalence of depression among the Amish do not include, for example, those who had to leave the community for all sorts of reasons—but rather that the internalization of choices is a complex phenomenon that should be taken into account when considering health promotion. In fact, these observations allow us to underscore a fundamental point regarding autonomy: it cannot be promoted in isolation from other elements that are fundamental to its exercise. It might be added that the difference between a religious group and a liberal community lies in the level of support and solidarity they usually provide. This intuition is confirmed by studies on self-determination, which have demonstrated that it is not so much the source and the objective quality of a person's choices as the support received while these choices are being made that positively affects a person's wellbeing (Ryan & Deci, 2000).

This leads us to observe that the quality of the choices people make (their substantive autonomy) is of secondary importance to their health relative to their capacity to make choices (their procedural autonomy), and that, consequently, any theory that seeks to clarify the relationship between autonomy and health should underscore the precedence of procedural over substantive autonomy. This precedence is of major significance to any valid conception of autonomy promotion, and I would like to consider such a conception here[5].

[5] Perhaps it should also be maintained that a valid conception of health promotion should, similarly, assign priority to the strengthening of the capacities crucial to health over the quality of the effective choices made by the individuals concerned. Exploration of this idea, unfortunately, falls outside of the scope of this paper.

4 WHAT IS AUTONOMY PROMOTION?

What form should a conception of autonomy promotion take, particularly if it must appear justifiable to those who do not consider it to be important? The main issue at stake here is that of paternalism. Determination of the level of paternalism considered acceptable in interventions by a state in the life of its citizens is a classic normative problem in the public health field (Cf. Childress et al., 2002 ; Bayer & Fairchild, 2004). What is generally implied by paternalism is the idea that the state is justified in obliging individuals to act in their own interests when it is apparent that they are going to behave in a manner that is harmful to their health. Paternalism stems from the idea that it is necessary to intervene to protect individuals from themselves. Clearly, situations exist in which such interventions are justifiable; when, for example, the individuals do not have the capacity to make informed choices (as in the case of children) or when the restrictions placed on individuals are, broadly speaking, negligible (as in the case of mandatory seat belt wearing). However, in the relevant literature, paternalism, as briefly defined here, is often rejected for the simple reason that its proponents are not able to morally justify the proposed constraints on the freedom of the individuals concerned, especially to the extent that these constraints are coercive.

5 PATERNALISM AND AUTONOMY

It is useful to distinguish four types of paternalism. Firstly, “strong paternalism” is the view that the state can legitimately prevent persons from acting in a manner that is contrary to their own interests. “Weak paternalism” is the view that the state should seek the informed consent of persons given to such practices, rather than attempt to oblige them against their will to act in their own interest. “Narrow paternalism” is limited to the use of coercive mechanisms and “broad paternalism” includes all possible relevant forms of intervention. The position compatible with the conception of autonomy and its promotion defended in this text is that of weak and broad paternalism.

Weak paternalism is congruent with the conception of autonomy promotion defended here because by seeking above all to ensure the consent of individuals, it assigns priority to the informed exercise of the capacity to make choices, and not to the quality of the choices thus made. Weak paternalism depends, above all, on the capacity to give one’s consent, on the absence of unacceptable coercion (extortion, threats, physical coercion), and on assimilation of the information relevant to the exercise of a choice[6]. Weak paternalism is thus very useful in cases involving religious or cultural practices that large numbers of people who do not belong to the groups concerned may consider in some way or other reprehensible. In fact, we tolerate a large number of practices when they respect the conditions established under weak paternalism (think, for example, of certain sexual practices like S&M and swapping). What is important to recall here is that weak paternalism is compatible with the idea that individuals may autonomously choose to limit their own autonomy.

[6] In fact, as noted by Joel Feinberg, weak paternalism is not really paternalism as it is generally understood, because it does not seek to justify restricting the exercise of autonomy by individuals in the interests of their wellbeing (Feinberg, 1986, pp.15–16).

Broad paternalism opens the door to the use of an interesting range of potential actions other than coercion. Nuritt Guttman (2000) has identified the strategies that are generally used in the field of public health: apart from coercion, we find environmental strategies, incentives, persuasion, collaboration and facilitation. In the case being examined here, it must be emphasized that if weak and broad paternalism is the approach adopted, then coercion must be removed from the list of strategies, whereas the other strategies are legitimate[7]. Thus, we can envision a variety of strategies involving incentives, collaboration or facilitation (these are in fact the strategies preferred for "empowerment" initiatives) aimed at promoting autonomy.

6 AUTONOMY, PATERNALISM AND ADAPTIVE PREFERENCES

One objection to broad and weak paternalism can be expressed through reference to the problem of adaptive preferences. The concept of adaptive preferences refers to the idea that we all have a tendency to choose what is relatively accessible to us and not to choose what is not so accessible. The relative inaccessibility of certain choices may itself "constrain" some people to accept lives that are contrary to their wellbeing. The classic example of the problem of adaptive preferences is that of the status of women living in countries where their autonomy is not valued who themselves internalize this value system and consent to lead a life that is not autonomous (Nussbaum, 2000). Part of the solution to this problem has already been evoked. Such constraint cannot be attributed to the culture itself of individuals because the idea that we are "acted upon" by social regularities is meaningless. In part, the answer to this problem can be found in the conceptions of autonomy and weak paternalism that have been presented here.

Firstly, as I have maintained, the idea that autonomy can be promoted in isolation does not make sense. The solution to the problem of adaptive preferences necessitates a conception of autonomy promotion that includes several accompanying measures aimed at ensuring its success. Martha Nussbaum, emphasizing this point, states that autonomy promotion must be accompanied by other elements in order to be effective. These include, in particular, physical and psychological integrity, the absence of coercion (which is consistent with the absence of coercion demanded by weak paternalism), the possibility of maintaining significant social relationships (which is consistent with the idea that the quality of social relations is closely tied to the exercise of autonomy), the opportunity to escape from unfavourable environments, and access to quality information. Weak paternalism ensures that, provided these conditions are met and the persons concerned persist in leading a life that might be considered contrary to their wellbeing, their choice must be respected.

This, in turn, underlines the fact that the conception of autonomy promotion defended here respects the endorsement constraint described by Ronald Dworkin, which stipulates that a life cannot be fully appreciated unless it is endorsed. As the latter states:

[7] Guttman maintains that persuasion is to some degree coercive. The question of whether the strategies associated with broad paternalism are themselves on some levels coercive is an interesting one; however, it exceeds the scope of this paper.

> "Threats of criminal punishment corrupt rather than enhance critical judgment, and even if the conversions they induce are sincere, these conversions cannot be counted as genuine in deciding whether the threats have improved someone's life." (Dworkin, 2000, p. 218)

The conception I have defended here offers a solution to the apparent paradox of autonomy promotion referred to earlier in this text. It in fact proposes a way of reconciling the responsibility of institutions to protect and promote autonomy and the basic freedoms of persons who do not consider this to be important. This conception may have relevance not only for policies aimed specifically at "empowering" individuals or communities, but also for policies that may involve questions of reasonable accommodation (Dési, 2007).

Table 1 classifies various policies that address the issue of cultural pluralism in one way or another. The policies are classified according to whether or not they promote weak paternalism and according to the level of importance they assign to autonomy. Case 1 includes policies for which autonomy promotion is one of the main objectives and which employ coercive means, usually legislative measures that criminalize illiberal practices judged contrary to individual autonomy. Often these policies are motivated by the conviction that we must protect certain vulnerable sub-groups within given groups; thus, the example used in the table is the eradication of excision, but any other example of a targeted policy coercively protecting the autonomy of a "minority within a minority"[8] would have served equally well; for example, the ban on wearing the veil in public schools in France. Case 4 also includes policies for which autonomy promotion is central, but only those that do not use coercive methods. To return to the case of excision, instead of using a coercive approach, a number of initiatives in many countries have sought to reduce the abuses related to this practice and to change the conditions that cause it to be widespread in the first place; and in fact, these initiatives have generally been more effective than coercive eradication policies (see Shell-Duncan & Hernlund, 2000). Cases 2 and 5 refer to policies for which autonomy promotion is a secondary objective. This category includes social or family policies whose implementation would render illegal any cultural practice judged contrary to autonomy promotion, as defined by the policy. For example, Canada does not recognize polygamous marriages but nevertheless awards rights to women who have contracted such marriages, in cases where, for instance, they become separated. This situation contrasts with that in France, where not only are polygamous marriages illegal, but where women who had contracted such marriages and were living in France were expelled following adoption of the Pasqua law in 1993[9]. This law would be a good candidate for case 2. A policy that decriminalizes polygamy and actively seeks to award rights to women in polygamous unions would be a good example of case 5. Cases 3 and 6 refer to policies that may encroach, for potentially justifiable reasons, on the autonomy of certain cultural or religious sub-groups by prohibiting a practice that is central to the group's identity. These two categories obviously have less to do with autonomy promotion than the others, and yet, given its importance, it must still be taken into consideration. As an example, we have only to think of safety policies that impinge on the clothing customs of certain religious groups. Such a policy would be

[8] To borrow the title of the book by Enseinberg and Spinner-Halev.

[9] For more on this subject, see Campbell et al (2005).

coercive (case 3) if it invariably gave clothing-related safety demands precedence over cultural practices with which they entered into conflict; for example, the mandatory wearing of a safety hat on job sites and orthodox Sikh employees; or, the wearing of pre-determined clothing in an operating room and Muslim employees. On the other hand, if the policy was reasonably accommodating, i.e., it openly recognized the damaging effects of imposing clothing obligations on certain persons due to their inclusion in a given group and recognized that the accommodation of such persons did not necessarily constitute an excessive burden for the organizations having to apply the policy, it would be considered non-coercive (case 6).

These few considerations are aimed at illustrating, with the help of examples, the type of policy for which autonomy promotion is important. If the conception of autonomy promotion presented here is a valid one, then any policy for which it is an important goal (or even a significant concern) should opt for non-coercive methods or, as I have termed this approach, weak and broad paternalism. The central role played by autonomy in the health of individuals has been explicitly recognized in the field of public health, but if the conception presented here is valid, then 1) its promotion should be included within a broader framework of policies aimed at improving people's health and 2) its promotion cannot rely on coercive methods without invalidating itself. As a final note, it can be anticipated that policies inspired by the conception presented here would be more likely to achieve their goals than policies inspired by strong paternalism[10].

[10] An interesting parallel can be drawn between the conception defended here and the reduction of crimes related to substance abuse. In both cases, the approach advocated promotes ongoing contact between the targeted population and the public institutions implementing policies, as opposed to repression and criminalization, which, let it be stressed, have not succeeded in producing significant positive results. See, among others, Marlatt (1998).

Table 1 Examples of public policies characterized by their degree of paternalism and the level of importance assigned to autonomy promotion

DEGREE OF PATERNALISM / ROLE OF AUTONOMY	Coercive (strong and narrow)	Non-coercive
Autonomy is a principal objective of the policy.	1. Policies aimed at eradicating a cultural practice judged contrary to the autonomy of the persons concerned by making it illegal: e.g., the eradication of excision.	4. Policies aimed at improving the wellbeing of groups or sub-groups of persons through strategies such as education or facilitation: e.g., "empowerment" of women who belong to a community that practices excision.
Autonomy is a secondary objective of the policy.	2. Policies whose objective is not, strictly speaking, to promote the autonomy of the persons concerned, but that render illegal certain practices: e.g., the policy on marriage that forbids polygamy.	5. Policies whose goal is not, strictly speaking, to promote the autonomy of the persons concerned, but that make it an important goal and promote it non-coercively: e.g., family policies with a significant "outreach" program targeting immigrant communities with the intention of helping women in polygamous unions.
Autonomy is not a principal objective of the policy, but remains a concern, i.e., the policy must at the least justify the fact that it impinges on people's autonomy.	3. Policies whose main goal is to promote a given good, which in doing so impinge, through the use of coercion, on the autonomy of some of the persons concerned: e.g., safety policies on construction sites (wearing of safety hat vs. wearing of turban). Many classic cases involving reasonable accommodation fall into this category.	6. Policies whose main goal is to promote a given good, which in doing so impinge, in a non-coercive manner, on the autonomy of some of the persons concerned: e.g., policies promoting activities for young people that are flexible as to the clothing required for the proposed activities.

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