

Consent Is Not Enough

Autonomy, the Ontology of the Patient, and the Vocation of Medicine

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1.0 Consent as Moral Achievement and Moral Limit

THE MODERN DOCTRINE OF INFORMED consent represents a genuine moral achievement. Several histories converge in its development and should not be conflated. Research ethics was transformed by the Nazi medical experiments and by the deception and withholding of treatment in the United States Public Health Service study of untreated syphilis at Tuskegee. Clinical informed consent developed through partly distinct professional and legal challenges to undisclosed or coercive treatment. The common moral lesson is narrower than any single genealogy: expertise and benevolent intention do not confer unrestricted authority over another person's body. The patient or research subject must ordinarily be treated as a participant whose understanding and voluntary authorization precede intervention.¹

That correction was morally necessary, and nothing argued here proposes its reversal. Patients must be told the truth about their condition. Material risks and reasonable alternatives must be disclosed. Their questions must be answered, their values taken seriously, and their refusals ordinarily honored. Coercion, manipulation, and deception remain genuine wrongs, even when employed in the name of therapeutic benefit. The physician's judgment that an intervention would be beneficial does not, by itself, establish the authority to perform it on an unwilling patient.

Consent was therefore a necessary corrective to a paternalistic medicine that could too easily confuse professional expertise with moral jurisdiction. The patient is not merely a biological substrate upon which the physician exercises technical skill. He is a participant in the clinical encounter, and what happens to his body cannot ordinarily be decided without him.

Yet moral achievements can be asked to do more than they can bear. A principle that corrects one distortion can generate another when detached from the larger moral

framework within which it first made sense. The present criticism is therefore not that contemporary bioethics uniformly declares autonomy supreme. It is that, in many clinical, legal, and institutional settings, authorization has come to function as though it were the principal source of an intervention's legitimacy rather than one indispensable condition among others.

The resulting difficulty is not that contemporary bioethics takes patient agency too seriously. It is that agency is sometimes construed too thinly, as the capacity to form preferences and authorize their implementation. Medicine can then appear as the provision of technically competent services to autonomous consumers, while the physician becomes chiefly the professional who supplies information and executes the authorized choice.

This transformation raises three fundamental questions. First, does a patient's consent make an intervention medically or morally good, or does it merely remove one important prohibition against performing it? Second, does the patient's authority to refuse an intervention entail an authority to demand an intervention from another moral agent? Third, what accounts for the dignity of patients who cannot exercise autonomy at all?

These questions disclose a problem more basic than disputes over the application of informed consent. An autonomy principle need not claim to be an ontology, and the criticism here is not that it fails to accomplish a task it explicitly undertakes. The criticism is one of insufficiency: an ethics that makes present agency carry the decisive moral burden must nevertheless presuppose an account of the subject whose agency it is. Autonomy cannot by itself explain who the patient is, why he commands equal respect, or why his life remains morally significant when the capacities associated with autonomous agency are diminished or absent.

The patient precedes the patient's choices. He remains the patient when he cannot deliberate, remember, communicate, or consent. To understand why requires distinguishing at least three questions that are often run together: numerical identity through change, basic moral status, and authority to make a particular clinical decision. A theory may answer one without answering the others. Medical ethics therefore needs an account of personal identity and dignity that does not reduce the person to the present exercise of a function, together with an account of medicine in which professional judgment has moral content.

In previous contributions to this journal, I have argued that intrinsic accounts of personal identity are inadequate and that the individuation of persons is grounded finally in the intentional love of God.² I have also argued that vocation names not merely an occupation but a more fundamental ontological condition: the creature is called into being, relation, and responsibility.³ The present essay brings those arguments into the clinical setting.

Its central claim can be stated simply: consent is ordinarily necessary because the patient is a person, but consent is insufficient because the patient is more than a will. Medicine must honor agency without identifying the patient with agency, protect against paternalistic domination without erasing the physician's responsibility, and acknowledge that justice and the goods of medicine constrain what may be offered even when consent is present.

2.0 From Respect for Persons to the Ascendancy of Autonomy

2.1 The Moral Architecture of Modern Bioethics

THE NUREMBERG CODE PLACED VOLUNTARY consent at the center of ethical research involving human subjects, but it also imposed substantive limitations concerning scientific necessity, avoidable suffering, proportionality of risk, and the responsibilities of investigators. Consent was essential, but even voluntary consent could not legitimate every experiment.⁴

The Belmont Report likewise did not identify respect for autonomy with the whole of research ethics. It articulated three principles: respect for persons, beneficence, and justice. Informed consent was the principal practical expression of respect for persons; assessment of risks and benefits expressed beneficence; and fair subject selection expressed justice. Respect for persons itself contained two requirements: autonomous persons were to be treated as agents, while those with diminished autonomy were entitled to protection.⁵

This architecture matters. Consent was not intended to replace judgments about benefit, harm, justice, or protection of vulnerable persons. It was one indispensable element within a moral field containing several goods and obligations. The consent of a vulnerable subject did not relieve the investigator of duties to minimize harm, justify risk, and distribute burdens fairly.

The Nuremberg Code and the Belmont Report concern research rather than ordinary clinical care, and they should not be treated as the sole genealogy of clinical informed consent. Their relevance here is analogical and architectural: both make clear that autonomous authorization operates within, rather than in place of, substantive norms. The history and theory of clinical consent likewise distinguish an autonomous act of authorization from the institutional procedures by which consent is documented.⁶

A similar balance appears formally in the principlist framework developed by Tom Beauchamp and James Childress. Their *Principles of Biomedical Ethics* organizes biomedical morality around four *prima facie* principles: respect for autonomy, beneficence, non-maleficence, and justice. No principle possesses automatic lexical priority; each requires specification and balancing in concrete circumstances.⁷

The central criticism should therefore not be that principlism formally declares autonomy supreme. It does not. The more accurate claim is that autonomy has acquired practical and cultural priority in the reception of a formally balanced framework, especially where institutions can measure authorization more easily than benefit, proportionality, trust, or justice.

The competent patient's refusal of treatment ordinarily has powerful negative authority even when the physician believes treatment would preserve life or prevent grave injury. This is often entirely appropriate. Yet the resulting asymmetry can encourage a conceptual migration: because intervention without authorization is ordinarily prohibited, authorization begins to look like what makes intervention legitimate. That inference does not follow.

2.2 From Kantian Autonomy to Preference Satisfaction

The modern elevation of autonomy has a serious philosophical pedigree, but the concept has changed in transmission. Kantian autonomy does not mean unrestricted preference satisfaction. It names the rational will's self-legislation under a law valid for rational agency as such. The autonomous agent is not one who does whatever he happens to desire, but one whose maxim can answer to universal moral law.⁸

No simple genealogy runs from Kant to contemporary consumer choice. Nevertheless, modern accounts that connect distinctive moral standing with rational self-government have sometimes encouraged later theories to locate personhood in sophisticated capacities for choice. Mill's defense of liberty contributes a different emphasis: competent adults should ordinarily be free to pursue their own good in their own way, provided that they do not harm others.⁹

Within contemporary clinical culture, these more demanding accounts of autonomy have often been thinned into the idea that the patient is the authoritative source of his own values and that respect consists principally in facilitating choices formed from those values. Autonomy gradually ceases to name rational self-government and comes to name the sovereignty of preference.

Onora O'Neill has rightly warned that contemporary appeals to autonomy often lack a sufficiently coherent account of what autonomy requires. Multiplying options does not necessarily increase genuine agency, and the formal provision of information does not by itself create understanding or trust. A patient may be offered several choices and still remain frightened, confused, socially isolated, or unable to discern how those choices bear upon the life he is trying to live.¹⁰

The reduction of autonomy to choice therefore mistakes the outward form of agency for its moral substance. It imagines that the task of medicine is complete once information has been transferred and an uncoerced preference expressed. But clinical decisions are not selections from a morally neutral menu. They concern the

good and ill of an embodied person, and they are made within a relationship in which knowledge, vulnerability, dependence, fear, hope, and professional responsibility are unequally distributed.

In some capacity-based accounts of personhood, the capacities associated with autonomy assume a status structurally analogous to that once assigned to the rational soul or the *imago Dei*: they become the decisive features by which full moral standing is recognized. The analogy is structural rather than genealogical. It does not imply that principlism simply reproduces theology under secular terms, but it does disclose the extraordinary ontological burden placed upon capacities that can be absent, impaired, or intermittently exercised.

Contemporary accounts of relational autonomy rightly object that agency is neither formed nor exercised by isolated wills. Feminist, disability, and care-ethical treatments emphasize that social power, bodily dependence, family relations, material conditions, and practices of recognition can sustain or deform self-direction.¹¹ This correction matters clinically: a choice may be formally voluntary while shaped by dependency, stigma, fear, or institutional constraint. Yet relational autonomy remains primarily an account of agency and its social conditions. It does not by itself settle the prior question of why this embodied person retains equal moral standing when agency cannot presently be exercised or restored.

2.3 Engelhardt and the Procedural Settlement

H. Tristram Engelhardt Jr. drew the procedural implications of modern pluralism with unusual clarity. In a society of ‘moral strangers,’ he argued, no thick account of the human good possesses authority for everyone through secular reason alone. In the absence of a shared moral vision, permission becomes the nonviolent basis for coordinated action.¹²

The strength of Engelhardt’s position lies in its honesty. If no common account of human flourishing exists, the authorization of the persons involved appears to offer the only nonviolent basis for coordinated action. Consent becomes the bridge across moral difference. The physician need not endorse the patient’s values; it is enough that the physician disclose what he can provide and that the patient authorize what is done.

Yet a procedural settlement inevitably shapes the institutions it governs. When medicine is organized chiefly around permission, questions about what medicine is for can become subordinate to questions about who has authorized what. This is not a logical consequence of consent itself, but a recurrent institutional temptation: beneficence becomes thin, professional judgment becomes technically informative but morally reticent, and the clinical encounter begins to resemble a contract between provider and consumer.

Leon Kass and others have described one possible outcome as the transformation of medicine into a service industry.¹³ The criticism should not be directed at patient-centered care as such. It concerns a specific reduction: the physician possesses techniques, the patient supplies preferences, and ethical adequacy is measured chiefly by accurate disclosure and voluntary selection.

This picture is understandable in a pluralistic society, but it is not morally neutral. It contains an anthropology and a philosophy of medicine. The patient appears principally as a chooser, the physician principally as a provider, and medicine principally as a collection of techniques awaiting authorized use. What the picture suppresses is precisely what must now be recovered: the patient's embodied and dependent existence, the physician's continuing moral agency, and the substantive goods toward which medicine is properly ordered.

3.0 Why Consent Is Not Enough

3.1 Authorization and Justification

THE FIRST LIMITATION OF CONSENT IS NORMATIVE: consent authorizes, but it does not by itself justify. In the influential analysis of Faden and Beauchamp, informed consent in its primary moral sense is an autonomous authorization of a professional's action. Authorization changes who may act and upon what terms; it does not settle every feature of the action authorized.¹⁴

Authorization answers an important question: has the person whose body and life are directly implicated agreed to the proposed intervention? A negative answer will ordinarily prohibit proceeding. A positive answer, however, does not establish likely benefit, proportionality of risk, justice of access, fidelity to medicine's ends, or the moral permissibility of the clinician's participation.

The distinction can be illustrated outside medicine. Consent may transform what would otherwise be an assault into a permitted physical interaction, but it does not make every consensual act prudent, just, or good. Two people can agree to something degrading, exploitative, dangerously reckless, or injurious to others. The presence of consent changes the moral description of the act, but it does not exhaust that description.

The same is true in medicine. A patient's authorization can remove the wrong of unauthorized bodily intervention. It cannot create therapeutic benefit where none exists, convert a gravely disproportionate risk into a reasonable one, or transform an act foreign to medicine's goods into a medical good. Professional ethics accordingly continues to require physicians to recommend and provide interventions that are scientifically grounded and medically appropriate in light of the patient's goals.¹⁵

This does not mean that physicians possess comprehensive authority over the patient's good. The physician is not the ruler of the patient's life and cannot claim

expertise concerning every moral, familial, religious, or existential question that bears upon a decision. Medical beneficence must be bounded. The physician's proper concern is the health-related good of this embodied patient: truthful diagnosis, appropriate treatment, healing where possible, palliation where cure is impossible, relief of suffering, protection from medically caused harm, and accompaniment through illness and dying.

Within that bounded sphere, however, the physician's judgment remains genuinely moral. He is not merely predicting consequences for a patient who alone supplies all value. He is discerning whether a proposed act can reasonably be ordered toward the goods constitutive of medicine. Consent cannot substitute for this judgment because it answers a different question.

3.2 The Asymmetry between Refusal and Demand

A central confusion arises when the authority to refuse is treated as symmetrical with a general authority to demand. The two are related exercises of agency, but they generate different kinds of claims.¹⁶

The authority to refuse ordinarily follows from bodily integrity and from the patient's status as the person upon whom the intervention would be performed. A medically advisable procedure may not ordinarily be imposed upon a decisionally capable patient who rejects it. The physician may explain, warn, persuade, and seek to understand, but may not simply erase the patient's agency because he believes the choice unwise.¹⁷

The authority to prevent another person from acting upon one's body does not by itself entail authority to compel another person to act. Refusal establishes a limit upon intervention. A positive request makes a claim upon another agent, a professional practice, institutional resources, and sometimes third parties. Such claims may be valid, but they require grounds supplied by medical appropriateness, professional obligation, contract, emergency duty, or justice; they are not generated by preference alone.

A decisionally capable patient may refuse an antibiotic that would probably cure an infection. It does not follow that the same patient may require an antibiotic for a condition in which it offers no benefit. A patient may decline surgery because its burdens conflict with a tolerable life. It does not follow that he may require surgery the physician judges medically destructive. The right not to be treated is not a general right to compel treatment on one's own terms.¹⁸

This asymmetry is obscured when medicine is understood through the model of consumer choice. Consumers ordinarily select among goods offered for sale, and providers are expected to supply the selected product if contractual conditions are met. But the physician-patient relationship is not adequately described by this model. The physician is not the proprietor of a morally neutral inventory. He is a responsible participant in a practice whose skills are ordered toward characteristic goods.

Shared decision-making therefore involves two moral agents, not one chooser and one instrument. The patient brings knowledge of his history, burdens, commitments, fears, and hopes. The physician brings clinical knowledge, practiced judgment, and an obligation to recommend only what he believes can responsibly serve the patient's health-related good. A legitimate decision must respect both agencies. The patient need not accept what the physician recommends, and the physician need not perform whatever the patient requests.

3.3 Capacity and Moral Status

The second limitation is ontological. Autonomy is an activity of a subject; it cannot by itself explain the subject whose activity it is. Decision-making capacity, moreover, is decision-specific, can fluctuate, and is not identical with basic moral status.¹⁹

The difficulty becomes clearest in infants, persons with profound cognitive disabilities, patients in a coma, those undergoing acute psychosis, and persons in advanced dementia. Surrogate decision-making, advance directives, substituted judgment, and best-interest standards are indispensable, but their very existence reveals that the patient's moral significance does not depend on presently exercisable autonomy.²⁰

The Belmont Report acknowledged this point when it joined respect for autonomous agency with the duty to protect persons whose autonomy is diminished. But what grounds the latter duty? Why is diminished autonomy a reason for increased protection rather than reduced moral concern?

Principlism can assign such patients to the domains of beneficence and non-maleficence, but that classification does not yet explain why their good matters. Beneficence is owed to someone. Before one can determine what benefits the patient, one must already recognize the being before us as a patient whose good commands attention.

The problem becomes acute in theories that connect personhood or the strength of a claim to continued life with capacities such as self-consciousness, rational deliberation, future-directed preference, or psychological connectedness.

Singer distinguishes membership in the human species from personhood and associates the latter with rationality, self-consciousness, and awareness of oneself through time. Tooley makes a concept of oneself as a continuing subject, together with a corresponding desire to continue existing, central to a serious right to life. McMahan offers a more complex embodied-mind account, but the strength of time-relative interests in continued life varies with psychological unity. These theories differ materially and should not be collapsed into one another.²¹

They nevertheless share a family resemblance relevant here: the strength of the claim not to be killed is indexed wholly or substantially to psychologically sophisticated functioning or connectedness rather than to the enduring identity of the embodied human being.²²

The shared difficulty lies not in one disputed threshold but in the kind of criterion doing the moral work. The criteria are scalar, episodic, and vulnerable to interruption. A newborn, an adult under anesthesia, a patient with dementia, and a fully self-conscious adult differ dramatically in the capacities named by these theories.

If the moral claim of each depends upon the present strength of those capacities or upon the degree of psychological connectedness to a future self, equal human dignity becomes something to be reconstructed after the fact rather than something the theory can straightforwardly affirm.

These positions should not simply be labeled Kantian. Kant's moral philosophy cannot be reduced to contemporary functionalist criteria of personhood, and his account of duties concerning vulnerable human beings is more complex than such a genealogy sometimes suggests. The narrower and more defensible criticism is that modern functionalist appropriations of autonomy treat the capacities associated with agency as the basis of moral status rather than as activities of beings whose status is already given.

Once capacity bears this weight, moral equality becomes unstable. Capacities occur in degrees. Human beings differ radically in memory, intelligence, self-awareness, rational consistency, communicative ability, and control over their circumstances. If dignity is grounded in the degree to which such capacities are present, it becomes difficult to explain why dignity itself does not also occur in degrees.

Our most defensible clinical judgments presuppose that diminished function does not erase the patient. The person with advanced dementia may no longer remember family, formulate a life plan, understand a diagnosis, or recognize himself as the author of past choices. Yet he does not become a less proper object of care.

Disability and dementia scholarship has also shown that agency can persist at its margins through valuing, affective attachment, relationship, and responsiveness, even when full decisional capacity is absent.²³ One's dependence intensifies obligations; it does not dissolve them.

Autonomy-centered frameworks can accommodate this judgment through protection, beneficence, relational agency, or prior wishes. The narrower claim is that autonomy alone does not ground it. Medical ethics still requires an account of the being whose capacities vary, whose history remains one history, and whose good continues to matter through those variations.

3.4 Why a Richer Account Need Not Restore Paternalism

At this point an obvious objection arises. If consent is not the foundation of medical morality, and if physicians may appeal to objective medical goods, does the argument not simply restore the paternalism that informed consent rightly overcame?

The objection must be taken seriously. 'The patient's good' can conceal professional self-interest, institutional convenience, racial or disability bias, cultural

prejudice, and failure to listen. Medical history and contemporary disparities give abundant reason to distrust any account that places unrestricted interpretive authority in professional hands.

But rejecting autonomy as the master principle does not require returning to unilateral medical rule. The alternatives are not consumer sovereignty and professional sovereignty. A richer medical ethics places limitations on both patient demand and physician power.

The patient ordinarily retains authority to refuse. The physician must disclose relevant facts, give reasons, acknowledge uncertainty, invite questions, attend to disability and cultural perspectives, and distinguish clinical judgment from personal preference. Second opinions, ethics consultation, institutional review, legal protections, and mechanisms of appeal are not external annoyances; they are disciplines of fallible professional authority.

At the same time, the physician cannot be required to abandon judgment in order to prove that he has abandoned paternalism. Refusing to perform an intervention is not equivalent to imposing one. A physician who declines to provide what he judges harmful, futile, or incompatible with the goods of medicine has not thereby taken control of the patient's body. He has declined to make his own agency and skills instruments of the requested act.

The corrective to paternalism is not moral silence but responsible deliberation. It is a relationship in which neither party disappears: the patient is not reduced to a body, and the physician is not reduced to a tool.

The argument must therefore move from the limits of consent to the more basic question that both parties' responsibilities presuppose: who the patient is. Only an ontology of the patient can explain why agency must be honored without becoming the measure of worth, and why professional judgment must serve rather than dominate.

4.0 Who Is the Patient?

4.1 The Patient as Embodied Creature

THE PRECEDING CRITIQUE ESTABLISHES WHAT an adequate ontology of the patient must accomplish. It must account for the patient's identity and moral significance before, during, and after the exercise of autonomous choice. It must explain why vulnerability and dependence do not diminish dignity. And it must resist both the reduction of the patient to biological mechanism and the reduction of the patient to disembodied will.

Christian theology begins by identifying the patient as an embodied creature. This is not a decorative theological description appended to a bioethical argument. It makes a specific ontological claim. To be a creature is to exist as the recipient of

a life one did not originate and cannot finally secure. Existence is received before it is exercised. The person acts, chooses, creates, and assumes responsibility, but none of these activities explains why he exists in the first place.

The language of autonomy easily obscures this givenness. The autonomous self appears as the author of its purposes, the source of its values, and the proprietor of its body. But the body is not first a possession over which an otherwise disembodied will exercises sovereignty. The body is the concrete form in which the person exists. The patient does not merely *have* the body that is sick; the patient is bodily present in and through the illness.

Gilbert Meilaender, drawing upon Hans Jonas, has observed that living beings do not exist as rocks do, simply and fixedly identical with themselves. Organisms maintain themselves through metabolic exchange with an environment; their identity is enacted through dependence, activity, receptivity, and exposure to dissolution. Human life intensifies rather than escapes this creaturely structure. We live through bodies that require food, shelter, touch, language, culture, and the care of others.²⁴

In *Bioethics and the Character of Human Life*, Meilaender presses the ethical significance of this creatureliness. Human life has a character that is received rather than manufactured by choice. We are begotten rather than made, born into bodily histories and relations we did not select, and sustained by exchanges with others that no assertion of independence can abolish. The self is in this sense ecstatic: it lives outside itself in bodily dependence, temporal continuity, and bonds of obligation that precede reflective authorization.

This account exposes the abstraction involved in treating the patient as a self-contained will. Autonomy is real, but it is exercised only within an embodied life already given and sustained through relations of dependence. Meilaender thus supplies a powerful phenomenology and moral theology of creaturely life. Yet the account does not by itself provide a complete criterion of numerical identity: it shows why embodied dependence belongs to personal existence, but not finally why this patient remains this same person through radical psychological discontinuity. The extrinsic account developed below takes that further metaphysical step.

This creaturely structure bears directly upon the clinical relationship. Illness does not introduce dependence into an otherwise self-sufficient life; it intensifies and discloses a dependence that was always present. The person who becomes a patient discovers that the ordinary transparency of embodiment has been interrupted. The body no longer recedes into the background of action but imposes itself through pain, weakness, fear, limitation, and the need for assistance.

The clinical encounter begins in this asymmetry. One person appears in need, while another possesses knowledge and skills relevant to that need. The vulnerability is real, and precisely because it is real the patient requires protection against

domination. But vulnerability is not a defect that cancels personhood. It belongs to the creaturely condition within which personhood is lived.

The patient is therefore neither pure biology nor pure will. A reductive naturalism sees an organism whose malfunctioning mechanisms require repair. A voluntarist autonomy model sees a chooser whose body becomes the site upon which preferences are implemented. Christian anthropology sees an embodied creature: a living unity whose body, relations, history, agency, dependence, and destiny cannot be morally separated.

This creaturely account also limits medicine. Because life is received rather than manufactured, medicine cannot promise mastery over finitude. It can heal many diseases, relieve much suffering, extend life, and restore significant forms of function. It cannot remove creatureliness or turn mortality into a technical error. A medicine that treats death as the final failure of technique will either over-treat the dying or redefine death as a problem to be administered according to preference. A medicine that recognizes creaturely finitude can distinguish abandonment from the acceptance of limits and can remain faithful when cure is no longer possible.

4.2 The Patient as a Relationally Constituted Person

The patient is also a relationally constituted person. This claim must be stated carefully. It does not mean that social recognition creates personhood. If the person's identity depended upon recognition by family, community, or state, the isolated, unwanted, forgotten, and abandoned would possess the least secure claim to dignity. Social relations reveal and sustain much of human identity, but no human community possesses authority to create or extinguish the person.

The claim is instead that personal identity cannot finally be grounded in an inventory of intrinsic properties. Bodily continuity, psychological continuity, and theories of an immaterial soul each illuminate something important, but none can by itself explain the identity of this person across radical change.

The psychological criterion, classically associated with Locke and elaborated in contemporary form by Parfit, locates personal identity or what matters in identity in overlapping continuities of memory, intention, character, and consciousness.²⁵ This account appears congenial to an autonomy-centered ethics because it connects the person with the narrative structure of values and choices.

Yet the clinical consequences are troubling. The patient in advanced dementia may exhibit only fragmentary psychological continuity with the person who earlier formed an advance directive. Memories have disappeared, dispositions have altered, relationships are no longer recognized, and future-directed projects can no longer be conceived. If psychological continuity constitutes the person, the status of the present patient in relation to the earlier author of the directive becomes uncertain.

Bodily continuity avoids some of this difficulty, but it also appears insufficient as a complete theory of personal identity. The body changes throughout life, and the appeal to an immaterial soul faces the question of what individuates one soul from another. An appeal to bare haecceity may name rather than explain the individuality at issue.²⁶

The failure of intrinsic accounts does not entail that persons are unreal. It suggests that personal identity is fundamentally relational. The decisive question is not simply what properties the person possesses but in what individuating relation this person stands.

I have argued elsewhere that the intentional love of God supplies the uniquely specifying relation required for individuation.²⁷ God does not love humanity merely as an undifferentiated kind. God intends and loves particular persons. This relation is not elicited by the person's current properties and does not disappear when those properties alter.

This proposal develops an extrinsic criterion of individuation. Identity is grounded not in a property enclosed within the person but in the uniquely specifying divine relation in which the person stands. God's intentionality does not merely recognize an individuality already fully constituted elsewhere; it establishes and sustains the creature as the particular creature he is.

An objection must be anticipated. If divine love were elicited by rationality, self-consciousness, usefulness, or any other qualifying property, the appeal to God would simply reproduce graded dignity at a higher level. God would love more fully where the relevant capacities were more fully present.

But that is not the order of explanation proposed here. God does not first discover an independently constituted bearer of sufficient capacities. Nor does God then confer regard in proportion to those capacities. The divine intention is individuating. By intending this creature as this one, God establishes and sustains the relation in virtue of which the creature is this person. Capacities manifest the life of the person; they neither solicit nor measure the love that secures his identity.

The fuller defense of this claim belongs to the earlier argument concerning extrinsic individuation. Its implication for the present essay is narrower but decisive: divine love is not a response to person-making capacities. It is the relation within which the particular person and all his changing capacities are held together.

Applied to medicine, the implications are direct. The patient with dementia remains the same patient not because sufficient memories have survived, not because he can still narrate his life, and not because others happen to recognize him. He remains this patient because the divine intention by which he is this person has not altered. His capacities may diminish; the relation that grounds his identity does not.

Extrinsic individuation does not deny psychological or narrative discontinuity. The patient in advanced dementia may possess desires, affective responses, and forms of awareness markedly different from those of the earlier agent who executed an advance directive. These are differences within the history of one person, not evidence of numerically distinct subjects.

Three questions must remain distinct. Extrinsic individuation answers the numerical question of why these changing phases belong to one person. The doctrine of creation and divine love grounds equal dignity. Neither conclusion by itself decides how a prior directive should govern a present clinical situation. That question requires practical judgment about precedent autonomy, present experiential interests, residual capacities to value, burdens of treatment, and the fiduciary responsibilities of surrogates.²⁸

The same applies to the infant who has not yet developed rational agency, the unconscious patient who cannot manifest it, and the cognitively disabled person who may never exercise it in conventionally recognizable ways. They are not potential, former, or marginal persons. They are particular embodied creatures whose identities do not await the emergence of a qualifying function.

4.3 The Patient before God

The theological language that gathers these claims is *coram Deo*: the person exists before God.

The patient stands before God prior to standing before physician, hospital, family, insurer, court, or state. This priority is ontological, not merely chronological. It means that no human system confers the patient's ultimate worth. Medical institutions may recognize or fail to recognize that worth; legal systems may protect or violate it; families may cherish or neglect it. None creates it.

The *coram Deo* dimension of existence names the givenness of life. Address precedes achievement. God's creative address does not respond to the creature's accomplishment; it calls the creature into being. The person's dignity therefore cannot be contingent upon successfully displaying independence, rationality, social usefulness, self-awareness, or control.

The doctrine of the *imago Dei* expresses this dignity but should not itself be reduced to a capacity. If the image were identified exclusively with rationality, dominion, moral agency, or relational performance, it would appear most securely in those who exercise those functions most successfully. A theology adequate to vulnerability understands the image as God's relation to and intention for the whole embodied creature.²⁹

Robert Kolb's exposition of Luther's definition of the human creature clarifies the point. The human being is not defined first by an isolable faculty and only afterward

placed into relation with God. The creature is understood theologically through the whole posture of trust, love, and creaturely dependence before the Creator. Reason, will, dominion, responsibility, and social relation genuinely manifest human life in God's image. They are not threshold properties by which an otherwise indeterminate organism earns admission to personhood.

The image therefore belongs to the whole person in the concrete unity of embodied life and divine address. The infant does not bear the image merely in anticipation of future rational agency, and the patient with advanced dementia does not retain only a damaged remainder of it. Each is the creature whom God addresses, sustains, and calls into relation. Differences in functional capacity are clinically and morally relevant, but they are differences within an equality that those capacities do not create.

The patient's standing *coram Deo* has a corresponding *coram hominibus* dimension. Life before God does not terminate in private spiritual consolation. The creature addressed and loved by God appears before other creatures as a neighbor. The divine relation grounds human responsibility rather than replacing it.

The movement from one relation to the other is not an inference from divine valuation to an externally added ethical rule. It belongs to the social form of creaturely existence itself. God's address locates persons among other persons. The command to love the neighbor specifies how life received from God is to be lived in the world. The other's need does not create his dignity, but it makes a concrete claim upon the gifts, offices, and opportunities entrusted to those who encounter him.

The clinical encounter is one such relation of entrusted responsibility. The sick person appears before the physician not merely as the bearer of preferences. He appears as a neighbor whose vulnerability addresses the physician's knowledge and skill. Conversely, the physician does not become responsible only after a contractual request has generated an obligation. He already stands within an office whose capacities are ordered toward the service of precisely such need. The ontology of the patient and the vocation of the physician are therefore correlative: the one whom God sustains as this person is given to the physician as this neighbor.

This does not erase the patient's agency or convert illness into passivity. The patient remains an agent called to speak, question, deliberate, consent, refuse, and receive care within the limits of his condition. But the moral relation is deeper than an exchange between two sovereign wills. It is a meeting of embodied creatures whose unequal knowledge and vulnerability place them under different, though reciprocal, responsibilities.

The patient before the physician is therefore someone to whom more is owed than technical competence or procedural recognition. He is owed truthful attention to his embodied condition, protection against exploitation, proportionate care, relief

of suffering where possible, and continued presence when technical success is no longer available.

This account is explicitly theological and does not pretend that secular public reason compels assent to divine individuation or *coram Deo* existence. The argument is therefore layered. Philosophical and clinical considerations establish that autonomy presupposes a subject, capacities occur in degrees, authorization does not justify every act, and medicine cannot function without judgments of appropriateness and good. Theology offers a fuller account of why these claims cohere: identity and dignity rest in a relation that precedes every variable human capacity. The theological layer should deepen public reasons, not substitute confession for the work of argument.

5.0 What Is Medicine?

5.1 Medicine and the Health-Related Good of the Patient

AN ADEQUATE ACCOUNT OF THE PATIENT requires a corresponding account of medicine. If the patient is an embodied creature rather than a preference-bearing will, medicine cannot be understood merely as the technical implementation of authorized choices.

Edmund Pellegrino argued that medicine possesses an internal morality arising from the distinctive structure of the clinical encounter. A person made vulnerable by illness seeks assistance from one who professes relevant knowledge and skill; the profession is a public promise to use those capacities for the patient's good.³⁰

The appeal to internal goods is contested. Critics have argued that Pellegrino's account risks treating medicine's ends as an ahistorical essence and have proposed an evolutionary internal morality whose goals and duties are interpreted through the history of practice and common morality. The modest claim required here does not depend upon a frozen essence. It is that medicine's ends are corrigible but not infinitely plastic: a practice cannot become any technically possible service without losing the distinctions by which it remains medicine rather than engineering, commerce, punishment, or personal assistance.³¹

The good at issue must be described neither too narrowly nor too expansively. Medicine is not concerned only with biological function considered apart from the person. The restoration of a physiological measure can be medically pointless or even burdensome when detached from the condition of the whole patient. Yet medicine is also not responsible for producing human flourishing in its entirety. Physicians do not possess comprehensive authority over the patient's religious commitments, familial duties, political identity, ultimate happiness, or conception of the good life.

Medicine is ordered toward the health-related good of the embodied person. This includes truthful understanding of the patient's condition, prevention of avoidable

disease, healing and restoration where possible, proportionate preservation of life and function, relief of pain and other forms of suffering, palliation, and faithful accompaniment when cure is no longer available.

These goods are objective without being mechanically determinative. Their application requires prudential judgment. Health is not always the patient's highest immediate good. A patient may reasonably decline a burdensome treatment in order to remain at home, preserve clarity for a final conversation, fulfill a religious obligation, or avoid extending the dying process. Recognizing medicine's internal goods does not mean that the physician's preferred clinical outcome always governs.

It means instead that medical action must remain intelligibly related to the goods that make it medical action. The physician must be able to say not merely that the patient requested the intervention, but why the intervention belongs to the practice of healing, palliation, prevention, or care.

Consent cannot create this relation. It can authorize a medically responsible option, select among several such options, or reject all of them. It cannot by itself make an act therapeutic.

5.2 Practices, Internal Goods, and Professional Virtue

Alasdair MacIntyre's account of practices provides a wider framework. A practice is a coherent and complex form of socially established cooperative activity through which goods internal to that activity are realized in pursuit of standards of excellence appropriate to it.³² Internal goods differ from external goods such as income, prestige, institutional power, and market share.

Medicine is a practice in this sense. Diagnostic accuracy, clinical wisdom, technical excellence, proportionate therapy, truthful communication, and appropriate palliation are not simply products purchased by consumers. They are excellences internal to the activity of caring for the sick.

Practices require virtues because rules and techniques cannot anticipate every circumstance. The physician must possess dispositions enabling him to perceive and pursue the patient's good under conditions of uncertainty, competing obligations, emotional strain, institutional pressure, and personal inconvenience. Fidelity, honesty, compassion, practical wisdom, courage, humility, and justice are not optional personal decorations upon technical competence. They belong to competent medicine itself.

The consumer model threatens these goods from two directions. On one side, patient satisfaction can displace the distinction between what is desired and what is medically beneficial. On the other, institutional profitability and efficiency can turn both patient and physician into instruments of external goods. The autonomy

model may protect the patient from some forms of professional domination while leaving both parties exposed to market domination.

A patient can be offered many choices while the institution quietly determines which choices are affordable, reimbursable, legally convenient, or administratively efficient. Formal autonomy can coexist with severe practical dependence. Indeed, the language of patient choice can conceal institutional decisions by presenting structurally constrained options as though they were expressions of personal sovereignty.

Recovering the internal goods of medicine therefore protects both patient and physician. It allows the patient to ask whether an offered intervention genuinely serves his health-related good rather than merely generating revenue or avoiding liability. It allows the physician to resist pressures that would subordinate clinical judgment to institutional or consumer demand.

5.3 Medicine as Vocation

The Christian tradition adds a dimension not exhausted by the MacIntyrean account. The physician's calling is not only the consequence of entering a practice with internal goods. It is a vocation in the theological sense: a calling that comes from outside the self and places the physician in responsibility to God and neighbor.

Vocation does not name first what one chooses to do. It names what one is as a creature called into being and relation. The creature receives existence, gifts, circumstances, and neighbors that he did not create, and becomes responsible within those relations.³³

The physician's vocation specifies this more fundamental creaturely calling. The knowledge and skills of medicine are received through education, discipline, tradition, institutions, teachers, patients, and the created intelligibility of the body itself. They are not private possessions to be deployed without moral limit. They are gifts entrusted for service.

The neighbor appears to the physician in the particular vulnerability of illness. The physician is called to attend to that vulnerability through truthful judgment, competent care, and compassionate presence. He does not serve because the patient has manufactured an obligation through preference alone. He serves because this patient has been given to him as a neighbor within the concrete responsibilities of medical practice.

The vocational account does not romanticize medicine. Physicians work for wages, institutions operate under economic constraints, and clinical relationships are often brief, fragmented, and technologically mediated. Vocation does not require pretending that these external realities do not exist. It requires refusing to let them define what medicine ultimately is.

Medicine remains vocation even within bureaucracy because the physician remains answerable for what he does. Institutional policy, legal permission, financial incentive, and patient request can shape action, but they cannot wholly transfer moral responsibility away from the acting physician.

The category of vocation therefore adds something that a practice-based account alone cannot supply. MacIntyre can explain how medicine contains internal goods and standards of excellence that become intelligible through participation in the practice. Vocation identifies the giver of the gifts, the neighbor for whose sake they are exercised, and the responsibility under which the practitioner stands even when the institutions of the practice become corrupt. The physician is not answerable only to the historically developed norms of a profession; he is answerable through that profession to God and to the neighbor whom the office exists to serve.

Luther's paradox in *The Freedom of a Christian* gives this vocation its evangelical form. Before God, the Christian receives identity and righteousness rather than producing them; before the neighbor, the same Christian is freed for active service. Applied analogically to medicine, the physician need not secure his worth through mastery, cure, prestige, or the successful defeat of death. Because his identity is received rather than achieved, he can attend to the patient without making the patient the instrument of his own professional self-justification.

In Lutheran language, God ordinarily cares for creatures through creaturely offices and callings. The physician can therefore be described as one of the *larvae Dei*, the masks through which God's preserving care reaches the neighbor in need.³⁴ The image does not canonize every medical act; it intensifies accountability, since a mask can fail in its office and an institution can deform the practice entrusted to it.

Vocation also bounds medicine. The physician is called to heal, palliate, counsel, and accompany; he is not called to overcome creatureliness, guarantee happiness, or deliver salvation through technique. Nor should illness itself be romanticized as though every affliction were a divinely assigned lesson. The vocational claim concerns the responsibility created by the neighbor's need, not the moral approval of the disease that occasions it. Precisely because sickness is an evil to be resisted where possible, the physician's gifts are summoned into service; precisely because mortality cannot finally be mastered, that service must remain faithful when technical victory is no longer available.

5.4 Professional Conscience: Integral but Disciplined

The autonomy-centered framework often describes a physician's moral resistance as 'conscientious objection,' as though professional obligation were settled by patient demand and conscience entered afterward as a private exception. A vocational account rejects that presumption: conscience is the first-person form of responsibility

for what one does. But conscience is neither infallible nor self-authenticating. It must be tested by evidence, professional competence, medicine's goods, equal regard for patients, and the duties voluntarily undertaken in entering the profession.³⁵

A physician cannot act medically without judging what is being done, why it is being done, and whether he may responsibly participate. Professional formation and institutional deliberation may correct that judgment, but they cannot make the physician morally absent from his action.

Accordingly, neither conscience absolutism nor the claim that professional roles eliminate conscience is adequate. Legitimate protections may be conditioned by advance disclosure where possible, non-discrimination, emergency care, continuity of unrelated treatment, truthful explanation, and serious efforts to avoid abandonment or disproportionate burdens on patients and colleagues.³⁶

5.5 Faithful Accompaniment

Medicine's vocation becomes especially visible when cure is impossible. A technical conception of medicine tends to understand the incurable patient as a case in which medicine has failed or has nothing further to offer. A consumer conception may then oscillate between technological escalation and the provision of whatever final option the patient requests.

Paul Ramsey's description of the patient as person points toward another possibility.³⁷ The physician's task includes accompaniment: remaining truthfully and compassionately present to a person whose illness cannot be conquered.

The patient who is dying does not cease to be the proper object of medicine because cure has become impossible. The ends of medicine are not exhausted by defeating disease. Relief of suffering, avoidance of disproportionate treatment, truthful preparation for death, and refusal to abandon the patient remain genuine medical goods.

This is where the difference between consent and care becomes clearest. A signed form cannot accompany anyone. Authorization cannot substitute for fidelity. Consent protects the patient against being acted upon without permission; it does not by itself supply the presence through which medicine remains humane.

6.0 Consent within a Richer Medical Ethics

6.1 Consent as a Practice of Deliberation

ONCE PATIENT AND PHYSICIAN ARE UNDERSTOOD more adequately, informed consent can be recovered in a richer form. Consent is neither discarded nor demoted into irrelevance. It is returned to its proper function within a moral relationship already ordered toward goods that neither party creates by choosing them.

Informed consent should first be understood as a practice of communication and deliberation rather than a discrete legal event. The signature on a form may document consent, but it does not constitute understanding. Contemporary professional guidance likewise describes informed consent as a communicative process that culminates in authorization.³⁸

Genuine informed consent requires disclosure, comprehension, voluntariness, and decision-making capacity. These are not achieved simply by transferring data. Information must be interpreted in relation to the patient's circumstances; probabilities must be communicated intelligibly; uncertainty must be acknowledged; and the physician must seek to understand what the patient believes the options mean.³⁹

Deliberation differs from preference elicitation. Preference elicitation asks, "Which intervention do you want?" Deliberation asks, "What are we trying to accomplish, what goods are at stake, what burdens are proportionate, and which available course can responsibly serve this patient?"

The physician should not manipulate the patient toward a predetermined answer. But neither should he pretend to be indifferent. A recommendation is not a violation of autonomy when it is honestly offered, supported by reasons, responsive to the patient's circumstances, and open to question. Patients often seek physicians precisely because they need judgment, not merely information.

Shared decision-making is therefore not a compromise halfway between paternalism and consumer sovereignty. It is joint practical reasoning in which asymmetrical forms of knowledge are brought into conversation. The physician knows medicine in ways the patient does not; the patient knows the concrete life in which treatment will be received in ways the physician does not. Neither knowledge is dispensable.⁴⁰

6.2 The Moral Sequence of Medical Authorization

A richer medical ethics distinguishes at least four questions that an autonomy-centered model can compress.⁴¹

1. Is the proposed intervention medically responsible? Does it bear an intelligible relation to the patient's health-related good? Is there reasonable evidence of benefit, and are risks and burdens proportionate?
2. Is the intervention responsive to this patient's goals, commitments, relationships, and understanding of acceptable burden? Patient values do not create medical benefit, but they are indispensable to judging what benefit means in this life.
3. Is the intervention morally and institutionally permissible? This includes professional integrity, justice, stewardship of scarce resources, and the interests of other persons who may be affected.

4. Has the patient or legitimate surrogate authorized the intervention after adequate disclosure and deliberation?

An affirmative answer to the fourth question cannot compensate for negative answers to the first three. Nor do affirmative answers to the first three compensate for the absence of the fourth. A medically responsible and morally permissible intervention may still not ordinarily be imposed upon a decisionally capable refusing patient.

These questions are not merely chronological steps. They are mutually informing dimensions of responsible action. Patient values affect the assessment of burdens and benefits; evidence shapes which options can honestly be offered; justice and professional commitments establish limits; and authorization completes rather than creates the moral intelligibility of the act.

6.3 Incapacity, Surrogacy, and Vulnerability

The richer framework is especially important when the patient lacks decision-making capacity. Advance directives, substituted judgment, and best-interest standards can preserve self-determination and guide care, but each has limits. Surrogate authority is fiduciary rather than proprietary, and the physician remains responsible for clinical judgment.⁴²

Prior wishes ordinarily deserve serious, often presumptive, authority because they belong to the history of this patient and may express enduring values and critical interests. They should not, however, be treated as a disembodied sovereign ruling mechanically over a present dependent life. The classic debate between precedent autonomy and present interests shows why neither the earlier nor the current perspective can simply erase the other.⁴³

The tension is clearest when a patient who once rejected life with disability later appears content, responsive, and relationally engaged. Dresser emphasizes the moral claims of the present person; Dworkin defends the authority of earlier critical interests; Jaworska shows that persons with dementia may retain capacities to value even after losing full decisional competence. A responsible judgment must attend to all three insights rather than reducing the case to a contest between an 'authentic' former self and an 'inauthentic' present one.⁴⁴

A surrogate does not become proprietor of the patient's life. The surrogate is entrusted to interpret and protect the patient's good by considering known commitments, prior statements, present experience, residual agency, relationships, and proportionate medical interests.⁴⁵

Best-interest judgments should also be freed from the suspicion that they are merely disguised paternalism. Some judgment of the patient's good is unavoidable whenever the patient cannot decide. The moral question is not whether such judgment

will occur but whether it will be disciplined by an adequate account of the person, transparent reasoning, clinical evidence, protection from conflicts of interest, and appropriate communal review.

The patient with diminished capacity is not respected by pretending that dependence does not exist. He is respected by receiving the protection, interpretation, and care appropriate to his actual condition. Equal dignity does not always require identical modes of decision-making. It requires that differences in capacity never become differences in fundamental worth.

6.4 The Limits of Requested Action

A richer doctrine of informed consent also clarifies the limits of patient request. The patient may challenge a physician's judgment, seek a second opinion, and refuse what is offered. But preference alone cannot establish the medical character, distributive priority, or moral legitimacy of an intervention.⁴⁶

This conclusion does not depend upon resolving every contemporary controversy. It applies across the spectrum of medical practice. Requests for medically non-beneficial antibiotics, disproportionate surgery, unnecessary diagnostic testing, continued invasive treatment during irreversible dying, elective enhancement, assisted reproduction, abortion, and physician-assisted death raise different moral questions. They should not be collapsed into a single category.

What unites them is only the formal point that authorization cannot settle their substantive moral character. Each requires judgments concerning the nature of the act, medicine's ends, benefits and harms, justice, the interests of other affected persons, and the integrity of the professionals involved.

This formal limitation is important in pluralistic societies. It permits disagreement to be identified rather than concealed. When participants disagree about whether an intervention is healing, killing, restoring, mutilating, relieving suffering, or abandoning the vulnerable, the dispute concerns the description and moral reality of the act. It cannot be dissolved by observing that someone consents.

When a physician declines a requested act, refusal must be distinguished from abandonment. A defense of conscience does not permit arbitrary withholding of ordinary care, discrimination, concealment of relevant information, abandonment in an emergency, or contemptuous treatment. Nor does every clinical disagreement rise to conscience; many concern uncertain evidence or prudent interpretation of goals.⁴⁷

Where the physician judges that an act would directly contradict medicine's goods or make him an agent of serious moral wrong, the demand for compliance requires justification. He remains obligated to communicate candidly, disclose foreseeable limits, provide emergency and unrelated care, and protect the patient against

abandonment. Institutions also bear responsibility to design access arrangements that do not treat either patient or clinician as morally negligible.⁴⁸

The precise requirements of referral or transfer remain contested, particularly where referral is understood as intentional facilitation of the disputed act. Those disputes should be analyzed in terms of cooperation, burden, access, and continuity of care rather than hidden beneath slogans. What cannot be surrendered is the recognition that patient and physician remain moral agents.

Referral is therefore not automatically morally neutral, but neither is every transfer equivalent to direct performance. Its permissibility depends upon the nature of the act, the object and intention of the referral, the proximity of cooperation, available alternatives, the patient's vulnerability, and the professional's remaining duties.⁴⁹

Consent is powerful within its proper domain. It marks the patient's participation, protects bodily integrity, and prevents the physician from substituting professional will for patient agency. It is powerless to convert moral disagreement into neutrality.

6.5 What the Richer Framework Protects

A medical ethics that situates consent rather than enthrones it protects several goods simultaneously.

It protects the patient's agency by maintaining the requirement of disclosure, understanding, voluntariness, and authorization. The physician cannot appeal to objective goods as a pretext for secrecy or coercion.

It protects vulnerable patients by grounding their dignity in something deeper than present decision-making capacity. The infant, the unconscious patient, and the person with dementia do not become peripheral cases within an ethics designed for independent choosers.

It protects the physician's agency by recognizing that medical professionals remain responsible for the acts they perform. Technical competence does not cancel moral accountability.

It protects medicine from reduction to commerce by distinguishing patient good from patient satisfaction and internal goods from institutional or market goods.

It protects the truthfulness of the clinical encounter by allowing physicians to say that not everything technically possible, legally permitted, or sincerely requested is medically wise.

Finally, it protects accompaniment. When neither cure nor preference satisfaction can resolve the patient's condition, the physician still has something to offer: competent palliation, truthful presence, and fidelity to the person who remains before him.

The fundamental distinction can therefore be stated again. Consent is ordinarily necessary because the patient is a person. He is not a passive object, and what

happens to his body demands his participation. Consent is insufficient because the patient is more than a will. He is an embodied creature whose life is received, a relationally constituted person whose identity survives radical changes of capacity, and a self who stands before God independently of every successful act of choice.

7.0 Conclusion

MODERN INFORMED CONSENT EMERGED FROM a justified protest against the reduction of patients and research subjects to objects of professional expertise. The protest was right. Physicians and investigators do not acquire unrestricted authority over other persons by possessing knowledge, skill, or benevolent intentions. Patients must ordinarily understand and authorize what is done to them.

But an indispensable safeguard is not yet a complete moral foundation. Consent cannot explain by itself why the patient commands respect, why the patient who cannot consent remains fully within the moral community, what goods medicine properly serves, how justice limits choice, or why the physician remains responsible for acts the patient requests.

A more adequate medical ethics begins by recognizing that the patient precedes his preferences. Philosophically, this means distinguishing identity, status, capacity, authorization, and good. Theologically, it means confessing the patient as an embodied creature whose identity is sustained in the intentional love of God and whose dignity does not fluctuate with performance.

Medicine adequate to this patient must be more than a service industry. It is a practice ordered toward the health-related good of embodied persons and a vocation in which knowledge and skill are given for the service of vulnerable neighbors. Its goods include healing, truthful diagnosis, proportionate treatment, relief of suffering, palliation, and faithful accompaniment.

The physician who practices medicine as vocation does not rule the patient. He must listen, disclose, recommend, receive refusal, and remain accountable for the power conferred by expertise. But neither does he disappear into competent compliance. He remains a moral agent answerable for whether his actions serve the goods entrusted to medicine.

The physician's retained agency is therefore not a rival to the patient's dignity, but its vocational counterpart: the patient's identity calls forth responsible judgment in service of his good.

Consent belongs necessarily within this richer medical ethics. It protects bodily integrity and honors the patient's participation without constituting the whole. The patient entering the clinic is not first and finally a will but a creature—embodied, dependent, addressed, loved, and called—whose dignity the physician is summoned to serve.

The framework developed here should now be tested in focused treatments of medical aid in dying and the just allocation of scarce medical resources, where the relations among consent, professional vocation, vulnerability, and equal dignity come under especially severe pressure.

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Notes

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15. American Medical Association, *Code of Medical Ethics*, Opinion 5.5, “Medically Ineffective Interventions.”
16. See *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), on the liberty interest of a competent person in refusing treatment; American Medical Association, Code of Medical Ethics, Opinion 5.3, “Withholding or Withdrawing Life-Sustaining Treatment,” <https://code-medical-ethics.ama-assn.org/ethics-opinions/withholding-or-withdrawing-life-sustaining-treatment>, and Opinion 5.5, “Medically Ineffective Interventions,” <https://code-medical-ethics.ama-assn.org/ethics-opinions/medically-ineffective-interventions>, accessed July 1, 2026. The ethical asymmetry defended here does not deny that positive entitlements can arise from emergency duties, contractual relationships, anti-discrimination law, or justice.
17. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990); American Medical Association, *Code of Medical Ethics*, Opinion 5.3, “Withholding or Withdrawing Life-Sustaining Treatment.”
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