Autonomy and the Subjective Character of Experience

KIM ATKINS

ABSTRACT  In his famous paper, What Is It Like To Be A Bat?, Thomas Nagel argues against a reductive physicalist account of consciousness by highlighting what he calls “the subjective character of experience”. In this paper I will argue that Nagel’s insight is important for understanding the value placed on patient autonomy in medical ethics. Appreciation of the subjective character of experience brings with it the necessity for an epistemological humility with respect to the lives of others and what can be said to be “right” for them. Appreciation of the subjective character of experience lies at the heart of empathy and our capacity to make decisions that genuinely reflect respect for the patient's autonomy.

Through the example of a case involving extreme medical intervention, I identify some impediments to the proper recognition of autonomy. These kind of cases highlight the significance of affective responses with respect to the subjective character of experience, and, by extension, to our capacity to imagine and act in accordance with another’s perspective. I argue that affective responses are appropriate and needed considerations in the case where one must attempt to assume another’s perspective in order to respect autonomy. I conclude that understanding that experience has an irreducibly subjective character is essential to respecting patient autonomy.

In his famous paper, “What Is It Like To Be A Bat?” [1], Thomas Nagel argues against a reductive physicalist account of consciousness by highlighting what he calls “the subjective character of experience”. For Nagel, the approach to explaining our experiences in terms of physical processes alone cannot succeed because the objectivity appropriate to explanations of the physical world can only move us away from a fuller understanding of an experience rather than closer to it. In this paper I will argue that Nagel’s insight is important for understanding the value placed on patient autonomy in medical ethics. An appreciation of the subjective character of experience lies at the heart of empathy and our capacity to make decisions that genuinely reflect respect for the patient’s autonomy. Through the example of a case involving extreme medical intervention, I identify some impediments to the proper recognition of autonomy. These kind of cases highlight the significance of affective responses with respect to the subjective character of experience, and, by extension, to our capacity to respect patient autonomy. I argue that affective responses are appropriate and needed considerations in the case where one must attempt to assume another’s perspective. I conclude that understanding the subjective character of experience is essential to respecting patient autonomy.

I

Thomas Nagel argues that for every creature that is capable of having experiences there is something it is like to be that creature [2]. Implicit in Nagel’s claim is the view
that consciousness always entails self-consciousness, that is, consciousness of one’s thoughts as one’s own (as distinct from consciousness of oneself as a kind of object) — a position that has had wide philosophical acceptance since at least the seventeenth century [3]. On this view, for something to count as an experience it must have a subject. Experiences are, by definition, experienced; they are always had by “one” whose experiences they are. Experiences are not things that exist independently like peculiar objects in a mental ether, but are always attributable to a subject who is capable of taking those experiences as his or her own [4]. As Kant argues, all experiences — all “representations” — must have a subject to whom they can be ascribed:

It must be possible for ‘I think’ to accompany all my representations; for otherwise something would be represented in me which could not be thought at all, and that is equivalent to saying that the representation would be impossible, or at least, it would be nothing to me. [5]

All experience (all “representations” or thoughts) must be ascribable to a subject to count as an experience or thought or representation [6]. That means that we can’t isolate our understanding of (i.e. the meaning of), an experience from the perspective of the subject whose experience it is. The reductionist project of accounting for experience in terms of physical processes alone supposes that such a separation is possible. It is just this supposition that grounds the emphasis on objectivity in the reductionist approach. Nagel challenges this supposition in order to show the incapacity of objectivity to provide us with more understanding of any experience.

Nagel demonstrates his point using the example of a bat’s perceptions. The bat is a useful heuristic device because it is biologically complex enough for us to imagine that it has complex experiences, for example, hunting mobile prey, maintaining its place in a colony and avoiding danger in a diverse and dynamic environment. We can imagine this because it has a sophisticated sensory apparatus which it employs in the pursuit of these activities. Importantly, though, the bat is sufficiently different from us for us to suppose that its experiences are quite alien to our own. Since the bat’s primary mode of perception — sonar — is unlike human vision and hearing, it conceivably presents the bat with an experiential world quite unlike the human world.

If we wanted to understand bat experience, then, we would need to know, for one thing, how to perceive using sonar. To this end we could give a scientific account of sonar as a “kind of three-dimensional forward perception” [7], setting out all the elements and processes involved, the laws according to which each operate, and the manner in which they are functionally related. Unfortunately, this is not going to be of great help. It is one thing to know the laws of operation of a mode of perception, and quite another to actually perceive through that medium. When we want to understand bat experience we want to know, not just how a bat works, but what it is like to be a bat. Even if we knew how the bat’s shrieks were projected, and their reflections and deflections translated into a cognitive or behavioural schema — even if we knew all the objective facts that there were to know about bat sonar and bat behaviour — that would bring us no closer to knowing what it is like to be a bat. The problem is that we can extrapolate from our own case only so far: imagining ourselves capable of flight, eating insects and using echolocation may tell us what it is like for us to behave like bats, but it will not describe what it is like for the bat to be a bat [8].

© Society for Applied Philosophy, 2000
Despite its difference from our own, it is neither irrational nor unimaginable that there be such a thing as bat experience. In other words, even though we could never know what it is actually like, we are nonetheless capable of thinking that there is something that it is like to be a bat. This ‘something that it is like’ is what Nagel calls the “subjective character of experience” [9]. This feature of experience not only holds between creatures of different species and with different perceptual apparatus, but also between individual subjects of the same species. It is, Nagel argues, a feature of experience per se. This is a direct result of the fact that perceptions are attached to a specific individual perspective; every experience embodies a first-person point of view. The specificity of the first-person perspective means that, in the case of humans, even though I can know that other people perceive and experience in a similar way to me, there is always something unique about each person’s experience, something that cannot be made fully explicit [10]. Thus, it is each subject’s particular point of view that underlies the subjective character of experience and constitutes ‘what it is like to be’ that subject.

Although the example of the bat suggests that the specificity of the subjective character of experience is tied to bodily form, in the case of human subjectivity our subjective sense of self is not merely bodily. That is, we gain a sense of self and a concrete understanding of our bodily states intersubjectively [11]. That means that what it is like to be in any particular state is always informed by a familial, social and historical context. This can be demonstrated by a brief survey of the history of medicine: certain states of illness no longer exist because behaviours which were once considered symptomatic of a pathology are no longer so regarded [12]. A well-known example is the case of so-called “female hysteria” of the nineteenth century — a supposed gynaco-cerebral condition that can be linked directly to a certain way of regarding women and their behaviours rather than to any merely organic disturbance. The regard of other people plays a constitutive role in our experiences, even of ourselves, as Sartre showed in his analysis of the emotions of shame and pride, and which de Beauvoir demonstrated in her analysis of the social forces from which women’s understanding of their own femaleness is articulated [13]. Identity is undeniably discursive, but even so, the individuality, the specificity, of each person’s perceptual and cognitive faculties endows each subject with a certain unique “take” on experiences which are nonetheless socially and historically situated. That experience has an irreducibly subjective aspect is not incompatible with contemporary views of subjectivity as intersubjective, historical and fragmentary. In fact it is precisely this condition to which narrative models of identity are addressed [14].

The specificity of a subject’s point of view means that the subjective character of experience is “irreducible”, that is, that it cannot be reduced to impersonal, scientific or physicalist terms [15]. The reason why physicalism can’t do the job of fully describing experience is not that the subject is a non-physical thing, but, rather, because of a logical problem: the problem of trying to capture something unique using tools proper to the general. To illustrate the nature of the logical difficulty, Nagel distinguishes experience from more objective phenomena, for example, lightning. He argues that lightning could be understood from a number of points of view. A Martian, for example, who did not perceive through vision could still understand lightning because “lightning has an objective character that is not exhausted by its visual appearance” [16]. That is, lightning is a phenomenon the character of which can be expressed in the
language of physics, i.e. by the use of descriptions of electrical forces, etc., without the need to appeal to the way lightning looks and sounds to us humans. In contrast,

It is difficult to understand what could be meant by the objective character of an experience apart from the particular point of view from which its subject apprehends it. After all, what would be left of what it was like to be a bat if one removed the viewpoint of the bat? [17]

The role of the ‘point of view’ puts an inquiry into the nature of experience at odds with our other types of epistemological inquiry. Typically, when we strive to understand the world better, we strive to be free of the partiality of our own subjective points of view (i.e. how things ‘appear’ to me), and aspire to an account of the same phenomenon in terms of properties that can be identified by anyone in general (how things ‘really’ are), hence the importance of reproducibility of scientific test results. When we strive for objectivity in our knowledge of the physical world we strive to express a phenomenon in terms of universal laws and categories. In other words, we are typically reductionist with respect to knowledge of the external world. However, when it comes to understanding experience, striving for this kind of objectivity can only move us further from our object of study:

The idea of moving from appearance to reality seems to make no sense here. What is the analogue in this case to pursuing a more objective understanding of the same phenomena by abandoning the initial subjective viewpoint toward them in favour of another that is objective but concerns the same thing? Certainly it appears unlikely that we will get closer to the real nature of human experience by leaving behind the particularity of our human point of view and striving for a description in terms accessible to beings who could not imagine what it was like to be us. [18]

II

It is the particularity of our points of view that we respect when we respect autonomy. Autonomy, in the liberal tradition, is generally understood as self-determination: the freedom to pursue one’s own conception of the good life, just as long as it does not impinge upon another’s identical freedom [19]. On this view, each subject is best placed to judge what is good for him or her. This idea implicitly acknowledges that experience has an irreducibly subjective character, and it is this character that underlies the rule of non-interference (or ‘negative freedom’). To be more precise in respect of negative freedom, autonomy is to be understood as self-direction, not as self-determination in the strong sense of a singular and self-originating force. Autonomy conceived as self-direction acknowledges that one cannot be the originator of oneself nor have complete control over one’s desires, volitions and beliefs, but rather, that in being able to direct one’s life, autonomous agency consists in being rationally accountable for one’s actions and beliefs, in having a degree of independence from the beliefs and assessments of others, and being able to set and pursue goals that one judges as being worthy [20]. So, respect for autonomy as freedom to pursue one’s own conception of the good life is not as simple as Mill’s liberalism seems to put it. It does not mean leaving people alone to make of their lives what they may; it means making a place within our
collaborative existences for each other’s specific values and differences. As Rudi Visker has recently argued against Rorty’s “liberal ironist”,

people do not want to be left alone. They want . . . to be taken on their own terms. They do not dream of a bazaar which will tolerate whatever they do in their private clubs as long as they do not hurt others’ feelings. They want to see their names respected as well as the names of those who handed over to them their values. And they fear that . . . optimism about being able to and having to extend the range of ‘us’ as far as possible, seems to neglect what is at stake in the names they care for and the names they reject. [21]

It is, then, appreciation of, and respect for our individual perspectives that underlie the value we place on autonomy [22]. If we accept that the subjective character of experience is irreducible and that it is grounded in the particularity of our points of view, then we are bound to realize that our respect for each other’s differences and autonomy embodies a respect for the particularity of each other’s points of view. Respect for autonomy is at the same time recognition of the irreducible differences that separate us as subjects. Respect for autonomy is an acknowledgement of the limitations of our knowledge of other people and a willingness to incorporate that understanding into our own world views. When we respect autonomy we don’t simply observe another’s freedom from a distance, as it were; we accede to our fundamental fallibility and an epistemological humility. It is in recognition of the fact that we cannot experience from another’s perspective that we normally refrain from judging what will best make another’s life good for them. In other words, we must respect each other’s freedom to direct our own lives according to our own conceptions of the good because we cannot be the subject of another’s life. While we can imagine, we cannot know objectively ‘what it is like to be’ another person, no matter how many facts we are in possession of, hence, the low regard in which paternalism is held within liberalism.

I have been arguing that the subjective character of experience cannot be captured by the universalising methodology of objectivity. However, this does not prevent us from knowing that there is such a thing, nor from imagining what any particular situation might be like for me. It is, indeed, this knowledge, coupled with imagination, that allows me to empathise. I now want to argue that the more extreme the experience of illness, the more profound are the implications of this view for patient autonomy, because of the increasing difficulty for carers to raise the spectre of the subjective character of very unpleasant experience.

Discussing relatively simple conditions, for example, chicken pox, presents little difficulty. We might begin with a visual description of the clinical appearance of the disease, then add an account of the physiological/biochemical or haematological processes involved, and we could point out the duration and level of physical debility that accompanies it. No doubt we would probably feel quite comfortable offering suggestions about the possible subjective character of the disease, e.g. that the itching may ‘drive you mad’, that you will become irritable from loss of sleep and that you will feel lonely because other people will avoid you.

However, with more debilitating and deforming conditions it becomes more difficult to discuss their possible subjective character. For the carers of women undergoing chemotherapy it is very difficult to address the emotional impact of being unable to enjoy sexual activity because of the particular type of discomfort that results from
damage to mucous membranes; it is very difficult to address the possibility of contem-
plating suicide that may arise from feelings of worthlessness, pain, lethargy and 
debilitation, social isolation, or financial distress. These kinds of experiences can give a 
very dark and desperate character to ‘what it is like to be’ very ill. However, there is 
much evidence to demonstrate the ameliorating effects of counselling where the sub-
jective character of the experience is legitimated. This gives us very good reason to 
attempt to address the subjective character of illness in our discussions with those who 
are to undergo treatment.

But even if there were not clinical reasons, there are ethical reasons for addressing 
the subjective character of experience with those in our care. Consistent with valuing 
autonomy, the only fully informed consent is one where the subjective character of the 
experience has been allowed to take its place. Making way for the subjective character 
of experience is not achieved by offering up more facts for the person to ‘face’, it is 
achieved by allowing a place for the expression of a person’s perspective on the nature 
of their illness and the treatment they are being offered. Feelings of anger, fear, pity 
and hope are legitimate factors in the decision-making process at every stage of treat-
ment. Those feelings and that person’s unique perspective on their situation are facts. 

To illustrate, the Jehovah’s witness who will not accept blood at the cost of her own life 
is not stupid — she is not deficient in facts or the ability to use them — she is, perhaps 
more than any other involved party can be, fully cognisant of the relevant facts. There 
is something that it is like to be a Jehovah’s witness whose survival depends on a blood 
transfusion, and it is this ‘what it is like to be’ that so eludes and mystifies her carers, 
committed as they are to the value of objectivity. We might want to criticise the 
practice of denying oneself life-saving treatment on some other grounds, for example, 
because of its effects on those the dying person expects to care for her, but it simply 
misses the point to criticise the practice on the grounds of insufficient objectivity.

III

I want to look now at a more complex case where the ill person is incapable of exercis-
ing his or her autonomy. In the course of arguing for a consideration of the subjective 
character of experience I will also identify some possible impediments to such a con-
sideration. The case I have in mind is that of a middle-aged man (I will call him Henry), 
who has suffered a massive right ventricular infarction during coronary artery bypass 
surgery and who is failing to respond to therapy including inotropic support and intra-
aortic counterpulsation. 24 hours post-operatively, a trans-oesophageal echocardiogram 
reveals that almost the entire right ventricle is immobile. Henry is unconscious, ventilated, 
on a pacemaker and in acute renal failure. Without additional treatment he will almost 
certainly die within 48 hours. The only available treatment is to insert a right ventricular 
assist device (RVAD), and hope that his ventricle recovers quickly.

It should be noted that his current treatment of inotropes and counterpulsation is 
much less beneficial to an impaired right ventricle than to the left ventricle, so there is, 
arguably, more of a case to be made, in general, in favour of the use of the RVAD than 
a left ventricular assist device (LVAD). There is a remote chance that the right ventricle 
will regain some function within the next 72 hours [23] and that Henry will eventually 
go home — permanently disabled but to an unknown degree.
The surgeon quite appropriately turns to Henry’s immediate family for guidance. He informs them of the technical aspects of the treatment, and he informs them of the slim chances of recovery, of risks of sepsis, re-infarction, haemorrhage, brain damage and a myriad of other complications. He informs them that Henry will be sedated and probably feel little if any pain during the few days that he is on the RVAD, but that it will be “very hard work” for him during the long and fraught process of recovery. The surgeon also informs the family that they should expect their lives to be severely disrupted for at least a month if the RVAD is successful, and for whatever time Henry has after that.

There is little doubt that the family have been given all the available information about the procedure and its prospects. However, neither surgeon nor nurse is likely to attempt to convey to the family, or encourage them to imagine, what it is like to be on an RVAD or recovering from one. Chances are the staff will do their best to discourage such gruesome thoughts, which, in all likelihood, they consider to be negative and unproductive.

I have chosen this case because the use of an RVAD involves gross violation of bodily integrity. I think that it is useful to consider a case where bodily integrity is compromised to this degree because one’s body is inseparable from one’s person, and to witness such a violation evokes very strong responses in us with respect to our conceptions of person and the special value we place on humanity. No better hard evidence of the connection between the body and personal identity can be found than in one’s responses to huge physical changes in the person most close to oneself. The values we have for persons are most dramatically revealed in these cases through our ability or failure to treat the patient as a person who acts and suffers and whose existence matters to him in very specific kinds of ways.

I am emphasizing the patient’s bodily state here, because our perception of the human body really does lie close to the heart of our capacity to see another being as human, and to treat that being humanely and with respect for their autonomy. As Locke succinctly observed:

> whatever is talked of other definitions, ingenious observation puts it past doubt that the idea in our minds of which the sound man in our mouths is the sign, is nothing else but of an animal of such a certain form: since I think I may be confident that whoever shall see a creature his own shape and make, though it had no more reason all its life than a cat or a parrot, would call him still a man; or whoever should hear a cat or a parrot discourse, reason and philosophize, would call or think it nothing but a cat or parrot; and say the one was a dull irrational man and the other a very intelligent parrot. [24]

Whilst we could not doubt that the sight of a patient with a grossly violated body was still the sight of a person, that experience can be so disturbing that it can impair one’s capacity to identify and empathise with that person’s situation and needs in a way that is appropriate to that situation. Such, I believe is the situation with the RVAD patient. The sight of the patient with internal structures and organs exposed and amalgamated to machinery suggests an experience that is barely compatible with that of a human being. Certainly it challenges one’s capacity to imagine such a patient participating in normal activities of life. That the patient could be, for example, profoundly religious, a great naturalist, or a committed Marxist, is not a concern that occupies much of the time of Intensive Care staff. This can be a significant impediment to the carer’s...
capacity to act in a manner consistent with respect for autonomy. One’s sense of humanity can be eroded in subtle ways, and one of those ways originates in our responses to another’s physical appearance [25]. The further removed Henry is from the appearance of a normal person, the more effort is required to treat him as a person. The first casualty of Intensive Care is personality. With the absence of a sense of what it is like to be Henry, comes an absence of a sense of the possible subjective character of Henry’s experience on the RVAD, and the lack of the former makes it almost impossible to imagine what Henry would make of the latter. This makes it difficult to determine what Henry could reasonably be expected to consent to.

We know that there is such a thing as the subjective character of experience, and, by extension, we know that it plays a large role in determining one’s actions and preferences because it is expressive of our particular perspectives. However disturbing it is to see someone, especially one’s loved one, on something like an RVAD, it is essential that one tries to imagine what it is like to be that particular person on an RVAD if one is to attempt to act from respect for that person’s autonomy. The difficulty here lies not in becoming more objective, but in being appropriately subjective. That is, the difficulty lies in distinguishing the subjective character of the decision-maker’s (imagined) experience of being on an RVAD from the (imagined) subjective character of that particular person’s experience of being on an RVAD. I need to imagine not just what it would be like for me to be on an RVAD, but what it would be like for Henry.

Unlike the case of bat experience, humans’ bodies and persons are sufficiently similar for us to at least imagine roughly the subjective character of certain situations for certain people if our life experiences and values are sufficiently similar. It is, typically, in families or intimate relationships that we find similarity between the members’ personalities, experiences and values, and it is for these reasons that we consider family members able to provide reliable guidance in decision making. These people have at least intimations of what it is like to be that person, and it is to these intimations we must appeal if we value autonomy once we admit that autonomy is expressive of ‘what it is like to be’ that person. Insisting that a decision be made from a fully objective perspective can only produce a decision that is further from the patient’s own point of view, not closer to it.

Conclusion

There is, for each of us, something that it is like to be ‘me’, and it is called the subjective character of experience. Our subjectivity grounds the value we attach to persons and personal autonomy. When we are faced with the regrettable position of having to make dire decisions on behalf of another, the only way to act so as to respect that person’s autonomy is to promote a consideration of that person’s subjective perspective. That means talking about what it might be like for that person to be that person. I am not arguing that autonomy is the only relevant ethical consideration in cases such as the one I have presented, and I am not arguing that objectivity has no place. My argument is simply that there must be a place for consideration of the subjective character of experience if we are to understand a patient’s situation in the fullest way possible, and thus, to act in a manner most consistent with valuing fully informed consent.

Kim Atkins, 7/16 Margaret Street, Russell Lea, NSW 2046 Australia.

© Society for Applied Philosophy, 2000
NOTES

[4] This immediately raises the question of the possibility of unconscious experiences or ideas. This need not be addressed here. We can, for the purposes of this paper, confine our discussion to conscious experience or experiences of which one can become conscious and the argument stands.
[6] The important proviso here is that it must be possible to ascribe a thought to a subject. This allows for unconscious or subconscious ideas: I do not need to be actually aware of all my thoughts, but it is necessary that I be able to self-ascribe a thought if it is, in fact, to be mine. Henry Allison describes this as a “necessary possibility”, in Allison (1983) Kant’s Transcendental Idealism: an interpretation and defense (New Haven, Yale University Press), p. 140.
[15] Nagel, op. cit., p. 172: “if the facts of experience — facts about what it is like for the experiencing organism — are only accessible from one point of view, then it is a mystery how the true character of experiences could be revealed in a physical operation of that organism.”
[23] Cardiac surgeons at Sydney’s Royal Prince Alfred Hospital have suggested to me that a figure of 10% is optimistic.
[25] We need only think of the power of racism and sexism, and of the treatment of the handicapped to illustrate this point.