Chapter 1
Habilitation, Healthy Agency, and Patient-Participation

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ABSTRACT

This chapter argues, on ethical grounds, that wherever possible patient-participation must be kept consistent with the level of healthy rational agency that is, or might be, available to the patient. Merely compliant patient-participation is not enough. This is also true of patient-adaptation or adjustment. Mere adaptive compliance is not enough. Accepting patient-consent, cooperation, and compliance as an adequate indication of genuine agentic participation is often hard to avoid, but such acceptance is also often inconsistent with appropriate healthcare. These conclusions follow, as a matter of empirically informed practical ethics, from an analysis of the lifelong habilitative tasks that face every human being, and the role that the patient’s healthy agency plays in the development, protection, or restoration of the patient’s agency itself and the patient’s basic good health generally.

INTRODUCTION

The Aims of This Chapter and Its Relation to the Book as a Whole

The purpose of this chapter is to argue for the practical and ethical importance, in all healthcare contexts, of a certain conception of individual human agency – called here “healthy” agency. This form of agency is too often neglected or underemphasized in philosophy, psychology, and healthcare contexts.

In philosophy, this happens when discussions of agency are confined to metaphysical or moral problems about agent causation, volition, and moral responsibility. See, for a recent book length example, Understanding Human Agency (Mayr, 2011). In psychology, it happens when agentic activity is thought of in terms of the individual’s consciously self-centric pursuits, either together with or in opposition to more communal ones. See the recent anthology called Agency and Joint Attention (Metcalfe & Terrace, 2013).

As other chapters in the present volume will show, explicitly or implicitly, a distinction between active agents and passive patients is readily available in healthcare contexts. Moreover, in some healthcare
contexts a persistent effort is made to engage patients’ active agentic powers in their own wellness and healthcare treatment programs. Nonetheless, situations abound in which the health of the patient’s agency is neglected in healthcare research, policy, funding, and treatment decisions. Instead, it is relegated to matters of nonmedical training rather than medical treatment, and coaching rather than therapy.

This does not happen as much, of course, in places where healthy agency is by definition close to the center of treatment concerns – for example in “performance medicine” for soldiers, athletes, and other high-risk and high stress occupations, and in behavioral health contexts for people who are persistently self-destructive or compulsively antisocial. Even there, however, the relatively meager social resources allocated to the problems of agentic health may lead to its neglect in practice.

Overview of the Argument

This chapter will argue that there is an identifiable form of agency that is an essential aspect of basic good health for human beings. Thus for the same reasons healthcare professionals accept an ethical requirement to treat patients properly for broken bones, spinal cord injuries, diabetes, and life-threatening cancer they ought to accept that the proper treatment of a patient’s unhealthy agency is an ethical requirement also. It then follows that just as it is unethical to set the patient’s broken femur but leave his coincidently discovered kidney disease untreated, so too it is unethical to treat the femur and the kidneys but leave his coincidently discovered unhealthy agentic abilities untreated. Putting that into practice calls for some significant changes.

The argument to those conclusions will open with a set of background considerations. Because this chapter will be a piece of ground-level, practical, philosophical ethics – and not a report of research findings, policy analysis, or clinical practice – it will begin with some remarks about the nature of practical versus theoretical ethics, and the use practical ethics can make of the places where competing forms of ethical theory intersect, in practice, over a large area of common ground. Those remarks will include reminders about the way in which practical ethics must be well-informed by empirical work in history and the medical and behavioral sciences about that common ethical ground. This section will conclude with attention to the “circumstances of justice” – a schematic, common-ground account of special relevance for guiding normative arguments.

The main body of the argument is divided into two major parts. The first of these is the **Argument from Habilitation to Basic Good Health**, and it begins with a discussion of the lifelong human need for habilitation. This is followed by a discussion of the conceptions of basic good health and healthy agency – both in terms of standard treatments of the definition of health itself and in terms that come from focusing on habilitative necessities. Basic good health in habilitative terms is then defined as a large segment of a continuum of health states and conditions ranging from worst to best – a segment that includes both physical and psychological indices and both negative and positive dimensions. In a nutshell: in habilitative terms, basic good health is an age-appropriate, environment-specific combination of the absence of ill health and the presence of some important physical and psychological powers and strengths that are necessary for achieving and receiving habilitative necessities. Basic good health is quite distinct from ideal health, or even extremely robust health.

The second major part is the **Argument from Basic Good Health to Agentic Participation**. It begins with the premise that basically healthy agentic powers and strengths are a necessary component of basic good health. The significance of this for practical ethics is then described first in general terms, followed