

# Freedom as non-domination in behavioral and biomedical research

Research Ethics

2018, Vol. 14(3) 1–15

© The Author(s) 2017

Article reuse guidelines:

[sagepub.com/journals-permissions](http://sagepub.com/journals-permissions)

DOI: 10.1177/1747016117719064

[journals.sagepub.com/home/rea](http://journals.sagepub.com/home/rea)**Aidan Kestigian**

Carnegie Mellon University, USA

## Abstract

In the biomedical and behavioral sciences, it is widely recognized that researchers conducting studies involving human participants must respect the autonomy of research subjects. There is significant debate in the clinical research ethics and bioethics literatures about what it means for an individual to be autonomous. According to proponents of the Liberal Conception of Autonomy (LCA), an autonomous person is an agent who has interests and opinions and the capacity to deliberate about them. In contrast, proponents of the Relational Conception of Autonomy (RCA) argue that because humans are social creatures, autonomy is a relational concept and ought to be recognized as such by medical professionals. In this article, I argue that the LCA/RCA debate is flawed, and that the notion of freedom as non-domination, rather than autonomy, ought to be adopted for biomedical research ethics policies regarding informed consent and research agenda-setting. I then argue that this view of freedom should also be adopted for research ethics policies for the behavioral social sciences.

## Keywords

autonomy, clinical research, non-domination, oppression, research involving human subjects, social science

## Introduction

In the biomedical and behavioral sciences, it is widely recognized that research involving human participants must respect the autonomy of research subjects. According to federal guidelines in the United States, an autonomous person is an

## Corresponding author:

Ms Aidan Kestigian, Department of Philosophy, Carnegie Mellon University, 5000 Forbes Avenue, Baker Hall 161, Pittsburgh, PA 15213, USA.

Email: [akestigian@cmu.edu](mailto:akestigian@cmu.edu)



Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (<http://www.creativecommons.org/licenses/by-nc/4.0/>)

which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).

agent with a capacity to deliberate about her interests and the ability pursue her goals (US Department of Health & Human Services, 1979). This view has substantive implications for research policy. For example, researchers must respect research subjects' autonomy by allowing them to thoughtfully consider and willingly consent to participate in research (US Department of Health & Human Services, 2009).

Some medical ethicists have argued that federal policy for the treatment of human subjects in the biomedical sciences is flawed because it is founded on a false conception of autonomy and personhood. Research subjects are not atomistic agents with independent goals and interests, but are instead situated within and constituted by their social context (Baylis et al., 2008). In particular, critics argue the current policy is deficient because it ignores the effects of oppression on research subjects' autonomy. On the critics' view, researchers should recognize oppression as a limitation on autonomy in the informed consent phase and, further, should direct their research to counteract oppression. In particular, oppressed groups ought to be included in decisions regarding the direction of research to ensure that their medical needs are addressed.

Although I agree with the critics that oppression in biomedical research is a real problem that must be addressed, I argue that their critique of current policy is flawed. Those who support the current policy could accept that oppression diminishes autonomy in the informed consent phase because oppression impedes one's ability to choose or hinders one's capacity to deliberate. In addition, critics of current policy fail to fully justify their claim that researchers have an obligation to actively fight oppression by redirecting their research. But on this point, proponents of the current policy fare no better. I argue that Philip Pettit's view of freedom as non-domination can better encapsulate both the proponents' and critics' requirement of informed consent, and the critics' beliefs that (a) there exist groups that are oppressed in clinical research and that (b) clinical researchers have an obligation to include members of oppressed groups in decisions regarding the direction of that research. I then argue that this view of freedom should be adopted for research ethics policies for the behavioral social sciences.

In what follows, I will focus on the concepts of autonomy and freedom as they apply to behavioral and biomedical research policy in the United States only. Although respect for autonomy is recognized as a tenet of research policy in other countries and international bodies as well, and some of my arguments may be applicable to regulatory systems that use language similar to that of US policy, I do not aim to make those generalizations here.

## **Respect for autonomy in biomedical and behavioral research**

The United States Department of Health and Human Services states that biomedical and behavioral research involving human subjects ought to respect three main

principles: respect for persons, beneficence, and justice (US Department of Health & Human Services, 1979). Under beneficence, researchers are obligated to promote research subjects' well-being by minimizing harms and maximizing benefits accruing to those participants. To be just, researchers must fairly divide the benefits and burdens of their study. Respect for persons requires that a research subject be (a) treated as an autonomous agent and (b) protected if her autonomy is diminished. An autonomous person is defined as an agent who has interests and opinions and the capacity to deliberate about them, and can act in order to achieve her goals (Raz, 1986: 32; US Department of Health & Human Services, 1979). Call this view of autonomy the Liberal Conception of Autonomy (hereafter LCA). Proponents argue that the LCA protects a research subject's right to willingly consent to participate in research. In order for an agent to choose autonomously to participate in research under LCA, that choice must be free of controlling influences such as coercion or compulsion (Beauchamp and Childress, 2001).

I call the conception of autonomy just described 'Liberal' because it is commonly attributed to the moral and political tradition of Liberalism. In this tradition, an autonomous person is one who is 'author of his life' (Raz, 1986: 369). Under this conception of autonomy, a person is autonomous if she is able to control decisions throughout her lifetime such that she is able to achieve her chosen goals.

Critics argue that the LCA is deficient because it focuses almost exclusively on subjects' independent decision-making capacities (Baylis et al., 1998: 235; Entwistle et al., 2010: 741), and fails to recognize how social relationships can influence one's autonomy. These critics argue that the LCA is deficient in part because it focuses too narrowly on an individual's ability to make choices given the options she has, and ignores questions about how the individual came to have those options in the first place and, in particular, how the individual's options and preferences might be influenced or interfered with by others. Humans are social creatures whose values, interests, options, and decisions are shaped by their social relationships (Mackenzie and Stoljar, 2000: 3–32). For example, a woman living within a patriarchal society may be limited in the jobs and activities available to her because the patriarchy discourages women from those pursuits, and has diminished autonomy as a result. In this sense, autonomy is a 'relational' concept, and henceforth I will refer to this conception as the 'Relational Conception of Autonomy', or RCA. In the case of healthcare, proponents of RCA argue that 'patients are not self-contained units in terms of their health needs, for their health status is inevitably affected by their particular historical, social, and economic position' (Baylis et al., 2008: 201; Kenny et al., 2010: 9–11).

Proponents of RCA are especially concerned with the federal research ethics standards as they apply to clinical research.<sup>1</sup> They argue that clinical researchers must be attuned to research subjects' social and institutional circumstances in determining whether those subjects are autonomous. In particular, proponents of

RCA note that oppressive interpersonal relationships can diminish a research subject's autonomy (McLeod and Sherwin, 2000: 259). A significant contribution of the RCA literature has been to increase awareness of the ways in which oppression affects research subjects. Although oppression has many faces, and can affect individuals in a variety of ways, a person or group is said to be oppressed if that person or group is systematically disadvantaged. Because oppression is a phenomenon that exists at the societal level, proponents of the RCA are concerned with the ways in which social institutions and practices 'can be modified to reduce their oppressive impact and increase their liberatory potential' (Baylis et al., 1998: 235). Their claim is that oppression can exist within, and be exacerbated by, social institutions and, further, that we have a shared moral responsibility to reduce and not increase existing oppression (Sherwin, 1992: 161).

It is important to note the scope of researchers' obligations on the RCA view. When proponents of RCA call on clinical researchers to combat oppression, their goal is to have researchers be aware of the ways in which groups experience oppression in general, and attempt to combat that oppression in their work. Clinical researchers are directed to combat oppression specifically as it arises in clinical research. This is one type of oppression that oppressed groups experience in society more generally. Thus, the main focus of this article is oppression that exists within, and can be exacerbated by, medical practice and clinical research. Although the proponents of RCA do not define oppression in clinical research explicitly, in general they describe oppressed groups in medical fields as those who are systematically denied adequate healthcare and attention by the research community because of their group membership. For example, RCA proponents' examples of oppressed groups focus heavily on women and racial and ethnic minority groups – groups that they argue are frequently under-represented in medical research (Baylis et al., 1998: 240).

The proponents of RCA cite four ways that oppression can diminish a person's autonomy (McLeod and Sherwin, 2000: 261–262). First, oppression may limit the set of options a person has available to choose from. Second, oppression may shape an individual's values and desires such that the person is no longer able to choose autonomously. This problem is frequently referred to as a person's constructing 'adaptive preferences'. Third, oppression may prevent individuals from gaining the skills necessary to choose effectively. Here, critics are referring to the psychological, mental and emotional skills one needs to be an effective decision-maker. Finally, oppression may prevent a person from trusting or identifying with her choices.

Proponents of RCA argue that because oppression can influence autonomy in these ways, researchers who work within social institutions that can perpetuate oppression must adopt new practices to evaluate and address the effects of oppression on their research subjects. Researchers should ensure that their work contributes to the overall well-being of oppressed groups (McLeod and Sherwin, 2000:

261). Here, I will focus on two of the RCA proponents' specific policy proposals. First, proponents of RCA argue that researchers must recognize that oppression may hinder a research subject's ability to autonomously consent to participate in a clinical study (McLeod and Sherwin, 2000: 261; Sherwin, 2012; Stoljar, 2011). Second, because oppression affects groups as well as individuals, proponents of RCA argue that researchers ought to fight oppression in clinical research by improving healthcare for oppressed groups, and, in particular, by redirecting their research to study oppressed groups (Baylis et al., 1998: 246). As the proponents of RCA argue, the healthcare of oppressed groups has been understudied because biomedical researchers are incentivized to serve the interests of dominant classes (Baylis et al., 1998: 236; Sherwin, 1992: 167). To this end, proponents of RCA argue that members of oppressed groups ought to participate in decisions about the direction clinical research should take.<sup>2</sup>

The proponents of RCA focus on oppression because they believe that oppressive forces are related to, but distinct from, the coercive and compulsive influences commonly discussed in biomedical research ethics. Oppression functions in 'complex and often largely invisible ways, affecting whole social groups rather than simply disrupting isolated individuals' (McLeod and Sherwin, 2000: 259). As noted above, oppressed groups, although required to consent to participation in biomedical research, are frequently excluded from or underrepresented in research that may have implications for their well-being (Baylis et al., 1998: 237–243). For this reason, the proponents of RCA believe that oppression has been largely ignored by the research ethics literature that focuses on the autonomy of individuals.

Although I agree with the RCA proponents that oppression may hinder one's ability to willingly consent to participate in research, I do not believe that there is as significant a difference between the RCA and LCA requirements for informed consent as has been suggested. In particular, a sufficiently broad LCA could accept that oppression limits a research subject's autonomy in the informed consent stage. For example, like the proponents of RCA, proponents of LCA could identify oppression as an autonomy-diminishing influence when it limits the subject's ability to freely select amongst her options, such as the option to participate or not participate in a clinical trial that is relevant to one's well-being. In addition, when oppression influences the construction of one's values or the psychological capabilities necessary to make effective choices, a proponent of LCA could recognize oppression as a controlling force that will negatively influence a person's ability to choose autonomously throughout her lifetime. Thus, a broad LCA could accept oppression as a limitation on a research subject's ability to consent.

However, although a proponent of the LCA could acknowledge oppression as an autonomy-diminishing influence in the informed-consent stage, thereby agreeing with the RCA proponent that oppression negatively affects one's ability to consent, neither side of the debate has sufficiently explained or justified the role (if any) that

researchers ought to play in alleviating oppression within their field. In particular, neither side has provided adequate justification for the RCA supporters' second claim that clinical researchers ought to use their work to combat oppression.

First, consider the LCA. The LCA view outlined under current policy<sup>3</sup> focuses heavily on the guidelines that researchers must follow once they have determined which population they would like to study. The autonomy condition in particular has to do with the evaluation of potential study participants from an already selected demographic. This condition is largely concerned with non-interference, or the idea that research subjects should be able to make their choice about whether to consent to research or not without being unduly influenced by others. But none of these criteria requires that the field, as a whole, select its study populations and research projects so as to alleviate oppression. Thus, the LCA fails to address the question of whether researchers have this specific obligation, or explain how researchers ought to direct their work to counteract oppression in their fields.

The proponents of RCA similarly fail to fully justify the claim that researchers have a moral responsibility to alleviate oppression by including members of oppressed groups in the research planning process. As was just noted, when research is focused on groups who experience oppression, critics and proponents of the LCA view can say that researchers must be aware of the ways in which oppression might limit a subject's ability to choose autonomously, in particular when the subject is choosing to participate in a clinical study. If a specific study were to increase oppression, one could argue that the researchers involved owe their study participants some good because of the harm done to them. But neither of these obligations at the level of individuals necessarily implies an obligation to counteract oppression at the level of medical institutions. Even if we agree with the proponents of RCA that research subjects' autonomy can be influenced by their social relationships, and that there is a general moral obligation to fight oppression, it has yet to be made clear why researchers in particular have an obligation to fight oppression in their field by redirecting the focus of their research toward certain groups and inviting them into the research design stage. Thus, neither the critics nor the proponents of current policy have fully explained why researchers have an obligation to actively fight oppression with their research. Something more is needed to justify this obligation.

It is important to make clear how oppression influences informed consent, and why the existence of oppression ought to inform research policy, because addressing each of these issues in practice may place significant burdens on clinical researchers and their research subjects. For example, if it is the case that oppression can influence one's ability to willingly consent to research, then researchers must be aware of this fact and be able to identify oppression when soliciting research subjects. Researchers may be required to participate in significant training in order to be able to identify oppressive forces. Further, if clinical research

must be redirected to study oppressed groups, and if those groups, as RCA proponents claim, ought to be included in the research policy planning process, then research must be coordinated and organized to address each of these points. In particular, researchers may be required to perform outreach to groups that experience oppression in clinical research, and invite them into the research planning process.

Members of oppressed social groups may also face burdens when participating in clinical research policy design. For example, effective participation in the policy design process may require a large time investment and a high level of clinical expertise (Sleath and Rucker, 2001: 40). Because both of the RCA proponent's proposals may require further activity and resource allocation on the part of clinical researchers and the medical institutional as a whole, and require participants in the planning process to shoulder significant burdens, it is important that we make clear what researchers and research participants' obligations are with respect to oppression in clinical research.

In the next section, I argue that one can use Philip Pettit's framework of freedom as non-domination ('FND') to address each of the points raised above. As I will argue, the FND framework can explain what oppression is, and why it is wrong, in informed consent and policy-making for clinical research. Although I agree with the proponents of RCA that oppression has many faces, one must be able to characterize the phenomenon in order to identify it and make proposals for its eradication. This is particularly important in matters of policy, where what we aim for is a definition of oppression that can be made known to clinical researchers and research subjects such that they may identify and combat oppression in practice. In particular, I will provide a definition of oppression that can be used to explain how (a) oppression can hinder a research subject's ability to willingly consent to participate in research and explain how (b) the existence of oppression in clinical research obligates clinicians to redirect their research. Thus, I am taking seriously the RCA proponent's claim that researchers have specific obligations in the fight to end oppression, and I am providing a theory that can explain why those specific obligations exist. In particular, I will explain why researchers are obligated to include members of oppressed groups in the research planning stage. Importantly, I will be providing a framework that can explain oppression as it arises in matters of informed consent and research policy at the institutional level, and not oppression broadly construed.

## **Freedom as non-domination in biomedical research**

I argue that Philip Pettit's view of freedom as non-domination can make better sense of the three main components of the debate discussed above: (i) LCA's focus on informed and consensual decision-making; (ii) the RCA's claim that oppression

can hinder a person's ability to consent to participate in research; and (iii) the RCA's claim that biomedical research should be directed so as to decrease oppression in medicine by including members of oppressed groups in the research design stage. According to Pettit, a person  $x$  is 'dominated' in a choice by person or group  $y$  when  $y$  has a power of interfering in the choice that is not controlled by  $x$  (Pettit, 2012: 50). Person  $x$ 's choice is 'controlled' by  $y$  if  $y$  can interfere with  $x$ 's choice at  $y$ 's will or discretion (Pettit, 2012: 58). Interference occurs when person  $y$  removes, alters, or misrepresents one of the options available to  $x$  (Pettit, 2012: 50–56). On this view, freedom is the absence of control that negatively affects a person's ability to choose for herself (Laborde and Maynor, 2008: 18).

Domination thus defined is a widespread phenomenon. We can identify many mundane activities that would count as 'dominating'. For example, when I give my students an assignment that is required to pass my course, I am effectively altering the options available to them.<sup>4</sup> The students must choose to do the assignment if they wish to pass the course. Examples like this may lead one to think that Pettit's definition of domination is too wide in scope. But Pettit has an answer to this concern. Although many social relationships may qualify as dominating, what truly matters for Pettit is the extent to which domination affects one's ability to assume public status, both objective and subjective. According to Pettit, people ought to enjoy freedom as non-domination to the extent that they are able to satisfy 'the eyeball test'. A person passes the eyeball test when she 'is able to look others in the eye without reason for the fear or deference that a power of interference may inspire' (Pettit, 2012: 84). Thus, although many kinds of social relationships may count as dominating, we ought to concern ourselves with those that that inspire fear of interference or deference to an interfering power.

Within the framework of freedom as non-domination, oppression can be characterized as one form of domination. A person  $x$  who belongs to group  $y$  is oppressed by some person or group  $z$  if  $x$ 's choices are dominated by  $z$  on the (perhaps implicit) grounds that person  $x$  belongs to group  $y$ . In other words, person  $x$  is oppressed when she is dominated in her choice because of her membership of group  $y$  (Kramer, 2008: 43). This characterization fits nicely with the RCA proponent's claims about oppression in clinical research. For example, proponents of RCA argue that women are oppressed in medicine because their ability to choose particular treatments is reliant on the dominant group (those who direct biomedical research) choosing to pursue research in women's healthcare (Baylis et al., 1998: 237–243). Although the definition of domination, like the LCA, focuses on an individual's choices, Pettit's view makes room for the RCA proponent's argument that individuals and groups can negatively influence one another's choices. Unlike LCA, Pettit's view acknowledges that a person can be wronged simply because a dominant person or class has the *ability* to affect the individual's choice, even if the dominant group does not choose to do so. Thus, the freedom as non-domination view can explain what is



wrong with interfering with an individual's ability to choose (the focus of LCA), and recognize the negative impact that social relationships can have on an individual's options (a focus of RCA). In this way, Pettit's view bridges the divide between the choice-centric LCA and the RCA social account of autonomy.

Philip Pettit's view of freedom is housed within the larger framework of Republican political theory.<sup>5</sup> In the last decade, several authors have discussed the implications of Republicanism for medical ethics, and in particular, for public health ethics. Republicanism acknowledges 'the relational nature of the human self ... and the contextual, social nature of the actor's meaningful, symbolically mediated relationships with others' (Harré, 1998; Jennings, 2007: 37). Once we recognize that humans are socially constituted, these authors argue that we can justify social interventions in the name of public health. For example, whereas a proponent of the LCA might reject a legal requirement that individuals receive vaccinations because that requirement overrides the individual's ability to choose to receive a vaccination or not, a proponent of Republicanism could justify a vaccination requirement on the grounds that one person's health is not independent of another's. My health relies (at least in part) on the health of the people around me, and vice versa. If I do not receive a vaccination, I jeopardize the health of those around me. In this sense, human communities are built on a 'web of interdependencies', which includes dependencies of health and welfare (Jennings, 2009).

The view of freedom presented above is very much in line with these remarks on public health. Like other authors in the Republican tradition, Pettit's view begins with an understanding of individuals as social creatures. Once we understand people in this way, we can begin to clarify the moral and political obligations of community members to one another, and, in particular, of physicians and other medical professionals to their patients and research subjects. What I aim to do below is extend the application of Republicanism to the context of research involving human subjects, and in particular, to the issues of informed consent and research agenda-setting. With the Republican view of oppression as domination in hand, I argue that Pettit's view can capture the LCA and RCA's commitment to free decision-making on the part of the research subject in the informed consent phase and, in addition, the RCA's view that oppression can negatively affect a research subject's ability to consent to research. I then go on to argue that the freedom as non-domination view can do something that neither of the autonomy views discussed above was able to do: to justify an obligation on the part of researchers to redirect their work to study health issues that affect oppressed groups.

First, consider the notion of informed consent. Under the LCA and RCA views, research subjects must autonomously choose to participate in research. Although Pettit's view focuses on freedom instead of autonomy, Pettit would still require that research subjects enter willingly into research. In particular, on Pettit's view, subjects must control their choice to participate in research.<sup>6</sup> That is, subjects must

agree to participate in research in such a way that a subject's will is the determinant of her participation, and not the will of the researcher or some third party.

Consider the second but related claim raised by RCA proponents that oppression may hinder a person's capacity to consent to participation in research. Because oppression is a form of domination, oppression is a capacity to interfere with one's choice. When a person is oppressed with respect to her choice to enter into research, that person is not in a position to fully control her choice to consent. What is required, then, is a procedure for researchers to evaluate when oppression is sufficiently detrimental to a research subject's capacity to choose that the person is no longer able to control that choice and legitimately consent. This is precisely the kind of policy change championed by the proponents of RCA above.

To this point, I have argued that, like the RCA and LCA accounts, the freedom as non-domination framework can explain the significance of informed consent in clinical research, and further, can explain oppression's negative effects on one's ability to consent. I have focused exclusively on the notion of consent as it applies to research involving human participants. Importantly, I have not explored other related concepts, such as coercion, manipulation, or exploitation.<sup>7</sup> Future applications of the freedom as non-domination framework to clinical research should explore these important concepts, and compare them to the notions of exploitation, manipulation, and coercion on the traditional autonomy accounts. Now, I aim to show that, unlike RCA and LCA, the freedom as non-domination framework can justify the particular obligation cited by the RCA proponents above. In particular, I will argue that the freedom as non-domination framework can justify the RCA proponent's claim that research ought to be directed so as to help reduce oppression.

On Pettit's view, justice requires the protection and enjoyment of equal freedom as non-domination amongst citizens with respect to a fundamental set of choices – what Pettit calls 'basic liberties' (Pettit, 2012: 77). The basic liberties are a set of choices that are capable of being exercised by all, and capable of satisfying each, consistent with their satisfying all. They include, for example, freedoms of expression and movement (Pettit, 2012: 103). When a person or group does not enjoy one or several of the basic liberties to the same extent as other citizens, that person or group is less free.

Because oppression in the context of healthcare refers to a group's systematic inability to choose adequate treatment for their health needs because of their group membership, oppression is one form of domination in medicine. For Pettit, the ability to choose treatments for one's medical needs and the ability to receive support for disability is one realm of choice that must be protected to ensure equal freedom as non-domination (Pettit, 2012: 112). When these choices are not protected, the sick and the disabled are vulnerable to domination by others because of their medical status.

Thus, on Pettit's view, we as a political community have an obligation of justice to reduce oppression such that every person enjoys equal freedom as non-domination in healthcare. As noted above, fighting for equal freedom as non-domination would involve, among other things, ensuring that every patient has the ability to choose the treatment options she needs. However, before a physician can offer a patient treatment, the medical community requires evidence that indicates that the treatment in question will be effective in its intended purpose (US Food and Drug Administration, 2006). Determining whether a particular treatment is effective is a major role of clinical research, and, as the critics above argue, oppressed groups have historically been understudied in biomedical research because research is commonly conducted so as to be in the interest of dominant classes, thus significantly limiting the treatment options available to oppressed groups. Therefore, clinical research is a necessary step in the alleviation of oppression in healthcare.<sup>8</sup>

Thus far, I have argued that clinical researchers have an obligation to fight oppression via clinical research. Now I would like to address the final component of the RCA proponent's claim: that clinical research ought to be redirected by inviting members of oppressed groups into the research planning process.

There are various reasons one could present in favor of inclusive research agenda-setting. Here, I will discuss one particular reason related to freedom as non-domination. Recall that under freedom as non-domination, individuals ought to be protected in their ability to choose treatments for their medical needs and receive support for disability. Including members of an underrepresented group in the policy design process is necessary to learn what the group's medical needs are. Without this information, the medical institution would be unable to identify a group's medical needs, and assist in the design of research that would address the medical concerns of the group.

Note, however, that experienced clinical researchers and physicians also have an important role to play in research design decisions. Clinical expertise is required to help patients identify and understand their medical needs, and explain available avenues for treatment. Without this information, patients who are not trained as physicians or clinical researchers would likely be unable to propose research studies to address the needs of oppressed groups. Thus, the policy design process requires a cooperative dialogue between members of groups who face oppression and expert clinicians in order to combat oppression as it arises in clinical research and healthcare.

## **Freedom as non-domination in behavioral research policy-setting**

Thus far, I have focused on oppression in biomedical research. In this section, I wish to briefly argue that, under the framework of freedom as non-domination,

inclusive research policy-setting should be adopted for behavioral social scientific research as well.

The social sciences are so named because they are disciplines focused on the ways in which human behavior can influence social environments, and vice versa (Economic and Social Research Council, n.d.). Research in the social sciences provides the foundation for policies that govern interpersonal relationships and the relationships that exist between citizens and their social and political institutions. For example, political science research on American electoral behavior attempts to understand the ways that voters come to make decisions during elections. On the basis of this research, some political scientists have argued that the research provides evidence as to how we can better structure our electoral procedures.<sup>9</sup>

Above, I noted that under Philip Pettit's account of freedom, members of political communities have an obligation to alleviate oppression so as to achieve equality of freedom as non-domination for all citizens. In particular, I argued that medical researchers have an obligation to direct their research so as to counteract oppression as it arises in the clinical research. Here, I argue that a very similar argument applies in the case of the social sciences. That is, researchers in the social sciences have an obligation to counteract oppression as it arises in social scientific fields.

In medicine, oppressed individuals include those who were systematically denied access to adequate healthcare because of their membership in a particular group. We can expand our understanding of oppression to the social and political spheres as follows. Oppressed individuals include those who are systematically denied access to adequate social and political goods, such as education or political representation, because of their membership in a particular demographic. As in the case of medicine, social and political policies that aim to alleviate social and political oppression must be grounded in some evidence, generated through social scientific studies, that those policies will be effective in promoting equality in freedom of non-domination.<sup>10</sup> Thus, social scientific research is necessary in order to alleviate social and political oppression. This fact grounds the obligation of social scientific researchers to orient their research toward alleviating oppression.<sup>11</sup> Including members of oppressed groups in the policy design stage is a necessary step in learning about those groups' social and political needs and designing research programs that will address those needs in practice.

## Conclusion

This article applies Philip Pettit's framework of freedom as non-domination to the case of oppression in behavioral and biomedical research. I argue that Pettit's view can better justify researchers' obligation to alleviate oppression than the competing liberal and relational accounts of autonomy. Future work should make precise what obligations researchers have to their research subjects under freedom as

non-domination, and provide a procedure those researchers can use to evaluate the effects of oppression on research subjects' freedom.

## Acknowledgements

The author would like to thank Dr Danielle Wenner, Dr Elizabeth Victor, and the participants of the Autonomy and Applied Ethics Colloquium Session at the 2016 APA Central Meeting for their helpful comments and suggestions.

## Conflicts of interest

The author declares that there is no conflict of interest.

## Funding

All articles in Research Ethics are published as open access. There are no submission charges and no Article Processing Charges as these are fully funded by institutions through Knowledge Unlatched, resulting in no direct charge to authors. For more information about Knowledge Unlatched please see here: <http://www.knowledgeunlatched.org>.

## Notes

1. Importantly, what I say here is in reference to US federal guidelines only. Policy institutions outside of the USA have made some headway towards understanding autonomy as a relational concept. For example, the CIOMS International Ethical Guidelines for Health-related Research Involving Humans acknowledges that interpersonal relationships, and in particular, relationships that exist between a research subject and a physician, may influence one's ability to voluntarily consent to research (CIOMS, 2016: 35–36).
2. Note that this is different than the requirement that research subjects participate in the planning of a particular study. It is widely recognized that study populations should be involved in the planning of studies that will affect their groups specifically. For example, populations from which test subjects are drawn should have a say in what counts as a fair division of benefits and burdens. The claim cited here has to do with the inclusion of oppressed groups in decisions about the direction of biomedical research as a discipline.
3. It should be noted that the NIH Revitalization Act of 1993 mandates the increased inclusion of women and minority groups in NIH clinical trials. The act does not, however, mandate the inclusion of women, minority groups, or other groups commonly recognized as oppressed in scientists' research selection and planning process. Here, I am arguing that the three principles outlined in the Belmont Report fail to justify this latter obligation.
4. The author thanks an audience member at the APA Central Division Meeting 2016 for this helpful example.
5. This view is housed within a particular branch of Republican political philosophy. Pettit notes that his view of freedom is based on three main assumptions: the reality of personal choice, the possibility of alien control over one's choice, and the fact that control of a person A over person B implies that B's control over A is diminished (what Pettit calls the 'positionality' of control) (Pettit, 2008: 104–110). These assumptions limit the applicability of Pettit's theory to various societies and states. For example, it would be difficult to apply this theory in a context in which individual persons are not viewed as individualized agents but as part of a larger collective.

6. Pettit argues that control is a stronger requirement than the traditional notion of consent in the literature on autonomy. In medical research, control requires that a person be able to choose to end her participation in a research study at any time, whereas consent is an event that occurs only at the beginning of the study. For a discussion of this distinction, see (Pettit, 2012: 157–160). Pettit's notion of control matches the current understanding of consent in clinical research, in which a research participant is able to end her participation at any time.
7. Thank you to an anonymous referee for noting this limitation of my argument.
8. It should be noted that here I am not arguing that research must be equally focused on various groups, or that equal time or funding ought to be spent on the studying each kind of group-specific treatment. All I have argued is that, on Pettit's view, we can justify the critics' claim that researchers have an obligation to help fight oppression through biomedical research. This obligation arises in virtue of researchers' roles in the discovery and testing of treatment options. How much research must be focused on oppressed vs un-oppressed groups in order to achieve equal freedom as non-domination in healthcare, or how research ought to be directed so as to best fight oppression, are further questions that cannot be addressed here.
9. For example, Shineman (2012) argues that mobilization efforts are beneficial to making voters more informed about ballot issues.
10. In support of the use of evidence-based policy-making, the US government established the Evidence-Based Policymaking Commission, which aims to enhance the use of data in the evaluation of government programs (US Congress, 2016).
11. Again, how and to what extent research should be focused on oppressed groups in order to achieve equal freedom as non-domination in healthcare are further questions that must be answered to make this obligation concrete, but cannot be addressed here.

## References

- Baylis F, Downie J and Sherwin S (1998) Reframing research involving humans. In: Sherwin S (ed.) *The Politics of Women's Health: Exploring Agency and Autonomy*. Philadelphia: Temple University Press, 234–260.
- Baylis F, Kenny NP and Sherwin S (2008) A relational account of public health ethics. *Public Health Ethics* 1(3): 196–209.
- Beauchamp TL and Childress JF (2001) *Principles of Biomedical Ethics*. Oxford: Oxford University Press.
- Council for International Organizations of Medical Sciences (2016) International ethics guidelines for health-related research involving humans. Available at: <http://cioms.ch/ethical-guidelines-2016/WEB-CIOMS-EthicalGuidelines.pdf> (accessed 12 February 2017).
- Economic and Social Research Council (n.d.) *What is social science?* Available at: <http://www.esrc.ac.uk/about-esrc/what-is-social-science/> (accessed 9 April 2015).
- Entwistle VA, Carter SM, Cribb A and McCaffrey K (2010) Supporting patient autonomy: The importance of clinician-patient relationships. *Journal of General Internal Medicine* 25(7): 741–745.
- Harré R (1998) *The Singular Self*. London: SAGE.
- Jennings B (2007) Public health and civic republicanism: Toward an alternative framework for public health ethics. In: Dawson A and Verweij M (eds) *Ethics, Prevention, and Public Health*. Oxford: Oxford University Press.
- Jennings B (2009) Public health and liberty: Beyond the Millian Paradigm. *Public Health Ethics* 2(2): 123–134.

- Kenny NP, Sherwin SB and Baylis FE (2010) Re-visioning public health ethics: A relational perspective. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique* 101(1): 9–11.
- Kramer M (2008) Liberty and domination. In: Laborde C and Maynor J (eds) *Republicanism and Political Theory*. Oxford: Blackwell Publishing, 31–57.
- Laborde C and Maynor J (eds) (2008) *Republicanism and Political Theory*. Oxford: Blackwell Publishing.
- Mackenzie C and Stoljar N (eds) (2000) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford: Oxford University Press.
- McLeod C and Sherwin S (2000) Relational autonomy, self-trust, and health care for patients who are oppressed. In: Mackenzie C and Sherwin S (eds) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford: Oxford University Press.
- Pettit P (2008) Republican freedom: Three axioms, four theorems. In: Laborde C and Maynor J (eds) *Republicanism and Political Theory*. Oxford: Blackwell Publishing, 102–130.
- Pettit P (2012) *On the People's Terms: A Republican Theory and Model of Democracy*. Cambridge: Cambridge University Press.
- Raz J (1986) *The Morality of Freedom*. Oxford: Oxford University Press.
- Sherwin S (1992) *No Longer Patient: Feminist Ethics & Health Care*. Philadelphia: Temple University Press.
- Sherwin S (2012) A relational approach to autonomy in health care. In: Gedge E and Waluchow V (eds) *Readings in Health Care Ethics*. Ontario: Broadview, 14–32.
- Shineman V (2012) *Incentivizing participation increases political information: Evidence from a randomized field experiment*. Paper presented at the annual experimental methods conference of the New York University Center for Experimental Social Science, New York University, New York.
- Sleath B and Rucker TD (2001) Consumer participation in health policy decisions: Empowerment or puffery? *Journal of Health Care for the Poor and Underserved* 12(1): 35–49.
- Stoljar N (2011) Informed consent and relational conceptions of autonomy. *Journal of Medicine and Philosophy* 36(4): 375–384.
- US Congress (2016) *Evidence-based Policymaking Commission Act of 2016*. Public Law No. 114–40, 130 STAT. 317–21. Available at: <https://www.congress.gov/114/plaws/publ140/PLAW-114publ140.pdf> (accessed 20 June 2016).
- US Department of Health & Human Services (HHS), Office of Human Research Protections (1979) *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Available at: <http://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/> (accessed 1 April 2015).
- US Department of Health & Human Services (HHS), Office of Human Research Protections (2009) 45CFR §46. Available at: <http://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/> (accessed 1 April 2015).
- US Food and Drug Administration (FDA) (2006) Promoting safe and effective drugs for 100 years. Available at: <http://www.fda.gov/AboutFDA/WhatWeDo/History/ProductRegulation/PromotingSafeandEffectiveDrugsfor100Years/> (accessed 20 June 2016).