Understanding autonomy within philosophical tradition and modern medical ethics

The notion of autonomy is frequently used in ethical debates and taken for granted as a desirable value in medical practice. However, there is little consensus about what this term actually means. This article reviews the concept of autonomy within philosophical tradition and historical context. The second article in this series discusses the varieties of autonomy within clinical interaction and factors affecting the optimization of patient autonomy.

Introduction

The authors suggest there are at least three reasons to be interested in autonomy:

First, the value and promotion of patient autonomy is one of the guiding bioethical principles for the practice of modern medicine and is implicit in *Good Medical Practice* (General Medical Council, 2012). This document contains a guiding set of values which doctors are expected to uphold. Respect for autonomy is inter-woven throughout this document as so many of the practical ethical dilemmas faced by doctors encompass this issue.

Consider the patient who refuses a surgical procedure which the treating team feels the patient needs, or the patient who is withdrawing from alcohol but who refuses to stay in hospital. In this context it is an advantage to understand the conceptual framework which guides good, ethical practice and the values which should be upheld in such scenarios so that the legal tools (such as the Mental Capacity Act, the gaining of informed consent and the Mental Health Act) can be applied in a manner which is consistent with the spirit and purpose for which they were created.

Second, evidence suggests that patients are more likely to get better if they feel a heightened sense of self-efficacy and autonomy, i.e. their motivation for taking medication stems from an internal conviction that it is the right thing to do rather than simply complying with their doctors' instructions. This is simply because they are more likely to follow management plans (Williams et al, 1998), and with non-adherence rates of 20–60% in patients on medication for chronic disease the topic deserves doctors' attention (Bosworth, 2010).

Third, the concept of autonomy has a rich philosophical tradition going back (at least) to Kant. There are many different ways to approach autonomy and this is clearly reflected in the philosophical literature. Being knowledgeable about those theoretical considerations will help practitioners to encompass patient realities in a more meaningful way.

This first article introduces and analyses autonomy in a broad setting of different theoretical frameworks and traditions. It then suggests distinguishing between two universal kinds of autonomy (*Table 1*). Finally, it explains how autonomy came to be an important conception and value in modern bioethical thought.

The second article reviews some recent debates about patient autonomy in clinical interactions and the question of how it can be best promoted. It engages in a comprehensive discussion of the factors that can influence patient autonomy.

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Which autonomy?

Autonomy connotes a capacity for (or a state of) self-determination and self-government (from the Greek autos = self, nomos = law). Beyond this point, however, autonomy essentially serves as an umbrella term for a number of distinct concepts and theories in different areas of philosophy and other close-by disciplines. In what follows the authors will provide the necessary philosophical toolkit to navigate current debates of autonomy in the clinical context.

Personal autonomy *vs* group autonomy

The earliest detailed philosophical treatment of autonomy is found in Kant's moral philosophy where he defends the idea that an agent's behaviour is required to conform to principles that express autonomy of one's rational will. Another notion of autonomy finds expression earlier, however, in the classic writings of Sophocles. Here the word 'autonomous' turns up prominently during a scene of the play 'Antigone' in which the Chorus speaks

Table 1. Group autonomy *vs* personal autonomy in brief

Group autonomy	The ability of a group to be self-governing, e.g. the General Medical Council is a group of doctors which regulates the practice of all doctors in the UK. Therefore, doctors are, to a certain extent autonomous (i.e. self-regulating) professionals
Personal autonomy	Autonomy as a concept that draws attention to the conditions under which an individual's mental states and actions can be said to originate in the authentic self. This may be impaired when a patient experiences mental disorder, e.g. someone with bulimia nervosa who has compulsions to binge but wishes they did not act on them
	Autonomy as the ability of an individual to act freely, without coercion from external parties, e.g. this is exercised by a patient (who has the capacity) refusing antibiotics for a chest infection

to Antigone and explicates that her destiny (i.e. her departure towards Hades) is purely self-inflicted:

'*[G]uided by your own laws* and still alive, unlike any mortal before, you will descend to Hades' (Ant., authors' italics) (Jebb, 1891).

The context in which the notion is found here is very useful for the purposes of this article, for it helps to understand an initial basic distinction between two general kinds of autonomy. According to one approach, autonomy connotes the condition or right of a group, institution or state for self-determination or self-government, whereas the other approach is concerned with the self-determination, the personal autonomy, of individual agents.

What is interesting, now, is that Sophocles' play is essentially a discussion of the relation between the state and the individual and the inevitability of tragic outcomes when the individual is acting freely in disobedience to the state's authority. Hence, this confrontation – i.e. the state *vs* the individual – is what one might think of as a confrontation between these two senses of autonomy.

For the purpose of this article the authors will only consider the second group of accounts, those that do not focus on the self-determination of a group or state but that of an agent and his/her actions.

Personal autonomy: an overworked term?

As often commented, there is possibly no term of art more widely used, interpreted and appealed to today in moral and political theory than (personal) autonomy (Adams, 2009). Some philosophers have even felt it necessary to catalogue the different branches to keep them apart. In the book *Unprincipled Virtue*, Nomy Arpaly gives the following overview:

'There are *at least eight* distinct things we sometimes call "autonomy" […]. In discussion, we sometimes treat them *as if they were all the same*, or as if intuitions concerning any of them are equally relevant to the agency theorist who is trying to figure out what true autonomy consists in.' (Arpaly, 2003, authors' italics)

Arpaly correctly observes that it is crucial to not conflate the different branches of personal autonomy. According to her view, autonomy can be understood as:

1. Self-control (sometimes referred to as agent autonomy)
2. Material independence (personal efficacy)
3. Psychological independence
4. Normative moral autonomy (having moral rights)
5. Authenticity
6. Self-awareness and self-identification
7. Heroic autonomy
8. Reason-responsiveness.

Categorizing autonomy

What follows will consider two general kinds of personal autonomy relevant to the clinical context.

The first concept comprises views that draw attention to conditions under which an agent's desires, beliefs, reasons or actions can be considered as originating in the authentic self. According to this idea, autonomy is fundamentally a particular or relational property of the mind (for example consistency between desires, or a self-determined will) linking them to the self (Bolton and Banner, 2012). Many philosophers, both in the history of the continental and the analytic tradition, have defended such views. Prominent examples are found in the writings of Kant, Heidegger and Sartre.

Kant (1785) famously argued that every rational being's autonomous will is a will that legislates the universal law to itself (just another version of the infamous categorical imperative). Clearly, a rational and free agent will respond to reasons to determine his/her actions. But the great Kantian conception of autonomy also highlights that one would use a certain universal law to guide the decision-making process. Autonomy, understood like this, is essentially the self-imposition of the universal moral law.

A more contemporary treatment of the matter is found in the work of Harry Frankfurt (1971), where he developed a hierarchical model of mental states. Frankfurt argued that human beings have a distinctive ability to reflect about their first order desires or motives and form second order judgements and desires about them accordingly. Consider a person who wants to eat cake while, at the same time, wanting to lose weight. In this case, an autonomous agent would clearly refrain from eating the cake because autonomy with respect to a first order desire (eating the cake), on Frankfurt's view, means endorsing the possession of this first order desire*.

The second more pragmatic concept, however, comprises views concerned with the freedom of action understood as a political value. Such accounts are less concerned with a person's internal psychology that lends authorship to his/her action but with (the protection of) the individual's freedom in the context of state and society. These views highlight autonomy as a political value, typically invoked when a patient seeks to be free from paternalistic intervention.

The rise of autonomy as a value in medicine

It seems obvious that a patient's autonomous will should be respected. However, this has not always been the case; for example, one section of The Hippocratic Oath (5th century BC) states:

'Conceal most things from the patient… Give necessary orders with cheerfulness and serenity… revealing nothing of the patient's future or present condition' (Eyal, 2011).

This is in stark contrast to modern practice where the promotion of autonomy forms one of the essential bioethical pillars alongside non-maleficence, beneficence and justice. But how did it get there?

Modern bioethics emerged in reaction to the atrocities committed by German doctors working for the Nazis during their experimentation on subjects against their will. In order to prevent such things ever happening again the Nuremberg Code was established in 1947.

Wolpe (1998) charts the beginning of American bioethics from 1947 onwards, from a sociological perspective. He argues that the medical profession became increasingly powerful during the 1960s; however, this dominance was threatened by several exposures of bad practice among promi-

*There are many significant problems with hierarchical accounts of mental states, which mainly hinge around explaining what makes higher order desires special, i.e. more authentic. Despite these problems, Frankfurt's account is useful as it intuits something of what we know to be part of normal human experience, which is the normality of seemingly contradictory drives and desires which co-exist within one person.

nent medical researchers. This resulted in critiques from feminists and patients' rights groups attacking the patriarchal dominance of the profession. These attacks, Wolpe claims, created a gap for the pioneering bioethicists, a group of philosophers and theologians who saw an opportunity to escape the dead end of speculative metaethical debates and use their expertise to create a specialty for themselves attached to the prestigious and practical medical profession.

These pioneers faced a huge task in justifying their place as non-medics doing work which could impact medical practice. Out of the Kennedy Institute came an approach called 'Principlism' which was championed in Beauchamp and Childress's (2009) *Principles of Biomedical Ethics*. This book aimed to articulate an approach to solving clinical ethical dilemmas which did not rely on complex ethical theories but instead on the balancing of four key principles – autonomy, non-maleficence, beneficence and justice – in formulating a sound course of action to take when faced with an ethical dilemma.

Principlism faced much criticism yet it remains a significant concept. For the purposes of this article one of the most important criticisms is the over-dominance of autonomy which many feel wrongly 'trumps' the other principles in clinical decision making. Many argue that if patient autonomy is held up as the ultimate concern in clinical interactions other vitally important elements can be lost resulting in poorer patient care overall.

Autonomy may conflict most obviously with the principle of beneficence, in particular the autonomy of a patient with the clinician's intention (and duty) to act in their perceived best interest. Into this gap, in everyday practice, are inserted principles of a patient's capacity and acting in a patient's best interest if the patient does not display the capacity to do so him-/herself.

Of course what is important is that if a patient does display capacity the right to autonomy must be upheld and even if the decision the patient makes is thought to be unwise by the treating clinician it must be respected. Any other position on this issue is frequently derided as paternalistic which is generally regarded as undesirable. One interesting exception is in the case of mental illness where, if under section, even if a patient does display capacity to make a decision about treatment of a mental disorder or detention this can be overridden under the conditions of the Mental Health Act 1983. What is at stake here is akin to what was referred to earlier as autonomy in the political, pragmatic sense.

Also, and perhaps in a less obvious way, autonomy can conflict with justice. This is particularly evident in decisions of health-care economics. It is financially impossible to provide, for example, the best and most expensive chemotherapy agents to all without taking funds away which may pay for less sophisticated medications for other common diseases. This means that people cannot always have what they choose.

KEY POINTS

- A deeper understanding of autonomy can guide ethical decision making, facilitate patient empowerment and foster empathy.
- Autonomy can be basically translated as 'self-rule', but it serves as an umbrella term for a variety of diverse concepts.
- Personal autonomy can be contrasted with group autonomy.
- Personal autonomy can be further divided into concepts of autonomy which refer to a person's ability to act freely and without intervention and those which refer to a person's ability to make internally consistent decisions.
- Autonomy is one of the key principles in modern bioethics alongside non-maleficence, beneficence and justice.
- Autonomy was recognized as an important value to protect in medical practice following the atrocities of doctors working for the Nazi party in World War II.

Conclusions

Autonomy is an important concept in modern bioethics, but its diverse meanings in the philosophical literature are less commonly understood. For the sake of clarity, this article has initially drawn a distinction between group and personal autonomy. Personal autonomy can be further categorized into discussions about a person's ability to act freely in the sociopolitical sense and a person's ability to achieve an internal sense of autonomy. The prioritization of patient autonomy within modern medicine faces some criticism; however, a review of the historical rise of autonomy contains sobering lessons about the alternatives.

Having examined the concept of autonomy in a philosophical and historical context, the second article of this series will explore the concept of autonomy as it is expressed in clinical practice. **BJHM**

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