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Reframing patient-doctor relationships: relational autonomy and treating autonomy as a virtue

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ABSTRACT

Despite extensive theoretical debate, concrete efforts to overcome paternalism and unbalanced power relations between patients and doctors have produced limited results. In this article, I examine and build on the concept of relational autonomy to reframe the patient-doctor relationship. Specifically, I argue for an alternate form of autonomy anchored in Spinozism that recognises the relation between rationality and affectivity and moves away from the model of Cartesian dualism. I then use Filipino conceptions of individuality to explore treating autonomy as a systemic virtue, where 'virtue' is understood as a strength that requires support from systems of agency. In other words, autonomy as a systemic virtue is a practice of focusing on one's power of acting that is sustained by supportive relationships between individuals and social institutions.

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1. Introduction

The patient-doctor relationship has been under scrutiny for decades. In the seventy-five years since the Nuremberg Trials, the importance of respecting the autonomy and dignity of people seeking medical care has become a cornerstone of bioethics and a topic of political relevance. Although in the past thirty years, many professionals and institutions have countered medical paternalism by promoting person-centred care approaches, the official legal framework concerning informed consent is a more recent addition to healthcare law in the United Kingdom[1] (compared to North America, for example). An important example of this effort is the policy of 'shared decision making' which the National Health Service (NHS) in England defines as follows:

> Shared decision making (SDM) ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to decide on their treatment.
>
> The conversation brings together:
>
> • the clinician's expertise, such as treatment options, evidence, risks, and benefits

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- what the patient knows best: their preferences, personal circumstances, goals, values, and beliefs.

This model seems to delineate the expertise and responsibilities of each participant in an attempt to rectify the power imbalance between an expert (the medical practitioner) and a non-expert (the patient, or person seeking care). However, such models have proven very difficult to enact (Entwistle, Cribb, and Owens 2016; Coulter et al. 2017), not least because it is unclear what a 'collaborative process' looks like when the line between support and interference is so blurry in practice. Beyond the very real limitations of resources and time allocated to building patient-doctor relationships,[2] I suggest that the root of the theory-practice gap lies in a theoretical failure to consider the embodied and relational nature of autonomy in the decision-making process. I argue that the effort to practice effective SDM in healthcare must include a critical analysis of the philosophical assumptions about the nature of autonomy, including the belief that rational capacity and affectivity are heterogeneous. Specifically, I call for a focus on the assistive role of affectivity, its 'para-rationality'. By para-rationality I understand the embodied cognitive, imaginative, and emotive human capacities that aid and support the use of reason. I do not wish to eliminate the distinction between rationality and non-rationality, but I want to complicate their relationship and highlight how embodied rationality does not exist in a vacuum. If respecting the autonomy of patients is the goal of SDM and other person-centred policies, then we must rethink patient-doctor relationships in light of the reciprocity that exists between rationality and affectivity, a task best suited to relational theory.

The framework of relational autonomy lends itself well to the analysis of the feminist literature on bioethical issues as it acknowledges the cultural, material, and socio-political factors that co-construct individuality while remaining critical of the effects of oppressive norms on said individuality. For example, feminist bioethicists such as Susan Sherwin and Carolyn McLeod have been important contributors to relational theory from the beginning (McLeod and Sherwin 2000). However, feminist relational critiques of bioethics tend to stay within the confines of broadening the reach of rationality (Oshana 2015). My focus on non-rational or even para-rational[3] activity may elicit alarm from those who spent years advocating for the recognition of the rationality of patients in general and of marginalised people in particular. This concern is warranted. However, I argue, in the vein of feminist philosophers such as Genevieve Lloyd, that dismantling the rigid rationality/affectivity opposition can help validate people who have traditionally been excluded from the category of legitimate knowers. I argue against the assumption that reason is neutral and must therefore manifest itself in one, specific and narrow, way.

By focusing on the para-rational strength of affectivity, a fully relational account of autonomy allows for a transformation of the perceived binary of rationality/affectivity. Although relational autonomy theorists have underscored how key capacities for autonomy such as self-determination and self-governance are co-constituted by individuals and the people, institutions, and social norms in which they are embedded and with which they relate, they admit that the relation between autonomy and emotions or affectivity has been underdeveloped in the literature (Mackenzie 2019; Nedelsky 2012). Expanding on this ongoing conversation, I propose that treating autonomy as a 'virtue', or power of acting, the habitual practice of nurturing and developing one's essential striving to live, poses a more effective challenge to paternalism than the principle of respect for

autonomy (Beauchamp and Childress 2013). I situate my argument within the tradition of relational autonomy and take an approach outside of mainstream virtue ethics or deontology to focus on autonomy as a virtue, that is, as a practice of empowerment that is necessarily sustained and opposed by networks of relations. The account I develop allows me to focus on rejecting a version of autonomy that over-values supposedly neutral rationality.

I begin Section 2 by outlining my main point about treating autonomy as a virtue that requires practice and nurturing by individuals, in communities, and in and through the structures and institutions in which individuals and relationships are shaped and embedded. I also define what I mean by affectivity and reference Baruch Spinoza's use of affectivity to sketch how an account of relational autonomy is enriched when it is viewed as in a reciprocal relationship with the traits we associate with autonomy. I then discuss what Mackenzie (2019) identifies as the under-developed role of affectivity in the literature on relational autonomy and turn to an examination of Jeremiah Reyes' account of relational individuality and embodied rationality in Filipino virtue ethics as a step in filling that gap (2.2). In Section 3, I explain what I mean by using autonomy as a para-rational capacity and a virtue by using Sheila Wildeman's application of these relational insights to the patient-doctor relationship. This move challenges the idea that this relationship is limited to a dyadic and personal relationship where the focus is on the outcome of a biomedical interaction. This move also begins to expand the account of relational autonomy to examine the networks of relationships that shape the dyad of patient-doctor. In Section 4, I expand on the idea of autonomy as a relational virtue that is exercised at individual and collective levels, and I return to applying these insights to the patient-doctor relationship. In Section 5, I move the conversation from discussing autonomy as a relational virtue in general to autonomy as a virtue that highlights both the structural nature of oppression and the role of our collective responsibility to challenge and resist oppression.

2. Relational autonomy and affectivity, a tale of reciprocity

'Relational autonomy' is an umbrella term that houses different sub-theories that range from reforming classical liberal theory to exploring more neo-materialist avenues (Coole and Frost 2010). In this section, I provide a brief overview of the core principles of relational autonomy so that I may expand on some of its underlying and unstated assumptions, namely the importance of emotions for our capacity to be autonomous. I replace the notion of 'emotions' with 'affectivity' and 'affects', a shift inspired by the philosophy of Spinoza. In a Spinozist sense, affectivity is the individual's dual power to affect and to be affected or to change the world and be changed by the world. This kind of affectivity is dynamic and essentially productive, and it cannot be reduced to 'emotional states' as it involves a transition from one degree of power (or autonomy) to another (Spinoza and Hampshire 1996). Crucially for my argument, rather than drawing a strict line between rationality and affectivity in general, Spinoza views affectivity as a necessary part of one's experience of autonomy and he shifts attention to distinguishing empowering (active) affects from disempowering (passive) ones. Spinoza argues for an embodied notion of rationality that translates as a capacity for practical reason that one nurtures with the support of environmental factors, including affective causes. Reason, for

Spinoza, means understanding our affects through their causes, thereby helping us grasp what is truly advantageous for our empowerment or autonomous capacity. In other words, reason is a tool to help us orient ourselves in the world and to become more active and less passive; thus, following the guidance of reason is what Spinoza calls 'living a virtuous life.' Virtue here is not referring to a character trait one possesses, but an autonomous capacity, the individual's striving to understand herself and the world.

This is the kind of reciprocity between reason and affectivity that I want to highlight as present in various versions of relational autonomy, both in Western feminism and Filipino philosophy, and that I want to build on to refocus SDM practices. In what follows, I analyse Reyes (2015) notion of the relational individual as well as Wildeman's (2012) and Nedelsky's (2012) use of the normative function of reciprocity between parties to argue that relational autonomy should make explicit its relationship with affectivity as part of its critique of individualistic rationality.

2.1. Relational autonomy and the shadow of the para-rational

When Mackenzie and Stoljar published *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* in 2000, they wanted to capture the many facets of feminist critiques of mainstream individual autonomy. The edited volume showcases a variety of theoretical approaches that were challenging 'the conviction that the notion of individual autonomy is fundamentally individualistic and rationalistic' (Mackenzie and Stoljar 2000, 3). These feminist philosophers argue that, although every human being is embedded in a complex web of relationships, relationality and care have historically been the province of those who identify and are identified as women. Their work critiques the traditional and mainstream ideal of autonomy as the ability to free oneself from dependence, as an individual property that one either possesses or does not possess, and as representing a masculinist and reductive understanding of autonomy. The feminist concern with atomistic or hyper-individualistic accounts of autonomy is that it glosses over a fundamental reality of human existence (relationality), thus creating a system that elevates and values those who are most able to assert their independence. Relational autonomy theorists critique this definition of autonomy as independence and propose different avenues to reform it. Yet, at least in these early feminist accounts of relational autonomy, a commitment to the concept of individuality is retained.

To this end, most accounts of relational autonomy have emphasised that co-constituted rational and reflexive capacities are anchored in a strong individual self. These capacities include, but are not limited to, self-determination, self-governance, and self-authorisation, all activities that involve reflecting on our needs and desires in light of our socially-conditioned selves (Mackenzie 2019). Yet, relational theorists such as Mackenzie have also expressed the need to pay attention to the supportive aspects of para-rational capacities:

> [Relational] theorists argue that autonomy competence and capacities for critical reflection encompass a range of agential skills, including emotional and imaginative skills, not just reasoning skills. They, therefore, pose a challenge to mainstream autonomy theories that typically understand critical reflection in terms of reasons-responsiveness and think of emotions as passive elements of our psychologies. Nevertheless, the role of emotions and

> imagination in critical reflection and self-governing agency remains a relatively *under-explored* topic in the literature. (Mackenzie 2019, 26)

It is precisely this gap in the literature mentioned by Mackenzie that I wish to explore. I will argue that my account of para-rationality better captures the fully embodied experience of agency by reclaiming the productive qualities of affectivity from a narrative that paints it starkly in an anti-rational light. First, let us consider Reyes' account of relational individuality and embodied rationality in Filipino virtue ethics.

2.2. Embodied rationality: a Filipino account of relational individuality

My main argument against a conception of autonomy based on an ideal of pure rationality (thus framing the notion of 'rational capacity' in a narrow way) is that it over-values the neutrality of reason at the individual level as a foundation for ethical interaction. That kind of narrow focus does not encompass the fact that the human experience of rationality is never purely abstract: it is discovered and used by embodied individuals who are shaped by their affects. When reason is viewed as a neutral faculty, we paint an inadequate portrait of rational action. It encourages us to defend autonomy as a possession when relational theory teaches us that it is a dynamic capacity over which we never have complete control. That is why I turn to a virtue theoretic understanding of autonomy: it portrays autonomy as a fluctuating power and as a habit that, although practiced by an individual, benefits from receiving the support of others. It is cognizant of how much our relational selves are conditioned and how our past experiences and past and present environments shape our experience of rationality and, therefore, our experience of autonomy. Autonomy considered as a virtue allows us to account for this difference in experience by placing the individual within her material, religious, spiritual, and social contexts.

The association of rationality and autonomy, and specifically rationality free from affectivity, is a consequence of the modern European tradition following Descartes' formalisation of the body/mind dualism (Oshana 1998, 98). Relational theory is left grappling with a concept of individuality (and, consequently, of autonomy), rooted in the Cartesian Split. However, relational theories are not confined by the examination of Western individuality: relationality and relational individuality can be, and have been, conceived within other parameters. In an article that discusses virtue ethics, Reyes highlights two interconnected Filipino concepts: *loób* (one's relational will) and *kapwa* (acting towards others) (2015, 151). He presents these two terms as examples of philosophical 'pillars that support a special collection of virtues dedicated to strengthening and preserving human relationships' (148). Reyes claims that Filipino philosophical thought, formed in pre-colonial times and shaped by the Spanish and American periods of colonisation, contributes an interesting alternative voice to the discussion about virtue ethics. Specifically, he identifies the core quality of a Filipino ethics to be a focus on relationality and the relational agent (Reyes 2015). This approach to relational agency differs from Mackenzie's framework, notably with the absence of the focus on self-determination, thus troubling the notion of relational autonomy in the Western canon as well as of the idea of virtue.

Reyes claims that, because Filipino virtues are 'pre-rational', and because they rely much more on affective capabilities than on rational ones, they do not share the Western focus on virtues as individual qualities. Rather, partly because the traditional Filipino 'sense of self' did not develop within the enlightenment framework of the Cartesian

Split during the four centuries of Spanish colonisation and the pre-colonial tribal era, it does not separate affectivity and rationality in the same way that the Western tradition does. As a result, it is a useful analytical tool to use in the relational reframing of the conditions for autonomy. First, let us examine the concept of *loób*; it literally translates to 'inside', but Reyes warns us that we should not mistake it for a solipsistic internal faculty. Instead, *loób* refers to a relational or co-constituted agent, an essential striving-with:

> The confusion starts when people latch on to this literal translation of *loób* as 'inside' and use all sorts of twentieth-century Western philosophical and psychological theories to explain *loób*, with the subjective-objective dichotomy of Descartes or Kant looming in the background. […] One of the dangerous tendencies is to introduce a 'bifurcation' or 'dichotomy' on *loób*, between the inner person and the outside world, between subjectivity and objectivity […] (Reyes 2015, 153)

When we translate *loób* as 'one's will', we must clarify that it is not a disembodied Cartesian will that can be known through introspection alone. On the contrary, an individual's *loób* manifests itself in action, within everyday relationships with others, and not as a purely theoretical faculty. In this way, the idea of *loób* as an outward-facing virtue that can only be known through interaction (Reyes 2015, 155) departs from virtue as an individual character trait and becomes more akin to a Spinozist account of virtue as a 'power of acting'. For example, *loób* as self-direction can only be understood in relation to *kapwa*, or 'others.'

Kapwa should not be translated as 'otherness' or as that which is 'exterior' to the self. Reyes chooses to render it as 'together with the person' to bypass a mention of a 'self' altogether (2015, 156). The virtues that Reyes derives from this concept all have one thing in common: they place the utmost value on preserving and strengthening human relationships (167). Because of the relation between *loób* and *kapwa*, the concept of individual agency for Filipino philosophy[4] is radically relational. This is not a feature to overcome; it is the foundation for all ethics. Bypassing the tradition of Cartesian dualism for nearly three centuries, Filipino philosophical thought developed its account of selfhood by merging pre-colonial concepts anchored in the practical realities of tribal life with the Aristotelian and Thomistic philosophy imported by the Spanish colonisers. This theory values relational sensitivity (*hiya*) and the ability to reconstruct someone else's mental state (*pakikiramdam*) above making use of purely rational capacities of self-governance (Reyes 2015, 163–5). When we are examining the applications of relational theory in healthcare, this parallel exploration of relationality can teach us that non-Eurocentric accounts of non-individualistic autonomy exist and deserve our attention.

With Reyes, we discover that it is possible to develop a version of individuality and of autonomy that assumes relationality as the basis of all action and does not require that ethics be defined by the strict opposition of rationality and affectivity. We can see how Reyes' analysis answers Mackenzie's call for the inclusion of a 'range of agential skills' by bringing forth the notions of *loób* and *kapwa* that teach us that autonomy is expressed within a radically relational framework, one that requires strong supportive relationships. Now, for another relational response to dismantling the affective-rational binary, let us turn to Wildeman's (2012) analysis of 'insight' in mental health law to explain how the reciprocal relationship between affectivity and rationality can transform the conceptual framework used to evaluate patient-doctor relationships.

3. Affectivity and autonomy: the case of psychiatric insight

The realm of affectivity captures the ethical in-between, the 'fuzzy' area between the individual and the community, between what is 'me' and what is 'other'; this is what makes it a rich terrain for exploration. Western intellectual thought has neglected the para-rational role of affectivity, or how affect prepares one for rational thinking. Wildeman's (2012) analysis of the conditions of decision-making in a psychiatric context is an example of how relational theory brings to the foreground the affective experiences and assumptions that factor into our displays of rational capacity.

In 'Insight Revisited: Relationality and Psychiatric Treatment Decision-Making,' Wildeman examines the role of 'insight' in recognising how one's medical condition affects one's daily life. This is a legal term used in the context of mental health evaluations, where a person is deemed 'incapable' if they lack insight into their condition. In her analysis, Wildeman appeals to the work of Sherwin (1992), McLeod and Sherwin (2000) and Nedelsky (2012) to point out that this definition of rational capacity lacks an account of the multiple systemic factors that affect one's ability to exercise autonomy. Wildeman argues that the structure of a strictly rational approach to insight overlooks the atypical expressions of autonomy of 'mad people' when their self-knowledge does not fit the accepted paradigm. A truly adequate notion of capacity must reflect the diverse impact of the individual's relationship with structural and environmental conditions that facilitate or discourage insight as well as the affective biases that hinder the recognition of different versions of insight. For example, a patient's capacity to choose between treatment options (or indeed to choose any treatment at all) is conditioned by that person's economic status, education level, race, gender, and their previous experiences with the medical system. A person who has suffered from institutional violence might express insight in a non-standard way that reflects their coping mechanisms and values. In other words, the dissociation between rationality and affectivity creates an environment that rejects unexpected or atypical displays of autonomous thought. Our ways of understanding autonomy have a real impact on the lives of patients. Thus, it is paramount that we reflect on the nature of the standards we uphold to evaluate how inclusive or exclusive they are.

Wildeman also highlights the reciprocity between affectivity and autonomy when she broadens the scope of insight to include a critical evaluation of the capacity of medical practitioners. Sherwin (1992) had already established that, when it comes to informed consent and patient-doctor relationships, there is a difference between requiring a base-level of agency in the form of 'competence' and ensuring that the broader socio-political environment actively encourages autonomous abilities to self-govern and self-direct. In the context of considering the practical applications of health laws and policies, Wildeman claims that:

> mental health policymakers and practitioners should (…) be oriented not merely toward the evaluation of a patient's decisional capacity but also, and more fundamentally - even as a condition of fair evaluation - toward enabling reflection of a sort that would benefit the broader regulative ideal that Sherwin describes. (Wildeman 2012, 269)

In this passage, Wildeman warns us about what Nedelsky calls the 'affective biases' (274) of evaluators and policymakers, which is to say, the non-rational reasons, preferences, and prejudices embedded in assessment structures. Wildeman illustrates her argument with the

Starson case. In this Supreme Court of Canada case, doctors claimed that Mr. Starson lacked insight into his condition because he refused to acknowledge the efficacy of psychiatric treatment, but each party had a different interpretation of what this meant. Starson expressed that, while he recognised the value of psychotherapy, his traumatic experience taking psychiatric drugs was the main reason for his refusal of current treatment. In other words, he accepted that talk therapy was valuable and had helped him manage his symptoms; however, he fundamentally disagreed with the value of pharmaceutical psychiatric treatment in his case because of his previous negative experiences. To this the doctors objected that, even if we take his personal experience into account, Starson lacked insight because he thought of himself as a brilliant man, valuing his unconventional mind, and not as 'mentally ill', thereby refusing to identify with the category that the 'mentally healthy' doctors ascribed to him (Wildeman 2012, 262). The *Starson* case is a good example of how we can challenge the paradigms of rationality by unmasking the various affective factors that contribute to our idea of rational capacity. Ultimately, we have normalised certain depictions of rationality and devalued others; relational theory can help us to reflect on the para-rational affective conditions that prompt this categorisation.

When Wildeman stresses the necessity to examine the affective context of both the patient and the doctor, she pulls the focus away from the more vulnerable participant in the relationship to frame decisional capacity as something that is the product of collaborative efforts that are shaped by contexts, norms, structures, and conditions. This shift in perspective runs counter to the mainstream understanding of rationality according to which autonomy is something doctors, as health professionals, are assumed to possess and patients are assumed to fail to possess to the same degree. This assumption that patient autonomy is the given goal explains why efforts to promote respect for (patient) autonomy have so often been identified with non-interference to the detriment of the importance of nurturing supportive therapeutic relations. Wildeman pushes us to question this assumption and to include an account of the broader social and institutional conditions that affect our capacity for autonomy (2012, 267).

With her analysis of the *Starson* case, Wildeman has shown how we need to move beyond conceiving of autonomy in healthcare as based on an analysis of rationality as such. Importantly for my purposes, she brings to attention how affectivity works with rationality. In other words, our representation of an autonomous agent reflects our affective constitution, how our power of acting is shaped by biology, education, socialisation, institutional power, and social norms. Relational theory, in this case, encourages us to radically reframe the patient-doctor relationship with reciprocity at its core, thus challenging the paternalist model by using an expanded paradigm of expertise that treats patients as experts on their own lived experience. While this may counter-balance the assumed expertise of doctors and work to rectify some of the paternalist power dynamic, I do not believe it goes far enough to challenge the idea that individuals are solely responsible for aiding or impeding their autonomy. My expanded account of relational autonomy calls for an evaluation of how broader networks of relationships shape individual encounters and therefore affect the degree of autonomous capacity. My expanded account also highlights why I follow Spinoza and Reyes in conceiving of autonomy as a virtue or practice that requires collective support, distributing the responsibility for fostering autonomous capacity across individuals, and making clear that such responsibilities must be enacted in the context of their relationships.

4. Autonomy as a relational virtue

When I speak of autonomy as a virtue, I have in mind the Latin term *vis* or strength. The philosopher Spinoza explicitly identifies virtue with individual power of acting, what we would call autonomy (Spinoza and Hampshire 1996). This interpretation integrates the ethical connotations of virtue[5] with a robust understanding of individuality, thus bringing the relational dimension of autonomy to the forefront and opening up exploration of the in-between space where the boundaries of the individual and the communal blur together. This is the no-man's-land that traditional liberal individualist accounts of autonomy want no part of, electing instead to erect walls around the self, walls that can be defended with legal rights against the attacks of the State and all those who interfere with individual freedom and rights. While it is by no means my intention to deny the importance and usefulness of individual rights, I propose that it is beneficial to conceive of autonomy as a virtue, as a repeated, individual and collective, practice of focusing on the power at hand. This definition seems to be consistent with the relational idea of autonomy as a capacity to be developed, but it shifts the focus from the individual as an entity to power relations that are a collective responsibility. Specifically, it prompts us to examine how the conditions that foster or hinder autonomy exceed the inter-individual dynamic to create systems or ecosystems. By ecosystems, I refer to the complex web of relations that shape an individual's power of acting and that, even if they are composed of and nurtured by individual participants, exceed any one person's action.

Autonomy as a power/virtue situates itself in the landscape of relational autonomy theories by challenging the boundaries between the categories of substantive (Stoljar 2000) and procedural (Friedman 2000) types of autonomy. A Spinozist relational autonomy approaches the process of autonomous living from the perspective of relationality itself, from the essential reciprocity between increasing one's power of acting and living in an empowering society. Akin to the way Reyes discusses relational agency in a different context and with different conceptual anchors than those that Mackenzie, Wildeman, and Sherwin appeal to, autonomy as a virtue centres individual-communal reciprocity as an alternative analytical framework. In other words, autonomy as a virtue emphasises the need to develop and nurture supportive relationships not only in addition to fighting oppressive relations, but in order to fight them.

That the individual is always in relationships, ones that shape rational and affective capacities and call on us to examine how ethical norms and values are co-constituted, also means that striving for autonomy relationally is a collective responsibility. Consequently, if we view the capacity for autonomy as a relational power of being active rather than remaining mostly passive in our interdependent and embodied lives, we gain access to a model of degrees of autonomy. This allows us to explain how one can have a certain degree of autonomy under oppressive conditions, while recognising that greater degrees can be achieved in nurturing environments. In the following sections I examine three advantages to defining autonomy as a relational virtue and what this means in the context of the therapeutic relationship.[6]

4.1. Advantages to viewing autonomy as a virtue

There are three main advantages to viewing autonomy as a virtue or power of acting. First, it means that as long as someone is alive, they have at least a minimum amount of power that can be conserved and augmented.[7] In clinical settings, it becomes apparent that demanding a notion of an ideal autonomous capacity from patients is impractical, but we can still strive to increase their autonomy; SDM and person-centred care constitute an effort to achieve this. However, increasing one's power of acting by expanding the area over which a patient has control in her health plan is not the only option available. Relational theory teaches us that other kinds of changes to autonomy are also beneficial (Sangiacomo 2019). It also matters *how* a patient is empowered to act, how much she feels invested and involved in the decisions that affect her. In other words, it matters how autonomy is being promoted, and studies show that the focus on the 'neutral' dissemination of biomedical information does not produce the best decision-making experience (see Entwistle and Watt 2006; 2016). By understanding how factors such as trust, hope, and safety (all factors that are linked to affectivity) shape one's embodied experience of autonomy we can see how the patient-doctor relationship can be altered to provide better support. If autonomy is a virtue, a power of acting, it is a power that needs tending; it does not just sit there, fully formed. Instead of writing policies that assume that patients have a certain degree of rationality, a relational alternative would steer doctors and patients to build and invest in relationships that seek to augment the autonomy in each encounter. This would include relationships with teams, knowledge, and policy in addition to the particular patient-doctor relationship.

Secondly, if we treat autonomy as a virtue, we commit to a long game. Practising virtue is like building an empowering habit: it requires patience, perseverance, and a lot of help. Some would insist that virtuous living is a private project (Den Uyl 2003), but relational theory rejects this account in showing how relationships themselves impact on what virtuous agents can do and on possibilities for developing virtues in themselves and with and through relationships with others. On my account, autonomy does not have a linear growth trajectory and a person's autonomous actions should never be understood in a vacuum. For example, a person with a schizoaffective disorder might spend long periods not experiencing psychosis during which she develops a deep understanding of her condition, of her life goals, and her significant relationships with others. If, when she seeks care during a flare-up of her illness, her autonomy is treated as a virtue, the attending practitioners will take into account the best way to encourage her capacity for autonomy overall when they make treatment decisions. If a show of rationality is impossible in a moment, it is still necessary to tend to the para-rational environment to ensure it fosters the ongoing practice of autonomy, thus fostering a system of support. A habit is not something that disappears because we are not consistent at all times, and neither does our capacity to be autonomous. If we understand our sense of self relationally, we can see that our autonomy goes beyond discrete moments of autonomous action and that it requires commitment and, ideally, a conducive environment.

Finally, gleaning from the first two points we realise that, by treating autonomy as a virtue, we must hold two truths at the same time: we have the power through para-rational capacities to understand and to resist oppression. In other words, developing relational autonomy requires a relational effort, encompassing the dual aspect of

autonomy as a power of acting and as a practice of resistance. When considering a patient's autonomy, the responsibility falls not only on the patient herself, as an agent, and on the doctor treating her, but also on the healthcare system, the medical education curriculum, the managerial practices in hospitals, primary care/general practitioners' offices, care homes, and the political bodies that shape the societies in which we live. Mainstream accounts of autonomy (Beauchamp and Childress 2013) enjoin the individual practitioner to treat the patient as independently rational. By contrast, conceiving autonomy as a virtue has it as a shared responsibility, a project that involves stakeholders beyond the patient-doctor dyad.

4.2. Relational virtue and resisting oppression

If all selves are constituted relationally, then virtuous living, or ethical living, always concerns more than the agent, and, therefore, an agent's virtue does not depend solely on her own efforts; it is sustained or thwarted by the world in which she lives. Paying attention to the background norms, structures, and practices that create or hinder conditions for autonomy and recognising autonomy as an embodied set of affective and rational capacities can begin to combat the harmful consequences of oppressive norms. In this section, I will focus on how the concept of relational virtue can transform the way we view patient-doctor dynamics by proposing a distribution of ethical responsibility.

In my anecdotal experience, medical practitioners and policy-makers are concerned that a more egalitarian model will result in a reversal of the power dynamic[8], sometimes placing doctors in the position of having to choose between respecting their patient's autonomy (as expressed in their preferences) or following the standards of their profession.[9] If patient autonomy increases, then their preferences gain equal footing with medical recommendations and, if they happen to clash, there would seem to be no way out of that bind. This scenario posits that distributing decision-making authority in the therapeutic relationship will effectively hinder the physician's ability to perform their role. In other words, autonomy is viewed as a zero-sum game: one person's autonomy boost removes power from another. However, in the expanded model of relational autonomy I have defended, this example of a patient-doctor conflict could be reframed as an opportunity to share the responsibility to support autonomous action, the redistribution of power becoming a new way to combine individual powers to produce a collaborative effect or decision. It is not about whether the doctor or the patient has greater veto power, but about the ways in which the decision-making process is empowering in and through the relationship itself. Ultimately, this will involve creating a culture of adaptability, as determining what is an empowering relationship will vary from patient to patient and will inevitably include reflections on the role of healthcare and what should be the markers of good healthcare. Such a shift in perspective requires that the very structures of medical encounters, of service provision, of intra-departmental communication, and medical education be changed.

5. Sharing responsibility: a sketch

Systemic approaches rooted in relational autonomy can be transformative in many ways: they encourage us to be critical of our assumptions, to pay attention to para-rational

factors, and they empower us to fight for change. The importance of being critical of our assumptions arises in Sherwin's chapter on paternalism in *No Longer Patient* (1992). At the beginning of this article, I mentioned that overcoming paternalism has been one of the key goals of feminist bioethicists for many years. Paternalism in healthcare generally means the action of a practitioner on behalf of a patient, the key qualifier being that this action is performed with the benefit of the patient in mind and not the doctor's personal agenda. In the age of informed consent, it is only justified (legally and by mainstream bioethical standards) when the patient is incapable of making a rational decision when a decision is needed. However, this need not be the default position, and Sherwin points out that assuming that patients, as a class, are inferior knowers when it comes to their healthcare is and has been harmful, especially to marginalised people who seek care. Efforts to promote person-centred care have tried to address this power imbalance notably by requiring better communication practices, but Sherwin is clear that this is not enough for feminists, and I would add, for feminist relational theorists in particular: 'Feminist analysis demands a change in the ideology that governs patient-physician interaction, not just reforms in the details of specific encounters' (Sherwin 1992, 155). The call to validate patients' experiential knowledge of their health condition is a call for radical changes in the kinds of knowledge and information that are valued in a medical context, as we have seen with the *Starson* example. It goes beyond 'taking the patient's point of view into account'; it requires that patient contributions be treated as legitimate *knowledge*, as opposed to treating them as merely voicing a 'preference'. On my account, the integration of factors and capacities that are not traditionally deemed 'rational' into the practice of rational deliberation is a necessary part of re-distributing decision-making authority. Questioning the nature of 'valuable information' encourages us to examine the para-rational knowledge that contributes to an empowering interaction between patients and medical practitioners, transitioning from a model of beneficence to one of collaboration and co-production. In other words, efforts to recalibrate the power dynamic between patients and doctors, including SDM policies, must address the underlying assumptions about knowledge as a top-down process in healthcare and of what it means to 'share' the decision-making process.

Furthermore, the focus on the para-rational, on that which is not rational but that nevertheless supports our efforts to act rationally, converges with the Wildeman argument examined above. There are undeniable complications when we move away from a model of bounded selves attending to their rights in interactions with one another to one that assumes the sort of radical permeability in my expanded account of relational autonomy as co-constitution, co-creation, and collaboration. The latter may seem to make it harder to ascribe responsibility for the consequences, ethical and otherwise, of an agent's actions. However, I believe that this is the strength of a fully relational approach. It explores embodied rationality in a way that does not shy away from the para-rational and the power of affectivity. Once we are relieved of the premise that autonomy relies only on one's capacity for rationality, we can move toward a decision-making process that is judged on the basis of its empowering capacity through what I have defended as para-rationality. Fostering relational autonomy becomes a collective responsibility when we turn attention to the background structures and institutions that shape and entrench relationships of oppression, and that in turn shape notions of how knowledge is acquired.

Finally, a relational approach to sharing responsibility allows us to situate our experience within a broader context, thus helping us to identify the relations we need to develop to combat oppression. It is not enough to grapple with the racist, sexist, homophobic, transphobic, ableist, classist, and fatphobic aspects of the healthcare system, or, in other words, it is not enough to recognise and dismantle disempowering relationships such as that which is assumed in patient-doctor relations. Relational theory invites us to seek out and build empowering relations as well as troubling our existing relationships by expanding how we think about autonomy and virtue as shaped in and through relationships. This process can lead to asking for greater adaptability. Once I recognise that my autonomy does not depend entirely on myself, that it is shaped and sustained through my supportive relationships with others, I can pay attention to those relationships and use them to increase what Spinoza refers to as my 'power of acting' or my empowerment. A patient who realises this might feel more powerful knowing that she can find support even if her options are limited and can mobilise with others to demand the support she needs. A doctor who reflects on her practice as part of a complex system can petition her manager for better inter-departmental communication practices, or to integrate resources and expertise to promote an environment that is more conducive to the ongoing development of autonomy. The individual is still very much involved, but it reframes the principle of 'respect for autonomy' (Beauchamp and Childress 2013) as an ongoing process that requires building relationships of trust (instead of taking them for granted) and pushing for systemic change. Relational theory shows us that autonomy is dynamic and does not come fully formed; consequently, in a care-seeking/care-giving scenario like the patient-doctor relationship, autonomy should be reframed as a virtue or power that is developed in relation, trading the hierarchy of kinds of knowledge for a collaborative striving for discursive knowledge.

6. Conclusion

Feminist relational theory, as explored by the feminist bioethicists I have examined encourages us to together to determine possibilities for autonomy in relationships of inequality and oppression. Accounts of relational autonomy understand individuals to be situated in contexts that shape who we are, and always within interdependent webs of relation. From this vantage point, I have expanded mainstream accounts of relational autonomy to defend an account of para-rationality as embodied and as combining capacities of affectivity and rationality. In the context of the dyad of patient-doctor relationships, para-rationality can highlight ways of reasoning and knowing that highlight the relevance of broader networks of relationship and of the norms, structures, and practices that perpetuate relationships of oppression and inequality. Using these insights, I have also developed the idea of treating autonomy as a virtue of agents, both individually and collectively, responding to and challenging oppression.

I will end by clarifying that I am not discounting the vital role that legal frameworks play in protecting individuals from abuse, be it personal or institutional. I am suggesting that we may have over-invested in 'preserving' autonomy as an individualistic concept in our Western systems of justice and healthcare by defining state intervention as *de facto* undesirable interference while not addressing the practical effects of institutional and societal value systems that exclude a number of people from being recognised as

autonomous agents. I have argued instead that viewing autonomy relationally and as a virtue allows us to resist oppressive relationships. Within an SDM framework, this habitual focus on power translates into always considering what autonomy one has over any perceived lack of autonomous capacity. Building on the reciprocal nature of rationality and affectivity, I have illustrated what can emerge by way of autonomy and knowledge when the patient-doctor relationship is placed in the broader context of oppressive norms and structures that determine in advance whose autonomy counts.

Notes

1. The turning point being the *Montgomery v. Lanarkshire Health Board* decision in 2015 because it officially changed the legal standard of the patient's 'right to information' by obliging medical practitioners to disclose all of the material consequences of each treatment option. Previously, a doctor was entitled to withhold information if they were concerned that disclosure would place the patient under undue stress as long as this decision was validated by a body of other medical professionals.
2. It is beyond the scope of this article and my expertise to analyse the resource management issues that seriously affect the practice of adequate decision-making. The scarcity of time dedicated to patient-doctor encounters, the absence of continuous care delivery, and the lack of coordination between support services and medical services are all real and important obstacles to enacting shared decision-making policies. Hopefully, my argument for a relational account of autonomy can be used to re-examine the way forward when it comes to resource management.
3. I use para-rationality because 'irrationality' has accrued too many negative connotations, especially when it comes to disparaging women, Black, Indigenous, and people of colour as knowers. 'Non-rationality' is less loaded, but it is at once too vague, possibly encompassing everything that falls outside of the bounds of 'pure' rationality, and too specific in its role as a dialectical opposite. By using 'para-rationality', I refer to the supportive aspects of the non-rational, challenging the traditional binary and recognising the important and beneficial role affectivity plays in our rational understanding of the world.
4. Reyes makes it rightfully clear that his account represents *a* Filipino philosophy, not the Filipino philosophy, since, like all other schools of thought, the intellectual tradition of the Philippines is not a monolith.
5. The ethical connotations I have in mind include both the idea that virtue is associated with personal goodness as a character trait and the notion that virtuous living (the 'good life') often requires support from a similarily-minded community.
6. The premise that there is a collective and relational responsibility to encourage autonomy raises some important questions, notably about the challenges of collective action and the possibility of manipulation and abuse. It is beyond the remit of this paper to address these questions, but I do argue that investigating the relationality of autonomy is worth the risk.
7. Given the scope of this paper, I will focus on cases where patients are conscious, although a thorough Spinozist analysis would yield an argument in favour of unconscious people retaining power.
8. A legitimate concern, because this is the logical consequence of applying a consumer model to healthcare, one that assumes that the patient is 'always right', despite healthcare not being the same as any other consumable good or service.
9. For example, see Gawande (1999).

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