Relational Professional Autonomy

CHRIS MacDONALD

The notion of "relational" autonomy—as described by feminist scholars such as Susan Sherwin[1] and Anne Donchin[2]—has been the subject of a significant body of literature over the last few years and has recently generated some interest within the field of bioethics. Although the focus of this interest has been the autonomy of ordinary moral agents, the analysis of relational autonomy can usefully be extended to apply to the autonomy of professionals, not only as individual moral agents, but in their roles as professionals as well. In this paper, I argue that professional autonomy, rightly understood, is relational in nature. This understanding of professional autonomy stands to improve our understanding of professional ethics, as well as providing a particular, concrete example of what we mean when we call autonomy "relational" and "socially embedded."

It is crucial to note, at the outset, one difference between my project and those of Sherwin and Donchin. Sherwin and Donchin seek to highlight the relational nature of the autonomy of the *oppressed*, as a way of illustrating the pervasive barriers to autonomous action that exist for members of oppressed groups. In pointing to the relational nature of *professional* autonomy, my aim is not to claim that professionals in any way constitute an oppressed group, nor even to focus on the ways in which the autonomy of professionals may, from time to time, seem limited. Rather, my hope is that my project constitutes a friendly amendment to the work of Sherwin and Donchin and others in illustrating that the relational understanding of autonomy is a *general*, rather than a *specific*, theory and is capable of application to a wide range of kinds of subjects.

Relational Autonomy

The notion of "relational" autonomy has gained prominence as a reaction against the failings of the more traditional, liberal understanding of autonomy. The liberal understanding of autonomy is accused by critics of assuming an atomistic model of human agency and interaction. Such a model involves a "false conceptualization of individuals as capable of existing apart from any social relationships, as linked together only by voluntaristic social ties."[3] On this model, moral agents move through the world doing as they see fit, limited only by their own values and capacities, and all that other agents need do by way of respecting their autonomy is to refrain from interfering with the courses of action that agents choose. According to critics of this model, human experience—and, in particular, the experience of women—is better characterized as involving networks of relationships and interdependencies. These

Cambridge Quarterly of Healthcare Ethics (2002), **11**, 282–289. Printed in the USA.
Copyright © 2002 Cambridge University Press 0963-1801/02 $12.50

https://doi.org/10.1017/S0963180102113090 Published online by Cambridge University Press

relationships and interdependencies are, for the most part, neither chosen nor optional. Thus to focus on autonomy, in this individualistic sense, is rather beside the point; this criticism seems even more apt within the domain of healthcare, suffused as it is with relationships of care and dependency. Yet feminist scholars have rightly been hesitant to do away with the notion of autonomy altogether. As Donchin noted in these pages, "Appeals to autonomy as a *right* to make certain personal decisions without interference . . . has an emancipatory aim that can be effective in resisting the authority and overvaluation of traditional institutions"[4] (emphasis original). Thus rather than giving up on the notion of autonomy as radically misconceived, a number of feminist scholars have chosen to reconceptualize autonomy, based on a more accurate understanding of humans as deeply interconnected and interdependent. The revised picture of autonomy that has resulted has come to be known as "relational autonomy."

An understanding of relational autonomy, as explicated by Susan Sherwin,[5] requires a focus on the importance of supportive social conditions for fostering autonomous action. On such a view, individual autonomy is *socially dependent*: that is, the capacity and opportunity for autonomous action is dependent on our particular social relationships and the power structures in which we are embedded.[6] Autonomy requires more than freedom from interference: it requires that one's relationships with particular individuals and institutions be constituted in such a way as to give one *genuine* opportunities for choice. Autonomy, cashed out as it traditionally is in terms of negative rights—rights to noninterference—can be a hollow thing, when the world around me presents me with vanishingly few real options. Advocates of the relational understanding of autonomy argue that individuals are never fully independent; where autonomy is our goal, that goal should consist in achieving meaningful self-direction within an overall context of interdependency.

Sherwin suggests that effective autonomy is best achieved where the social conditions that support it are in place. Those social conditions will include not just the material security required for the agent to have a range of options, but also the supportive structures—both personal and political[7]—that give one the confidence to take charge of choices. Autonomy is affected by both "transformative experiences" and "socially constructed stereotypes." As Sherwin notes, "[w]hen the messages of reduced self-worth are internalized, agents [are transformed such that they] tend to lose the ability even to know their own objective interests."[8] The thus-transformed agent may be unable to take advantage of opportunities apparently open to her. And socially constructed stereotypes of various kinds may include ascriptions of varying degrees of capacity for autonomous action. The message that an agent—qua member of a stereotyped group—lacks the capacity for autonomous action (perhaps because she supposedly lacks some cognitive or emotional aptitude) may reasonably be expected to constitute a self-fulfilling prophecy. In healthcare settings, autonomy involves the ability and opportunity to make substantive decisions about the course of treatment and may require that patients act assertively in the face of professional prestige and authority. Various transformative experiences (e.g., diagnosis, relapse) and stereotypes (e.g., the "hysterical woman") are likely to affect patients' ability to so act. As Donchin points out, "Some women are inevitably better prepared to be assertive than others because social, educational, and economic class obviously influence one's self-assurance in the face of authority."[9]

https://doi.org/10.1017/S0963180102113090 Published online by Cambridge University Press

Professional Autonomy

Sherwin's and Donchin's own focus—and that of most feminist scholars—is on the oppressed, and their relative lack of autonomy, and the reasons for that lack. This focus is well motivated. But the focus of this paper is on the other side of that coin: what about the autonomy—indeed, the paradigmatic autonomy—of the privileged? What can be learned from it? Here, I examine the autonomy possessed by one privileged group, namely healthcare professionals. A "professional" is (roughly) a member of a self-regulating occupational group granted (by legislation) the exclusive right to practice in a particular field and having an avowed dedication to using their skills and knowledge in the service of others. Standard examples of professions in this sense include physicians, nurses, lawyers, and engineers.[10] I argue that professional autonomy—like other professional privileges and responsibilities—is explicitly, concretely, relational. This argument stands to improve our understandings both of professionalism and of the relational view of autonomy.[11]

The concept of professional autonomy has both a collective and an individual application. In its collective form, we use the term "professional autonomy" to indicate the privilege of self-governance accorded to a profession. Professions are given the power to set, within broad limits, their own standards and to enforce those standards on their members. The members of a profession, as a group, are given by society the privilege of setting their own standards of both technical and ethical excellence. Thus professional bodies typically have the authority to determine educational and licensing standards, to set and enforce standards of technical excellence and ethical propriety, and to grant and revoke licenses to practice.

In its individual application, the notion of professional autonomy has to do with the ability of particular professionals to make decisions that are not subject to authoritative review by those outside of the profession.[12] When we speak of the professional autonomy of an individual, what we are really speaking of is the right—indeed, the responsibility—of a member of a profession to act according to the shared standards of that profession.[13] Professional autonomy implies the right to exercise professional judgment—in adherence to professional standards—in the face of countervailing pressures from institutional authorities, disagreement with members of other professions, or inappropriate demands on the part of patients or clients or, more generally, the public. As an example, consider a physician's ability to determine the best course of treatment for her patients. Though physicians may at times rightly complain that their practice is overly constrained by, for example, budgetary imperatives handed down from on high, most decisions made by physicians cannot be dictated by nonphysicians. For example, if best medical judgment, based on the current standard of practice, indicates that a particular treatment is appropriate for a particular patient, then, provided this treatment is in fact covered by the provincial health plan (or private insurer, as the case may be), a physician is both legally and morally justified in acting according to that judgment, regardless of whether the hospital's accounting department has judged that a different treatment modality would be more economical.

Professional autonomy also provides justification for nurses (for example) acting according to their own professional judgment, rather than simply being told what to do by physicians. The professional autonomy that nurses so

https://doi.org/10.1017/S0963180102113090 Published online by Cambridge University Press

rightly claim means that nursing expertise carries with it its own authority. It means that nursing expertise is independent of, rather than subordinate to, medical expertise.

Both the autonomy of the profession as a whole and the autonomy of the individual professional in her work environment find their source in the social construction of the profession. Both the individual and the collective aspect of professional autonomy are rooted in (a) the socially legislated powers of professional societies, and (b) the social status bestowed on professionals by our culture and social institutions.

A profession, as a group, is more than a cartel of individuals who, through secrecy or force, maintain a monopoly over a body of knowledge or expertise or field of practice. The privilege of self-regulation is granted by society, usually by means of provincial or state legislation. Thus the profession's ability to grant licenses, for example, and to prosecute those who attempt to practice without a license, is a direct result of empowering legislation. It is the consent of society—as mediated through and expressed by the executive and legislative branches of government—that gives the profession this range of freedom and authority.

Further, the relative autonomy of a profession as a group is evident in the reluctance of courts to question the wisdom of standards of proficiency and ethical conduct set by professional bodies. The relative freedom from judicial review[14] enjoyed by most professions finds its source in the common-law understanding that, for the most part, only members of a given profession possess the expertise required to judge the appropriateness of the standards set by that profession. Professions might have either more or less autonomy, depending on the extent to which the courts are willing to defer to the profession. As it happens, most professions enjoy a great deal of autonomy in this regard.

Thus the freedom that a profession has to regulate the activities of its own members is deeply influenced by the profession's relationship with other segments of society, including the executive, legislative, and judicial branches of government.

It is even clearer, perhaps, that the autonomy that professionals enjoy as individuals is socially constructed. The ability to do the things that physicians do depends crucially on a whole range of social relations and social institutions. The physician's freedom to treat patients according to her best judgment, for example, is a direct result of her membership in a supporting institution—namely, a self-regulating professional body. When she acts according to the shared standards of her profession, her colleagues will (normally) lend her their support. On the other hand, when a physician decides to act according to her own interests (or even values), she may find herself at odds with her profession's code of ethics and thus may find her right to practice either curtailed or revoked.

Further, a physician only has the education and skills—preconditions of autonomous action as a clinician—that she has because of social factors, both personal and public, that allowed her to attend medical school, to complete residency, and so on. The training of most physicians is made possible by the financial backing of the trainee's family and/or society. And it is only by dint of having been granted, by a professional regulatory body, a license to practice that she can treat patients without fear of criminal prosecution (assuming she treats them according to the standards of the profession).

https://doi.org/10.1017/S0963180102113090 Published online by Cambridge University Press

Note also the importance of the "transformative experiences" and "socially constructed stereotypes" discussed by Sherwin in the power and authority granted to individual physicians. Medical school is almost a paradigm example of a transformative experience.[15] In medical school, trainees are taught the technical skills, as well as the self-reliance, that they will need in order to act independently as clinicians upon graduation. And the stereotypes to which physicians are subject are typically autonomy enhancing. Think, for example, of the image of the physician as archetypical healer, or even savior. Even the less flattering physician stereotypes (including attributions of overconfidence, arrogance, and egotism) would, if internalized, tend to enhance a physician's perception of herself as capable of autonomous action.

Finally, the degree of authority that we give physicians over both our healthcare as individuals and the shape of our healthcare system stems not just from the knowledge base and skills they possess, but also from the epistemic authority we grant them socially. We—the public—look to physicians in time of need. We rely on their expertise and, when we need their help, place our trust in their understanding of our bodies, even when that understanding conflicts with our own.

Thus both the things that a physician is able to do, and the things she is forbidden from doing, are determined by her relationships with particular individuals and institutions.

Implications

Thus it seems that much that Sherwin and Donchin and others have said about personal autonomy can be extended to apply to professional autonomy. The autonomy of professions, and of professionals, is rooted in their relationships with various individuals and groups. Professional autonomy, then, is best understood as relational in nature. I contend that this understanding of professional autonomy as relational is useful in two ways.

First, such an understanding serves to clarify the nature of professional ethics. Too often, professional ethics—and professional autonomy in particular—is characterized in an overly individualistic manner, as if professional autonomy were no different in kind from standard, liberal, personal autonomy. But, as I have argued elsewhere,[16] this understanding is inadequate. The ethical behavior of professionals is judged neither according to (or at least not exclusively according to) some abstract standard, nor even according to her own values, but according to the concrete ethical guidelines set out in professional codes of ethics and other policy statements issued by the relevant professional bodies. Individual professionals simply do not have the freedom to decide certain issues according to their own conscience. For example, romantic liaisons with recent patients are categorically forbidden, regardless of the individual physician's opinion of the propriety of such relationships. Similarly, the medical profession in Canada (at least) imposes on physicians who wish not to perform abortions a duty to refer patients to colleagues who are willing to do so, regardless of whether such a referral would itself present a crisis of conscience for the referring physician.

In a related vein, note that this understanding of professional autonomy as relational is crucial for understanding the power imbalance that exists between clinicians and their patients. The work of Sherwin and Donchin and others

https://doi.org/10.1017/S0963180102113090 Published online by Cambridge University Press

does an excellent job of highlighting the relational factors that help explain why some individual patients may be disempowered. But the power imbalance between clinicians and patients is, by definition, a matter of the relative power of the two parties involved. We cannot understand that imbalance without understanding the other side of the equation—namely, what it is that makes clinicians powerful. And the analysis presented here suggests that the clinician's power should be interpreted as flowing from the social structures and relationships in which she is embedded. Further, understanding the relational nature of professional autonomy is important in seeking strategies for remedying situations in which we think clinicians ought to have *more* autonomy. Although we often think of clinicians as having too much power and autonomy, at other times we may think otherwise, as when administrative constraints prevent clinicians from doing what is best for their patient or when we see power imbalances between professions (e.g., between medicine and nursing) threaten quality of care. In cases such as these, a first step toward remedying inappropriate levels of autonomy, or inappropriate distributions of autonomy, will be an accurate understanding of autonomy's nature and sources. I suggest that such an understanding must attend to the relational nature of autonomy.

The second major implication of seeing professional autonomy as relational is that it may help us to learn something about a relational understanding of autonomy more generally. Note first of all that Sherwin and Donchin begin, at least, with a descriptive thesis. They argue not that autonomy *should* depend on social relationships but that it just does so depend. The kinds and degrees of autonomy that agents experience just do depend on a range of social factors. I argue that professional autonomy constitutes a crucial test of the scope of Sherwin's and Donchin's descriptions of the nature of autonomy. A good descriptive theory should apply broadly. I conclude that the relational understanding of autonomy—in applying to at least both individual autonomy and professional autonomy—passes this crucial test.

Understanding professional autonomy as relational may help us understand better the attractive, but challenging, sense in which Sherwin and others tell us that all autonomy is relational. Terms such as "contextual" and "socially embedded," when applied to autonomy, are easy to pay lip service to without understanding their implications; terms such as "social construction" usually seem almost metaphorical, or at least intangible. Such notions are attractive to anyone who sees the strong impact of social setting on who we are, what we believe, and how we act. Yet to say that a notion as complex as autonomy is "socially constructed" or "relational" can be frustratingly vague. Does "socially constructed" mean "constructed by society" (and if so, in what sense?) or "constructed in a social setting" (and if so, by whom?) or "constructed as a social activity"? Professional autonomy provides a particular, concrete example of what we mean when we call autonomy "relational" and "socially constructed."

Without this clarification, a relational understanding of autonomy faces the same challenge faced by another major feminist contribution to bioethics—namely, the contextualization of the application of principles. Calls for attention to the relations that foster autonomy are likely to receive the same reply often heard in response to calls for attention to context: "Who ever thought things were otherwise? Of course principles apply in a way that is context dependent." Similarly, "of course autonomy depends on social relations." But I take

https://doi.org/10.1017/S0963180102113090 Published online by Cambridge University Press

it that feminist calls for attention to context and relationships are calls for those assumptions to be made real and to be attended to in concrete ways. I argue that the relational nature of professional autonomy, in particular, has not been clearly understood and that taking it seriously has real implications for the way we understand professionalism.

Conclusions

My conclusion suggests two exciting lines of investigation. First, it suggests that relational (or other nonindividualistic) understandings of autonomy could be better explored by looking not just at what the weak and the oppressed lack but also at what the powerful have. This is not to say that the ways in which the disadvantaged lack effective autonomy should be ignored; on the contrary, it is to say that such disadvantages might best be highlighted against a backdrop that included a better understanding of the social relations that permit the paradigmatically autonomous action of professionals and other privileged groups.

Secondly, this conclusion (that professional autonomy is relational) suggests a shift in focus within professional ethics and indeed bioethics as a whole. It suggests that approaches that emphasize the individual decisionmaking of particular healthcare professionals (whether based on principles or cases or ideals of virtue) will always be inadequate and that a more satisfying perspective on healthcare ethics must shift attention to the social relations and institutions that distribute power.

Notes

1. Sherwin S. A relational approach to autonomy in health care. In: Sherwin S, ed. *The Politics of Women's Health: Exploring Agency and Autonomy*. Philadelphia: Temple University Press, 1998.
2. Donchin A. Reworking autonomy: toward a feminist perspective. *Cambridge Quarterly of Healthcare Ethics* 1995;4:44–55.
3. See note 2, Donchin 1995:45. In particular, Donchin notes (p. 46) that the pervasiveness of this model of autonomy results in part from "the hold on moral consciousness of Cartesian, Hobbesian, and Kantian visions of self only contingently tied to their historically situated bodies, freely choosing their own ends in life without regard to their concrete circumstances."
4. See note 2, Donchin 1995:50.
5. See note 1, Sherwin 1998.
6. Note also that our *understanding* of what it means to be autonomous is also likely influenced by our social situations.
7. I agree with argument, often made by feminist scholars, that there is no real distinction between the personal and the political. My aim here is to point to a distinction between those supports that are part of one's immediate surroundings, and those that are part of larger social structures.
8. See note 1, Sherwin 1998:36.
9. See note 2, Donchin 1995:49.
10. Which occupational groups will count as professions, on this model, will vary according to jurisdiction. In some provinces in Canada, for example, social work is a regulated profession, whereas in other provinces it is not. Although my argument here applies most strongly to the legislated professions, it will apply, with varying degrees of strength, to other powerful and prestigious occupational groups as well.
11. Although most of the examples alluded to in this paper are drawn from the medical profession, I take it that everything said here will apply—with obvious modifications—to the other professions as well.

https://doi.org/10.1017/S0963180102113090 Published online by Cambridge University Press

12. I have argued elsewhere that we too often conflate the personal autonomy of the professional with her professional autonomy. The former is a characteristic that professionals have qua individual moral agents; the latter is a characteristic that they have qua member of a profession. And the two will often be in tension. See: MacDonald C. Clinical standards and the structure of professional obligation. *Professional Ethics* 2000;8(1):7–17.
13. For more on the self-regulatory function of professional standards, see note 12, MacDonald 2000.
14. Prosterman P. Who sets the standard? what happens when a court decides to put an entire profession on trial? *CA Magazine* 1992;125(4):46–50.
15. See: Price J, Price D, Williams G, Hoffenberg R. Changes in medical student attitudes as they progress through a medical course. *Journal of Medical Ethics* 1998;24(2):110–7.
16. See note 12, MacDonald 2000.

https://doi.org/10.1017/S0963180102113090 Published online by Cambridge University Press