ARTICLE

Historical Analysis of Personal Autonomy for Prospective Healthcare

Dennis Moeke, PhD[a,b] and Jeroen van Andel, PhD[c]

[a] Amsterdam Center for Business Analytics, VU University Amsterdam, The Netherlands
[b] Senior Researcher & Lecturer, School of Healthcare, Windesheim University of Applied Sciences, Almere, The Netherlands
[c] Policy advisor, General Union of Education, Utrecht, The Netherlands

Abstract

Background: Today most healthcare providers have embraced the principle of personal autonomy as central to their strategic aims and objectives. However, amongst healthcare providers there exist many different views on what personal autonomy is and how it should be facilitated.
Objectives: This study aims to explore how personal autonomy and related concepts such as individual liberty and individualism have been interpreted over the ages, what this means for our current understanding of personal autonomy in healthcare and how this may aid current policy discussions.
Methods: Qualitative investigation of historical views related to this topic.
Results: Three major traditions can be identified, each of which defines preconditions for autonomous behavior. These preconditions are: (1) rationality and rational faculties, (2) individual rights and legislation and (3) free property rights, free market and free trade. It was found that the three historical traditions still play a key role in current discussions on personal autonomy in healthcare.
Conclusions: A thorough understanding of these traditions may be quite helpful for health stakeholders in planning health services and policies.

Keywords

Patient-centered care, autonomy in healthcare, historical analysis, rationality, patient autonomy, human rights, paternalism, freedom, free market, consumerism.

Correspondence Address

Dr. Dennis Moeke, Amsterdam Center for Business Analytics, VU University Amsterdam, De Boelelaan 1081a, 1081 HV Amsterdam, The Netherlands. Email: d.moeke@vu.nl

Introduction

In recent decades much attention has been given to personal autonomy in healthcare decision-making [1,2]. Hence, it has even become one of the fundamental principles of medical ethics [3]. This increased emphasis on personal autonomy is often seen as a social reaction to a paternalistic tradition, whereby the healthcare professional makes decisions based on what he or she finds to be in the clients' best interest, i.e. 'the healthcare professional knows best' [1]. As such, the principle of personal autonomy respects the right of self-determination and non-interference of others when making decisions about themselves. In healthcare context it is usually associated with allowing or enabling clients to make decisions about their own healthcare [4]. Oshana describes this as: *"the condition of being self-directed, of having authority over one's choices and actions whenever these are significant to the direction of one's life"* [5, p.100].

Today most healthcare providers have embraced the principle of personal autonomy as central to their strategic aims and objectives. However, amongst healthcare providers there are many different views on what personal autonomy is and how it should be facilitated. This often leads to suboptimal policies, both within healthcare institutions as well as within the whole health system, which can affect both the individual patient and health services.

It is thus felt that policy makers and managers in healthcare are in need of guidance in their struggle with the concept of personal autonomy in healthcare.

Objectives

This study aims to explore how personal autonomy and related concepts such as individual liberty and individualism have been interpreted over the ages, what this means for our current understanding of personal

autonomy in healthcare and how this may aid current policy discussions and formulations.

Methods

Using existing literature, this study explores how the principle of personal autonomy (1) has been regarded by scholars over time, (2) how these viewpoints found their way into healthcare policy, and (3) still manifest themselves in current healthcare practice.

Results

Personal autonomy: historical interpretations

Personal autonomy and related concepts such as individual liberty and individualism have been the topic of discussion for over 2000 years. This subsection aims to show how these concepts have been interpreted over the ages.

Personal autonomy: early perspectives

The word autonomy stems from the Greek words αὐτο (autos) and *νόμος* (nomos) meaning: making one's own laws, or self-rule. However, in (pre-)Socratic Greece and the early Roman empire, individualism as known today was as good as non existent. The free citizens (who excluded women, children and slaves) [6] of cities such as Athens or Rome were seen as part of an indivisible body of citizens who had plights rather than rights to take responsibility for the welfare of the city-state or polis. Nevertheless, within this context concepts such as personal autonomy and liberty were already topics of discussion. Plato and Aristotle, for instance, devoted part of their work to discussing concepts such as self-rule and freedom.

In his Nicomachean Ethics and Politics, Aristotle provides one of the first systematic analyses of what we would now call 'personal autonomy' and how it relates to 'state intervention'. Aristotle states that, in essence, happiness is the main goal of all self-regulated (i.e. autonomous) human endeavor and that this happiness can be achieved in different ways. He feels, however, that there are better and worse notions of happiness and better and worse ways of achieving it:

> *Now of the chief good (i.e. of happiness) men seem to form their notions from the different forms of life, as we might naturally expect: the many and most low conceive it as pleasure, and hence they are content with the life of sensual enjoyment. For there are three lines of life which stand out prominently to view, that just mentioned, and the life of society, and thirdly the life of contemplation. [7, p.4]*

According to Aristotle, the highest form of happiness could only be achieved by reasonable and rational beings. Hence, only philosophers, those who were able to live a life of contemplation, would be able to reach this ultimate state of happiness. As such, personal autonomy was explained as self-rule in the sense that the individual could rule himself, and choose his individual path, only insofar as he was guided by reason.

A similar view is voiced by Plato [8] who stated that the ideal state or society ought to be organized in such a way that those with the faculties to rule, the philosopher or philosopher-king, would rule those who could not and thus create a maximum of happiness for both rulers and ruled.

The subject of (individual) liberty was also studied by the Roman stoic Epictetus [9]. He pursued the line of Plato and Aristotle by stating that true freedom is the greatest good of all and that it can be achieved only through a specific state of mind. Epictetus believed that as long as one is slave to desire, fear, ambition or tied to a friend, lover, spouse or sibling, one can never truly be free. To become truly autonomous one has to train one's mind in accepting God's will. That is, not to desire, prize or become attached to something or someone and accept the variable, unstable, unpredictable and unreliable nature of things. According to Epictatus, such a state of mind could be achieved through philosophical reflection:

> *Start with things that are least valuable and most liable to be lost –things such as a jug or a glass– and proceed to apply the same ideas to clothes, pets, livestock, property; then to yourself, your body, the body's parts, your children, your sibling and your wife. [9, p.71]*

Autonomy or self-rule in Epictetus' view can be described as being able to detach oneself from pleasure, pain, earthly needs and want and to accept things as they come.

In the medieval era the teachings of Plato, Epictetus and, in particular, Aristotle remained very influential. Augustine [10] for one agreed with Aristotle that every human strives to be happy. He further believed that it was the task of philosophers to define happiness (i.e. this supreme good) and how it should be achieved. According to Augustine, the task of moral philosophy was to perform an inquiry into this supreme good. That is, the good that provides the standards for all our actions and which is sought for its own sake and not as a means to an end.

Thus, in the early perspectives on personal autonomy, reason and the rational faculties were considered as preconditions for self-rule. Seen from this perspective, when individuals are lacking in reason or rationality, someone with the capacity to act rationally should decide for them.

Modernity and the birth of individualism

The Enlightenment was a great catalyst for a more egalitarian society, freedom of speech, press and individual rights. Or as Kant stated:

> *Enlightenment is man's emergence from his self-incurred immaturity. Immaturity is one's inability to use one's own understanding without the guidance of another. This immaturity is self-incurred if its cause is not lack of understanding but lack of resolution and courage to it without the guidance of another. The motto of the enlightenment is therefore: Sapere aude! Have courage to use your own understanding! [11, p.1]*

Within this context Rousseau wrote: "Man was born free and he is everywhere in chains" [12, p.49]. According to Rousseau, to renounce one's freedom is to renounce one's humanity, one's rights as a human and equally one's duties. The only reason that people would surrender their freedom is when they see advantage in doing so. According to Rousseau, the main difficulty concerning the topic of freedom may be expressed accordingly:

> *How to find a form of association which will defend the person and goods of each member with the collective force of all, and under which each individual, while uniting himself with the others, obeys no one but himself, and remains as free as before. [12, p.60]*

The answer to the question posed by Rousseau, was seen in the promotion and acceptance of values such as representative democracy, basic human rights, individual liberty and freedom of expression. The pursuit of these ideals eventually gave way to the events that resulted in the French Revolution [13].

The ideals which were central to the French Revolution, were further developed by John Stuart Mill and Isaiah Berlin. Both are often seen as the leading authors on the topic of (individual) liberty. Mill states that:

> *The only freedom which deservers the name is that of pursuing your own goods in your own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health whether bodily or mental and spiritual. [14, p.21]*

In addition, Berlin argues that individuals make choices based on the values that make them human:

> *In the end, men choose between ultimate values; they choose as they do because their life and thought are determined by fundamental moral categories and concepts that are, at any rate over large stretches of time and space, a part of their being and thought and sense of their own identity; part of what makes them human. [15, p.31]*

Late modernity: neo-liberal autonomy

From the 1980s onwards the dominant view on personal autonomy could be described as neo-liberal. The essence of neo-liberalist freedom or neo-liberal autonomy was strongly voiced by Nobel laureate economist Milton Friedman (1912-2006). According to Friedman, human well-beings could be best advanced by liberating an institutional framework characterized by free property rights, free market and free trade:

> *The great virtue of a free market system is that it does not care what color people are; it does not care what their religion is; it only cares whether they can produce something you want to buy. It is the most effective system we have discovered to enable people who hate one another to deal with one another and help one another. [16, p.19]*

Not only, according to Friedman, a free market system displays a form of "color-blindness", but a free economy "gives people what they want instead of what a particular group thinks they ought to want" [17, p.15].

Personal autonomy throughout history: conclusions

Although painted with rather broad strokes, it is felt that the overview presented above shows the major perspectives on (the facilitation of) personal autonomy. In the Classical perspective rationality is seen as precondition for personal autonomy in the sense that only rational individuals are able to govern their own lives and those who are not should be governed by rational rulers. In the Modern perspective individual rights and legislation are seen as the precondition for personal autonomy in the sense that after the Enlightenment individual rights or the rights of man became a major topic for the common people and, eventually, for governments as well.

In essence the principle of individual rights and legislation gave individuals the opportunity to pursue their personal life goals in any way they saw fit. In the Late Modern perspective free market and free trade are seen as the precondition for personal autonomy in the sense that being able to act as a consumer is regarded as acting autonomously.

Thus, these three major traditions can be summarized as follows (see also Figure 1.):

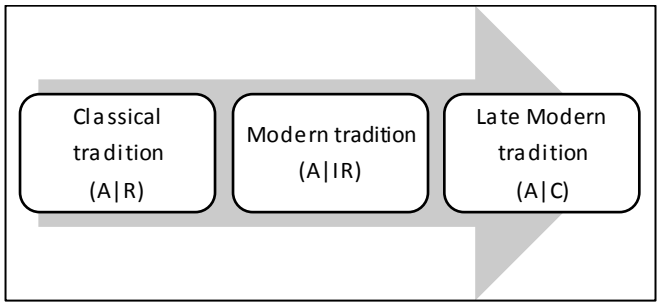
1. A Classical tradition (A|R) in which **rationality** is seen as the precondition for personal autonomy.

2. A Modern tradition (A|IR) in which **individual rights** and legislation are seen as the precondition for personal autonomy.

3. A Late Modern tradition (A|C) in which the concept of the **consumer**, free property rights, free market and free trade are seen as preconditions for personal autonomy

The following section provides an overview of how the three major traditions found their way towards healthcare policy.

Figure 1. Interpretation of personal autonomy throughout history



Personal autonomy in healthcare: historical development

Doctor knows best (A|R)

From a healthcare perspective, the Classical tradition dates back to Hippocrates of Cos (c.460-370 BC). Hippocrates was a Greek physicist and is regarded as the father of medicine as a rational science. He advocated a beneficent paternalistic paradigm in which physicians have the right to decide what is in the best interest of the patient. This is also reflected in the so-called Hippocratic oath, which is still taken today by students graduating from medical school. The oath states that: "I will use treatment to help the sick according to my ability and judgment". In other words, a physician should make decisions regarding the medical treatment of the patient based on his or her medical expertise. According to Will:

> *The language of the oath creates the impression that physicians (unlike others) have a superior knowledge that makes them capable of diagnosing illness, which carries with it the responsibility to offer treatments for the benefit of the sick. [18, p. 670]*

Hence, the healthcare professional alone had the knowledge and rationality to know what's best for the patient. This tradition continued up until the Enlightenment [18].

Patient rights (A|IR)

Legal protection of personal autonomy in healthcare traces its origins back to 28 January 1891, when the Prussian minister of the interior circulated a memorandum regarding the use of tuberculin in the prison system. In this memorandum (Ministerialblatt für die gesamte innere Verwaltung in den Koniglich Preussischen Staaten 1891. 52:27) the minister makes a clear reference to the autonomy of the patient:

> *Voraussetzung sei dabei, daß die Behandlung mit dem Kochschen Mittel nur in frischen und sonst geeigneten Fallen auch nicht gegen den Willen der Kranken angewendet werde. [It is also necessary that Koch's substance be used only in recent and appropriate cases and never against the will of the sick person].*

This official public document can be regarded as a major turning point in the shift from paternalism towards more respect for the individual rights of a patient.

The first detailed regulations on informed consent in Western medicine came in 1900 after critical press reports and political debate in the Prussian parliament on the Neisser case [19]. Albert Neisser, a German physician and bacteriologist, had injected serum from patients suffering from syphilis into a group of healthy patients, mostly prostitutes, who were admitted for other reasons. He had neither informed the women about the risks involved, nor had he obtained their consent. His experiment caused public debate as some of the women developed syphilis. The case led in 1900 to the adoption of the so-called Prussian Directive, in which the Prussian authorities advised medical directors of hospitals and clinics that research interventions should not go forward if "the human was a minor or not competent for other reasons" or if the subject had not given his or her "unambiguous consent" after a "proper explanation of the possible negative consequences" of the intervention. This was the first known governmental directive on clinical research practices [19].

Patient as consumer (A|C)

To help raise the effectiveness and efficiency of their public services, at the end of the 1980s many western countries adopted a new, strongly market-orientated form of public management known as New Public Management (NPM). From a NPM perspective, a welfare state is conceived as a market-based delivery system, while the citizen is seen as a consumer [20]. Consequently, the adherence to NPM ideology resulted in the introduction of market and quasi market-type mechanisms, which were thought to raise the 'customer responsiveness' of professional bureaucrats [21]. Eventually market principles, competition and choice found their way into healthcare sectors as well. In this new paradigm the patient was expected to act as a consumer [22]. Consequently, some policy makers and healthcare managers viewed personal autonomy as a market-based concept which defines healthcare users as individualistic actors striving to maximize their preferences. In this interpretation, the patient is regarded as a consumer in search of the best product (i.e. care, support, medicine, treatment, etc.). This rational-economic interpretation of patient autonomy resulted in the adoption of concepts such as hospitality [23, 24, 25] and an increased focus on consumer satisfaction [26, 27]. Furthermore, there has been a growing focus on providing patients with the right information about the benefits of the products of healthcare providers.

Current affairs: personal autonomy in healthcare today

All of the three perspectives presented above still seem to play a key role in current discussions on personal autonomy in healthcare. Below we describe with the help of anonymized real life examples, how the three major traditions shape current healthcare practice.

Example I reflecting the A|R Classical Tradition

Hospital X is a university medical center built to the highest standards of medical design and well equipped with 'state-of-the-art' technology. A highly skilled multidisciplinary team of specialists aims to provide the highest possible standards of clinical care in a research-informed environment. To ensure the best possible medical outcome for the patients, the hospital uses standardized, evidence-based multidisciplinary pathways. A pathway consists of an appropriate sequence of clinical interventions, timeframes and expected outcomes for a homogeneous patient group.

In this example, the knowledge and expertise of a team of specialists is dominant. Patients are seen as passive recipients of care and are considered incapable of making rational decisions about their own treatment. The focus lies on the physical aspect of the patients' disease with the purpose of ensuring the best possible clinical outcome according to the latest medical standards.

Example II reflecting the A|R Modern Tradition

Hospital Y strives to support the individual needs and preferences of its patients as much as possible. After patients are referred to the hospital, they can make an appointment with the specialist of their own choice at a time that suits the patient best. Patients are actively involved in the decision-making process and facilitated in self-management. For example, for patients with a chronic illness which requires frequent monitoring, there is the possibility to make use of telemonitoring equipment. This allows the patients to manage their own health.

In this example, the individual preferences and needs of the patient are taken as a starting point. The belief underlying this approach is that the patient is most knowledgeable about his or her own needs. The ultimate goal of this hospital is to facilitate and support the patient in such a way that the treatment meets the preferences of the client in terms of what, when, where and by whom.

Example III reflecting the A|C Late Modern Tradition

Hospital Z aims to make the hospital experience of patients and their visitors as pleasant as possible. Consequently, the hospital considers consumer service to be of the highest priority. Hospitality employees are available at the information desk in the main lobby to assist visitors as needed. The hospital has a wide range of cafés, restaurants, shops and other facilities to make the stay of the patients and visitors as pleasant as possible. The hospital offers the option to upgrade to a private or semi-private room at an extra charge. Furthermore, in return for extra payment, patients can make use of hotel style room service.

In this example, patients and visitors are regarded as persons who buy goods and/ or services from the hospital. Hence, as consumers, they have the power to choose how to spend their money. The aim of this hospital is to create ultimate customer satisfaction by providing the patient with services and products which meet or exceed their expectations.

Discussion

In this chapter we have considered the historical-philosophical underpinnings of personal autonomy in healthcare. Three main traditions were identified which still play a fundamental role in current discussions on personal autonomy in healthcare: the Classical, the Modern and the Late Modern traditions.

In the Classical tradition, rationality is seen as the precondition for personal autonomy in the sense that only rational individuals are able to govern their own lives and those who are not should be governed by rational rulers. Today we see this classical perspective represented by the fact that healthcare professionals are regarded as rational with regard to patients' health and thus able to decide for patients what they should and should not do, eat, drink, etc. In the Modern tradition, individual rights and legislation are seen as the precondition for personal autonomy in the sense that after the Enlightenment individual rights became a major topic for the common people and, eventually, for governments as well. In essence the principle of individual rights gave individuals the opportunity to pursue their personal life goals in any way they saw fit. Today this perspective is represented by laws, legal procedures and patients' rights organizations.

In the Late Modern tradition, free property rights, free market and free trade are seen as the precondition for personal autonomy in the sense that being able to act as a consumer is regarded as acting autonomously. Today users of publicly funded services are regarded more and more as customers who are in need of products provided by, for instance, government healthcare providers. When the patient is able to 'purchase' the product of his or her choice, he or she is then regarded as acting autonomously. Today this perspective is represented by organizations which have adopted concepts such as hospitality and customer service.

When facilitating personal autonomy in healthcare, policy makers should realize that tension exists between these three traditions, as follows.

Reflecting the classical tradition, although clients may be quite knowledgeable about their health situation, in most cases they may not know all the relevant clinical details and their consequences. Furthermore, in a stressful and/ or emergency situation relying on the opinion of a medical specialist or other healthcare

professionals can be a relief for the patient and the patients' family. A major pitfall of the classical perspective is a lack of respect for the ability of patients to make their own choices about their care or treatment. The opinion of the healthcare professional takes priority over the right to self-determination.

The main advantage of the modern perspective is that patients are able to make choices about their own healthcare based on their individual preferences and needs. In practice, this may imply that happiness and emotional welfare are put before physical health and safety. A possible pitfall of this approach is that it can lead to an organizational model in which healthcare professionals must comply with every patient request or demand. Furthermore, a fully demand-led model can result in cost-inefficiencies.

The third tradition allows patients to control their own healthcare costs, they become more conscientious about their spending on healthcare goods and services. It creates an incentive for healthcare consumers to make choices based on their individual needs, preferences and budget. Competition will encourage healthcare institutions to become more efficient and to allocate resources to their most profitable use. However, a healthcare system which is driven by competition and profit can lead to inequalities as it 'favors' wealthier healthcare consumers. Accordingly, medical care could become unaffordable for lower-income families. Furthermore, patients are not like regular customers as they are in a more vulnerable position and often lack the necessary information to make informed decisions.

The above shows that finding a suitable balance is a challenging quest. It raises interesting questions, for policy makers and managers in healthcare, about the extent to which it is possible to combine these traditions into a single organizational concept. The findings presented in this study may aid policy-makers, managers, and health stakeholders in general in their understanding and decision making on personal autonomy in healthcare.

Conclusions

Three traditions on personal autonomy have been elucidated in this study. The classical tradition emphasizes rationality, the modern is based on human rights, and the late modern focuses on the patient as consumer. This analysis may assist health stakeholders to understand more fully the concept of patient autonomy and to help evaluate the trade-offs that their policy choices might entail.

Acknowledgements and Disclosures

The authors do not report conflicts of interest concerning this paper.

References

[1] Proot IM, Crebolder HF, Abu-Saad HH, Meulen RH. Autonomy in the rehabilitation of stroke patients in nursing homes. A concept analysis. *Scandinavian Journal of Caring Sciences*. 1998; 12(3):139–145.

[2] Greaney AM, OMathuna DP, Scott PA. Patient autonomy and choice in healthcare: self-testing devices as a case in point. Medicine, *Health Care and Philosophy*. 2012; 15(4):383–395

[3] Beauchamp TL, Childress JF. Principles of biomedical ethics. 6th ed. New York: Oxford University Press, 2009.

[4] Entwistle VA, Carter SM, Cribb A, McCaffery K. Supporting patient autonomy: the importance of clinician-patient relationships. *Journal of General Internal Medicine*. 2010; 25(7):741–745.

[5] Oshana M. How much should we value autonomy? *Social Philosophy and Policy*. 2003; 20(2):99–126.

[6] Goff BE. Citizen Bacchea: women's ritual practice in ancient Greece. Berkeley, CA: University of California Press, 2004.

[7] Aristotle. Nichomachean Ethics. Mineola, New York: Dover Publications., 1998.

[8] Plato. Republic. Oxford: Oxford University Press, 1998.

[9] Epictetus. Of human freedom. New York: Penguin Books, 2010.

[10] Augustine S. Confessions. Translated by Henry Chadwick. Oxford: Oxford University Press, 1991.

[11] Kant I. An answer to the question: 'What is enlightenment?'. London: Penguin Books; 2010.

[12] Rousseau JJ. Rousseau: 'The Social Contract' and Other Later Political Writings. Cambridge: Cambridge University Press; 1997.

[13] Isreal JI. Democratic enlightenment. Philosophy, revolution, and human rights 1750-1790. Oxford: Oxford University Press; 2011.

[14] Mill JS. On Liberty. New York: Penguin Books; 2010.

[15] Berlin I. In: Two concepts of liberty. In Isaiah Berlin (1969) Four essays on liberty. Oxford: Oxford University Press; 1958. p. 118–172.

[16] Friedman M. Why government is the problem. Stanford, CA: Hoover Institution Press Publication; 1993.

[17] Friedman M. Capitalism and freedom. Chicago: University of Chicago press; 2009.

[18] Will JF. A brief historical and theoretical perspective on patient autonomy and medical decision making: part I: the beneficence model. *CHEST Journal*. 2011; 139(3):669–673.

[19] Vollmann J, Winau R. Informed consent in human experimentation before the Nuremberg code. BMJ: British Medical Journal. 1996; 313(7070):1445–1449.

[20] Olsen JP. In: Campbell CSJ, Peters BG, editors. Administrative reform and theories of organization. Pittsburgh, PA: University of Pittsburgh Press, 1988. p. 233–254.

[21] Pollitt C. Justification by works or by faith? Evaluating the new public management. Evaluation. 1995; 1(2):133–154.

[22] Calnan M. Consumerism and the provision of health care. *British Journal of Healthcare Management*. 2010; 16(1):37–39.

[23] Severt D, Aiello T, Elswick S, Cyr C. Hospitality in hospitals? *International Journal of Contemporary Hospitality Management*. 2008; 20(6):664–678.
[24] Aiello T, Severt D, Rompf P, Breiter D. A fundamental exploration of administrative views of hospital hospitality and service excellence. *Advances in Hospitality and Leisure*. 2010; 6:185–211.
[25] Wu Z, Hollis B, Tanner LK. The Application of Hospitality Elements in Hospitals/Practitioner application. *Journal of Healthcare Management*. 2013; 58(1):47.
[26] Abusalem S, Myer JA, Aljeesh Y. Patient satisfaction in home health care. *Journal of Clinical Nursing*. 2013; 22(17-18):2426–2435.
[27] Barr JK, Giannotti TE, Sofaer S, Duquette CE, Waters WJ, Petrillo MK. Using public reports of patient satisfaction for hospital quality improvement. *Health Services Research*. 2006; 41(3, part 1):663–682.