



Original article

Re-thinking relational autonomy: Challenging the triumph of autonomy through vulnerability

Re-pensar la autonomía relacional: desafiando el triunfo de la autonomía a través de la vulnerabilidad

Janet Delgado

University Institute of Woman's Studies, University of La Laguna, Vulnerability and Human Condition Initiative, Emory University, Gambrell Hall, 1301 Clifton Road, Atlanta, GA 30322, USA

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Abstract

Relational autonomy is a key concept in challenging the “triumph of the principle of autonomy” in bioethics. Considering the inextricable relationship between the concept of vulnerability and relational autonomy, it can be seen that autonomy and vulnerability are not incompatible. Because vulnerability is an unavoidable human condition, only through the network of relationships in which we are embedded is it possible to develop a capacity towards autonomy, understanding it through relationships. While there is a vast literature in bioethics about the term of relational autonomy, there is a lack of clarification, or systematization on the definition of the main characteristics of this term. Through the connection with a universal vulnerability concept, the aim of this paper is to develop the main characteristics of the term relational autonomy. Including the notion of vulnerability, relational autonomy can be understood as a capacity to make decisions, not as an individual, self-sufficient person, but as an individual being embedded in social relationships. A description is presented of five features of relational autonomy: relationships, capacity

E-mail address: jdelgadr@ull.edu.es

for decision making as a process, progression along the life course, professional commitment, and collectivity.

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Keywords: Relational autonomy; Vulnerability; Healthcare; Bioethics; Decision-making

Resumen

La autonomía relacional es un concepto clave a la hora de desafiar el “triunfo del principio de autonomía” en bioética. Considerando la inextricable relación que se da entre el concepto de vulnerabilidad y autonomía relacional, podemos darnos cuenta de que autonomía y vulnerabilidad no son incompatibles. Debido a que la vulnerabilidad es una condición humana inevitable, es solo a través de la red de relaciones con los demás en las que estamos insertos donde es posible desarrollar la capacidad de autonomía, entendiéndola relacionamente. Mientras que existe una amplia literatura en bioética sobre el término autonomía relacional, a la vez se da una falta de clarificación o sistematización en la definición y en la definición de las principales características del término. Mediante la conexión con el concepto universal de vulnerabilidad, el objetivo de este artículo consiste en desarrollar cuáles son las principales características que contiene el término de autonomía relacional. Incluyendo la noción de vulnerabilidad, la autonomía relacional puede ser entendida como la capacidad de tomar decisiones, no como individuos autosuficientes, sino como seres insertos en relaciones sociales. Describo cinco características de la autonomía relacional: relaciones, capacidad de tomar decisiones como un proceso, progresión a lo largo del curso de la vida, compromiso profesional y colectividad.

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Palabras clave: Autonomía relacional; Vulnerabilidad; Cuidado de la salud; Bioética; Toma de decisiones

Introduction

Vulnerability and autonomy have been thought of in terms of opposition: vulnerability as a lack of autonomy, and autonomy as a way to avoid vulnerability. This way of understanding the relationship between these two concepts is due to the misunderstanding of both. The starting point of this paper is the recognition that vulnerability is a human condition, inherent and shared by all human beings. In this sense, it is not a “lack”: it is the primary condition of human beings. We all share vulnerability, and we are all dependent on others because we are embedded in social relationships.

The concept of autonomy has been highly criticized by Feminist Theory (Dryden, 2008) and in this context, the term of relational autonomy has emerged as a critical term to better understand the meaning of autonomy. Understood in this way, we realize that human beings are always involved in a network of social relations. If there are no relationships and social conditions that allows autonomy to emerge, it is not possible to be an autonomous person. As a capacity, autonomy needs to be developed, and this is only possible at the core of supportive social relationships. The relational approaches can provide the possibility of correcting the excessive atomism that many individualistic perspectives have in bioethics (Jennings, 2016). For this purpose, the relational perspective (Downie & Llewellyn, 2012) can offer a different approach not only regarding the concept of autonomy or the vulnerability issue, but also regarding the relation between the two concepts.

I argue that vulnerability and relational autonomy are two intimately related terms: it is the same human being that is vulnerable and autonomous at the same time, but it is necessary to understand vulnerability and autonomy as relational terms. Over the last few years there has been an increasing amount of literature in Bioethics regarding the links between these two concepts (Mackenzie & Stoljar, 2000; Mackenzie, Rogers, & Dodds, 2013; Rogers, Mackenzie, & Dodds, 2012; Straehle, 2017). However, all of these proposals are focused on the connection between a pragmatic concept of vulnerability, a particular or contextual vulnerability approach, and the concept of relational autonomy. I argue that it is necessary to think about the links between the universal vulnerability approach and the notion of relational autonomy. In this regard, the concept of relational autonomy can be enriched with a series of characteristics that broaden knowledge about the same term, and that until now have not been sufficiently developed in bioethics. My purpose in this paper is to develop the concept of relational autonomy, and the connections I have encountered between this concept and the concept of vulnerability at the core of Fineman's vulnerability theory. For this end, I will start with a brief approach regarding some of the main ideas about vulnerability theory, then I will summarize how the concept of autonomy is generally understood in bioethics, and the main problems that emerge from this understanding. In the last part of the paper, I will broadly develop the main characteristics of the concept of relational autonomy.

A brief approach to vulnerability theory within bioethics

Within bioethics, the concept of vulnerability has been developed mainly in the field of biomedical research ethics. Undoubtedly, it has been very useful in

alerting researchers about the damages associated with biomedical research if minimum protection principles are not respected, particularly in certain circumstances, such as the incapacity to give informed consent or potential situations of exploitation. This way of understanding vulnerability in terms of vulnerable groups, represents the most extended influence in the development of vulnerability. However, this emphasis on the category of vulnerable population raises some problems. In this sense, vulnerability is a “dangerous” concept in bioethics, since it may stereotype those deemed vulnerable as passive, weak, and in need of protection, encouraging unwarranted paternalism and even discrimination (Rogers, Mackenzie & Dodds 2012; Ten Have, 2016).

Furthermore, a universal conception of vulnerability has been highly criticized in bioethics because it has been considered unhelpful. From a pragmatic analysis of vulnerability, some experts consider that we should stop asking so much about general accounts of vulnerability, because the way to ensure appropriate protections for research subjects is not to undertake an analysis of vulnerability in a broader sense (Allotey, Verghis, Alvarez-Castillo, & Reidpath, 2012; Hurst, 2008; Wendler, 2017). However, the concept of vulnerability is essential in bioethics not only for a pragmatic use, in the sense that it is applied to try to understand and solve contingent conditions that create vulnerability. Beyond pragmatism, it is a crucial concept in order to develop a new and distinctive ethic, more sensitive to responsibility for others in society. That is why I consider a theory on universal vulnerability to be so important (Delgado, 2017).

Universal or anthropological conceptions of vulnerability have been theorized by different authors (Butler, 2006, 2009; Levinas, 1961, 1972; MacIntyre, 2006; Nussbaum, 2006; Rendtorff, 2008; Ricoeur, 2008; Turner, 2006). For instance, Turner (2006) has developed the idea of vulnerability as common ontology shared by human beings. Rendtorff (2008) states that vulnerability must be considered as a universal expression of the human condition; as an expression of our finitude and fragile humanity.

In this paper, I will focus on Martha Fineman’s vulnerability theory. She has emphasized that vulnerability is universal and constant, it is the human condition (Fineman, 2008). Vulnerability defines what it means to be human, and this formulation reminds us our corporeality and fragility. As a common and shared condition for all human beings, vulnerability is not something that only affects specific population groups (Timmer, 2013). Fineman also emphasizes that while all human beings stand in a position of constant vulnerability, we are individually positioned differently.

We have different forms of embodiment, and people are situated differently within webs of economic and institutional relationships (Fineman, 2008). However, this does not mean that there are different kinds of vulnerability. There are no more or less vulnerable people.

One of the main aspects that Fineman emphasizes is that through the recognition of the inevitability and societal implications of human vulnerability, we can achieve a better understanding of and redefine our responsibilities as a society. The nature of human vulnerability constitutes the basis for the social justice claim that the state must be responsive to this reality in defining its responsibilities and obligations (Fineman, 2013). The vulnerable self is offered in contrast to the liberal self, which is theorized in terms of prevailing notions of autonomy and independence – an individualistic and narcissistic projection of the self, which promotes the ethics of individualism.

At this point, while vulnerability theory maintains an opposition towards the concept of autonomy, even in other re-formulations, I deem it highly important to rethink autonomy concept in bioethics field from the perspective of vulnerability approach. The concept of autonomy has had a huge impact on bioethics. It serves as a crucial concept and its importance highlights why it must now be reconsidered and redefined in relational terms. In bioethics as it is currently construed, there is a tension between responding to human vulnerability and promoting autonomy. Unmodified, the rhetoric of individual autonomy and personal responsibility can mask social injustices and structural inequalities. The relational perspective linked with vulnerability theory can maintain the value of autonomy and, at the same time, avoid the individualism and mandate of self-sufficiency associated with the liberal conceptions of autonomy. In order to address this problem, I shall consider some of the main problems regarding the liberal idea of autonomy in the field of bioethics.

What are the main problems in regard to autonomy?

The autonomy principle, and the concept of autonomous choice, is central in bioethics. In fact, most of the literature and debates have revolved around the notion of autonomy, particularly in relation to informed consent. This fact has led to the medical ethics mostly being associated with the principle of autonomy (Puyol, 2012; Varelius, 2006). Undoubtedly, this model of individualized autonomy was necessary at a time when paternalism was the main approach in clinical healthcare. The principle of autonomy has transformed the relationships between physicians or healthcare professionals and patients and this change has had positive aspects: more respect for

patient's opinions and more limits to the doctors and healthcare professional's activity without the patients' consent. In addition, advocacy for autonomy has achieved awareness about people's rights in the field of clinical practice or research. However, this recognition does not imply that it is not necessary to rethink autonomy.

Following mainly the philosophy of Kant and Mill, the autonomy principle has been related to freedom and the possibility of human development according to personal choices and desires.¹ The principle of autonomy in a modern pluralistic society is presented as the right to choose one's own way or version of the good life and is considered a supreme value (Charlesworth, 1993). The traditional idea of autonomy includes liberty and the active choices of the individual. Rendtorff (2008) emphasizes five important aspects of autonomy: the capacity for the creation of ideas and goals in life; the capacity of moral insight, "self-legislation" and privacy; the capacity of rational decision and action without coercion; the capacity of political involvement and personal responsibility, and the capacity of informed consent to medical experiments, etc.

In the field of bioethics, the principle of autonomy is expressed mainly in relation to the requirement of informed consent. Informed consent represents the assurance of complete self-determination for the patient undergoing medical treatment, signifying that the patient had a significant freedom of choice in relation to the medical treatment process. The essential element of informed consent is the provision of enough adequate information to ensure understanding, the exercise of the patient's free will if he or she is considered competent. However, the excessive emphasis on informed consent has turned relationships in healthcare into a mere contract between two parties. This fact has also brought about a fragmentation of the role that professions represent for society, instead of attending to the social wellbeing these professions desire.

The main problem regarding this conception of autonomy is that it perpetuates the myth about the existence of an independent, self-sufficient, and autonomous subject (Fineman, 2004). Within mainstream bioethics, as well as in political discourse, autonomy is structured by the liberal framework, which excessively emphasizes an individualistic, rational, and self-sufficient construction of the human being. Focusing only on autonomy renders invisible the fragility and vulnerability of the human condition, which means we all require care and respect. For that reason, a more

¹ For a broader and acute analyzes of Kant and Mill Philosophy and their influence in Bioethics, see Tauber (2005).

complex concept of human autonomy is necessary, one that includes human vulnerability ([Rendtorff, 2008](#)). In addition, it is important to realize that the focus on an unmodified principle of autonomy generates an individualistic and self-referential manner of understanding relations with others, which is especially problematic in the clinical context. Due to all this controversy, the primacy of autonomy has been questioned arguing that it is based on a distorted view of the individual who makes decisions independently and self-sufficiently, when the fact is that the decision is made in a context of personal and social relationships ([Camps, 2011](#)). Some of the problems in relation to a narrow or poorly conceived principle of respect for autonomy can encourage contractual relationships between patients and healthcare professionals ([Tauber, 2005](#)). In addition, it can lead patients or their families to feel isolated and with the responsibility to make decisions. This sensation of lack of support for that purpose can block conversations about different possible courses of action. Occasionally, respect for autonomy can force health professionals to act against their professional judgement. Some of these concerns can frustrate the potential of health professionals and the development of successful therapeutic relationship with patients ([Ells, Hunt, & Chambers-Evans, 2011](#)).

How to understand relational autonomy?

Due to these concerns, among others, the concept of autonomy has been highly criticized by Feminist Theory, and in this context, the term of relational autonomy has emerged as a critical term to better understand the meaning of autonomy ([Mackenzie & Stoljar, 2000](#)). Although there is more than one way to define and understand relational autonomy, this term broadens the scope of patient autonomy that health professionals must address. In addition to respecting the patient's right to make informed decisions, healthcare professionals must pay attention to the patient's preferences, values and network of relationships ([Ells et al., 2011](#)). Human beings are always involved in a network of social relations, and autonomy is not possible if there are no relationships and social conditions that allow this to take place. As a capacity, relational autonomy needs to be developed, and this is only possible at the core of supportive social relationships. In the context of healthcare, relational autonomy implies more emphasis on the how healthcare professionals create conditions to facilitate and support the patient's (and sometimes family) decision making process, instead of the patient's right to decide, without considering the relationship between the health care professional and the patient when making decisions.

Feminist theorists have questioned the assertion of universal and gender-neutral categories and values, arguing whether they can really apply to all human beings (Marsico, 2003). As traditionally conceived, autonomy is one of the so-called neutral values that has been investigated. A number of feminist scholars have claimed the concept of relational autonomy in an attempt to rethink autonomy along feminist lines (Mackenzie & Stoljar, 2000; Nedelsky, 1993, 2011). This discussion of autonomy reflects the need to address the concept modified by a relational frame. However, while scholars working in this area agree that both relationality and autonomy are significant aspects of human subjectivity that need to be understood together, there is a wide range of conceptions of how this interaction might be reconciled (Dryden, 2008). The term relational autonomy does not refer to a single unified conception of autonomy but is rather an umbrella term, designating a range of related perspectives (Mackenzie & Stoljar, 2000). The common conviction around which the term is built is that human beings are socially embedded and, consequently, people must be understood in the context of social relationships.²

Moser, Houtepen, Spreeuwenberg, and Widdershoven (2010) argue that autonomy can be fostered in responsive relationships when patients, nurses, healthcare team professionals and family members carry out care activities supported by a relational caring attitude.³ As Dove et al. (2017, p. 153) maintains, “relationships (with family, community and society), responsibility, care and interdependence are key attributes of relational autonomy: people develop their sense of self and form capacities and life plans through the relationships they forge on a daily and long-term basis”. In addition, we can consider this term intrinsically related to an ethics of care. Particularly, relational autonomy constitutes huger analytic and normative values than individualistic autonomy by inspiring a broader conception of human life that is socially embedded. “Such an account of autonomy promotes decision-making guided by an ethic of care and moral responsibility – whereby the person is respected as an individual but also is encouraged, at levels of legal architecture and clinical practice, to take account of her social situation such that she promotes her own flourishing as well as the flourishing of her social and natural environment” (Dove et al. (2017, p. 161–162)).

² In regard to relational autonomy, different conceptions of autonomy do not require the creation of different understandings of vulnerability, as Mackenzie and co-authors develop in Mackenzie et al. (2013).

³ In this regard, the relational care attitude is in the core of the reflection about the professional values. We can also think what happen with the autonomy of those professionals who are taken care of the patient. The relational turn on autonomy also implies a new way to think about the professional responsibility.

Heidenreich, Bremer, Materstvedt, Tidefelt, and Svantesson (2017) highlight the differences between theory and practice, since dealing with autonomy in everyday practice is more complicated. To describe the content of healthcare professionals' moral reasoning, they have conducted a qualitative study. In this research, the content of the moral reasoning was placed in two main categories: (a) how to balance convictions of what is good care and the discordant preferences for care assumed by the patient; and (b) how to establish a responsible relationship with the vulnerable person. They found that the moral reasoning was infused with discussions about patient autonomy, and these findings led them to clarify the professionals' perceptions of patient autonomy in clinical practice through the framework of relational autonomy. In this study, the professionals described their patients as being severely ill and in distress, all of which affected their decision-making capacity. They advocated that they could not leave the patient with their apparent deficient and inappropriate decisions which they thought would lead to harm because of lack of care. They were also morally troubled by the use of power to influence the patient and the risk of violating the patient's dignity and integrity. Contrary to autonomy interpreted in the traditional sense, relational autonomy could help as an interpretative tool to understand professionals' struggles in their findings. Relational autonomy implies commitment from professionals to support and promote the patient's capacity to make judgements that are correct according to their own wishes and values. The professionals in this study would not leave their patients to make decisions which they judge as not being in the patients' best interests (Heidenreich et al., 2017).

In addition, they found that responsibility emerged as an important subject during the discussions. Healthcare professionals expressed a responsibility to fulfil the patients' care needs. One of the main concerns that healthcare professionals discussed was to what extent it was legitimate to try to influence the patient. Another concern was the extent to which the general responsibility of the professional healthcare system reached. Health care professionals expressed determination to help and support patients in difficult situations, but also, expressed a need to stop in situations where they failed to achieve better care for the patients. This was due to situations where the healthcare system had defective opportunities to benefit patients (Heidenreich et al., 2017).

From relational approaches (Downie & Llewellyn, 2012) we can analyze the ways in which autonomy is associated and intertwined with relationships in both positive and negative aspects. The relational approach to autonomy asserts that people are principally social beings who develop the competency for autonomy through social

interaction with other persons (Casado, 2014). To better understand some of the main ideas about relational autonomy that I consider important, I will focus on the work of Nedelsky and Herrings.⁴

Nedelsky (2011) has developed a relational theory of rights founded on the idea of recognition. This theory holds that the conditions of individual freedom are constituted by the relations generated by intersubjective recognition, not by the absolute affirmation of each individual separately. This is the basis of the relational alternative that Nedelsky (1993) proposes as a substitute for conceiving subjective rights as individual and abstract exclusive demands. Traditionally, rights are considered barriers that protect individuals from the intrusion of others or from the state: rights define boundaries that others should not cross because it would violate our freedom and autonomy. This vision of rights ties in very well with the idea of autonomy as independence. Nedelsky argues this view of autonomy is wrong. What really makes autonomy possible is not separation from others but relationships with others. Furthermore, autonomy is not a quality that we possess at birth. Rather, the development of this capacity, or right, requires an environment that makes it possible. Collectivity can be both a source of autonomy and a threat to it. Nedelsky maintains that autonomy, as well as other values and rights, has to be seen in terms of relationships, since this view provides a broader understanding compared to conflict resolution. Without the network of relationships that constitutes our society, our essential humanity is not comprehensible. It does not only mean that people live in groups and have to interact with each other. Liberal rights' theory specifies the rights of people when they conflict with each other because persons have to interact with others: we are literally constituted by the relations of which we are part. Conventional liberal rights theories do not make the relationship fundamental to their understanding of the human subject, instead, this theory focuses on mediating conflicts, and not the mutual creation and sustenance (Nedelsky, 1993). Rather, the development of the capacity of autonomy requires an environment that makes it possible. This relational approach; the turn to understand rights as relational, also shifts the attention from the protection in front of the others towards the construction of relations that foster autonomy. For

⁴ In this paper, I will focus on the contribution of Nedelsky and Herrings. However, there are other approaches that I would like to comment. Other interesting contributions have been made by Anderson and Honneth (2005), who understand autonomy as a set of capacities that the individual acquires, and it leads one's own life. In addition, Noddings (2003) argues vulnerability and the needs of other people forces us to take care of them. It is also important to consider that Rendtorff (2008) has highlighted that in order to fully understand the significance of autonomy we have to expand this concept by other principles: dignity, integrity and vulnerability, which together with autonomy, help to define the necessary concern for the human person in bioethics. While autonomy helps us to focus on human rights and respect for people, it is not sufficient to provide the protection required in many health care limit situations (Rendtorff, 2008).

Nedelsky, we must become autonomous, and this capacity can only be nurtured in relationships with others. In addition, autonomy is not seen as a static attribute, but as a capacity that is continuously developing throughout our lives. “Autonomy is a capacity that exists only in the context of social relations that support it and only in conjunction with the internal sense of being autonomous” (Nedelsky, 1989, p. 25).

Herring (2014), who is also writing in law, points out four important aspects to consider in regard to relational autonomy. First, autonomy must be thought of in the context of broader social relations. The traditional autonomy promotes individualism which ignores the complexity of the relationships and connections that constitute people’s lives. The values of inter-dependence and connection, rather than self-sufficiently and independence, reflect a more precise reality for human beings. As his second point, he states that relational autonomy is very sensitive to the way in which our relationships constitute identities. Our relationships are the field upon which our goals are formed. This means that the individual capacity for autonomy can only be realized within the context of relationships. Relational autonomy does not reject the notion of the self but reflects how an individual with the support of family and friends is able to make decisions. A third point to consider is how relationships can impair or damage autonomy. If decisions are reached within a relational context, we need to be aware of the difficulties in determining the extent to which someone’s decision may be the result of oppression or manipulation of others. Some relationships are destructive towards personal autonomy and the challenge is to define which relationships promote autonomy and which are destructive. Herring considers that there is an inevitable tension: “The more our relational nature is emphasized, the harder it is to define where the boundary between being oppressed within a relationship to such an extent that one loses autonomy and where one is simply deeply embedded in relationship” (Herring, 2014, p. 23). Finally, relational autonomy implies some kind of responsibility or commitment to others. We can understand that it could be helpful or beneficial for people to be able to assume committed relationships. In this sense, it is necessary to think about ways to enforce those commitments and obligations.

New perspectives on relational autonomy through the link with vulnerability theory

Based on the current conception of relational autonomy exposed in the previous section, and including vulnerability theory perspective, I argue that relational autonomy is the capacity to make decisions, not as a self-sufficient individual, but as a

person constituted and embedded in social relationships. I propose the five main characteristics of relational autonomy that are important to consider regarding bioethics and the clinical context:

- 1 *Relationships*. People are social beings who develop the competency for decision making through social interaction with other persons. Autonomy is not a characteristic of human beings; it is not something we are born with. It is a fundamental element of human existence, but it has to be developed. More specifically, in the field of healthcare, it is important to realize that if healthcare professionals do not make this “construction of autonomy” possible, the idea of autonomy will be nothing but a myth or illusion. Similarly, regarding the concept of vulnerability, relational autonomy contains or reflects both positive and negative aspects. On the one hand, it is through the links with others that it is possible to make our own decisions. On the other hand, this means that autonomy can be totally undermined or curtailed if the necessary conditions are missing. Sometimes, this happens because of oppressive relationships, while in other cases this is a consequence of neglect or inattention, such as when people with power (healthcare providers) don’t create the needed conditions for autonomy. We need a social support to exercise and develop our autonomy skills (Guerra, 2009), which means that autonomy requires the recognition and respect of others. Moreover, a negative effect can be that it deflects or obscures a needed (but unequal) sense of responsibility – such as the responsibility of a healthcare provider to use their superior knowledge and access to resources in the best interest of the patient.
- 2 *Capacity for decision-making process*. Relational autonomy is a capacity, and requires a certain environment that makes it possible. This relational approach shifts attention away from protecting against the others to the construction of relationships that foster decision-making capacity.. It is a claim to respect the right of patients to make their own decision, not being forced to decide under pressure or oppression. But at the same time, at the core of healthcare, relational autonomy emphasizes the capacity to make decisions, and not only the patient’s legal right to make decisions, regardless how these decisions occur. The emphasis on how the process takes place is as important as the final decision itself. With regard to this point, relational autonomy is well reflected on the practice of shared decision-making.
- 3 *Process during the life course*. Relational autonomy is not a static attribute but a capacity that is developed throughout our lives. It does not refer to a specific moment; it represents a lifelong process to be able to make decisions in the context of healthcare. Vulnerability is constant throughout our lives (Fineman, 2017).

Consequently, social and institutional support is necessary during this period, and not just in particular or specific moments. One of the main aspects highlighted by the concept of relational autonomy is the importance of the relationship between the patient (or the patient and his or her family) and the healthcare professional. Relational autonomy not only refers to a specific moment; far from that, it represents a life-long process in order to be able to make the best decisions. While autonomy principle is understood as an occasional moment that occurs when patients need to consent or accept a health care treatment or practice, relational autonomy is the result of a process in which the patient and the family is involved. This capacity needs to be fostered by professionals in each one of the encounters with the patient, at different moments of their course life, and it will require not only information, but also education and tools for deliberation.

- 4 *Professional commitment.* The responsibility of the decision making process is shared by the patient and the healthcare professionals, but now more stress is placed on the professional's commitment that allows this process. A supportive relationship is required, based on care and that allows all the right conditions for decision making to flourish. These decisions emerge from communication, dialogue, and a process of shared decision-making between healthcare professionals and patients and/or relatives. The recognition of inevitable human vulnerability, along with the recognition of suffering, generates responsibilities for the care of the others. This recognition forms the origin of the ethics of care (Noddings, 2003). The health care professional–patient relationship is not a contractual relationship; it is fundamentally a relationship based on support. This important element is frequently forgotten within the healthcare environment when we exclusively focus on liberal autonomy principle. If healthcare professionals want to respect what people desire, they have to begin by forming the kind of professional relationship that will allow the patient to develop autonomy. This focus on the professional responsibility is an essential part of relational autonomy concept as I conceive it.
- 5 *Collectivity.* Relational autonomy also highlights the network of relationships where every one of us are involved. One important aspect that has not been considered in depth, when theorizing about relational autonomy, is the aspect of collectivity that emerges around this concept. This means that relational autonomy is not an individual attribute or capacity, it is only possible at the core of a community. In the context of healthcare, this community is conformed by the patient, the family, health care professionals, and the institution. It also includes the role of the healthcare professionals within society, what is expected from these professionals from the point of view of society. While autonomy principle promotes individualistic social values, relational autonomy highlights

the importance of collective commitment, collective actions, and the idea of how personal decisions are not individualistic, but they are crossed by the relationships we maintain throughout our lives. As Fineman (2017, pp. 10–11) explains, “developing a collective or social justice approach requires that we understand the nature of those who compose the collective”.

Finally, we should understand that autonomy and vulnerability are not incompatible. We can’t think or understand vulnerability completely without taking into account autonomy (relationally understood). In the same manner, we can’t think about autonomy without considering the inevitable and universal vulnerability that constitutes us all. As I have maintained, vulnerability theory and relational autonomy have an important impact on the way in which relationships of care between healthcare professionals and patients are performed.

Conclusions

The field of bioethics has mistakenly conceived autonomy and vulnerability as polar opposites: as human beings, we are constantly and universally both vulnerable and autonomous. Recognizing vulnerability reveals that there are obligations and duties towards patients that need to be assumed by institutions and by the state. These obligations include not only protection, but also the creation of the conditions for the development and promotion of patient autonomy. Understanding autonomy as a capacity that we need to develop, not as a right or principle, should change our perception of the responsibility of institutions, including the responsibility to recognize protection in circumstances when the application of autonomy can be frustrated by oppressive relations. Just as in truly understanding the human condition, we must recognize there are no more or less vulnerable persons, only those who are more or less resilient. Therefore, healthcare professionals must use their professional knowledge and expertise to foster patient relational autonomy.

Conflicts of interest

The author has no conflicts of interest to declare.

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References

- Allotey, P., Verghis, S., Alvarez-Castillo, F., & Reidpath, D. D. (2012). Vulnerability, equity and universal coverage – A concept note. *BMC Public Health*, 12(1), S2–S10, 118.
- Anderson, J., & Honneth, A. (2005). Autonomy, vulnerability, recognition and justice. In J. Christman, & J. Anderson (Eds.), *Autonomy and the challenges to liberalism. New essays*. New York: Cambridge University.
- Butler, J. (2006). *Precarious life. The power of the mourning and violence*. London, New York: Verso.
- Butler, J. (2009). *Frames of war*. London, New York: Verso.
- Camps, V. (2011). La autonomía, el principio “por defecto”. *Bioética & Debat*, 17(62), 11–13.
- Casado, A. (Ed.). (2014). *Autonomía con otros. Ensayos sobre bioética*. Madrid: Plaza y Valdés.
- Charlesworth, M. (1993). *Bioethics in a liberal society*. Cambridge: Cambridge University Press.
- Delgado, J. (2017). The relevance of the ethics of vulnerability in bioethics. *Les ateliers de l'éthique*, 12(2–3), 154–179. <http://dx.doi.org/10.7202/1051280ar>
- Dove, E., Kelly, S., Lucivero, F., Machirori, M., Dheensa, S., & Prainsack, B. (2017). Beyond individualism: Is there a place for relational autonomy in clinical practice and research? *Clinical Ethics*, 12(3), 150–165.
- Downie, J., & Llewellyn, J. J. (2012). *Being relational: Reflections on relational theory and health law*. UBC Press, Vancouver.
- Dryden, J. (2008). *Relational autonomy: Bridging a gap between feminism and German idealism*. Fordham University, ProQuest Dissertations Publishing.
- Ells, C., Hunt, M. R., & Chambers-Evans, J. (2011). Relational autonomy as an essential component of patient-centered care. *International Journal of Feminist Approaches to Bioethics*, 4(2), 79–101.
- Fineman, M. A. (2013). Equality, autonomy and the vulnerable subject in law and politics. In M. A. Fineman, & A. Gear (Eds.), *Vulnerability. reflections on a new ethical foundation for law and politics. gender in law, culture, and society*. Farnham: Ashgate.
- Fineman, M. A. (2004). *The autonomy myth. A theory of dependency*. New York: The New Press.
- Fineman, M. A. (2008). The vulnerable subject: Anchoring equality in the human condition. *Yale Journal of Law & Feminism*, 20(1).
- Fineman, M. (2017). Vulnerability and Inevitable Inequality. *Oslo Law Review*, 4, 133–149.
- Guerra, M. J. (2009). Vivir con los otros y/o vivir para los otros. *Autonomía, vínculos y ética feminista. Dilemata, Revista Internacional de Éticas Aplicadas*, 1, 71–83.
- Heidenreich, K., Bremer, A., Materstvedt, L. J., Tidefelt, U., & Svantesson, M. (2017). Relational autonomy in the care of the vulnerable: Health care professionals’ reasoning in Moral Case Deliberation (MCD). *Medicine, Health Care and Philosophy*.
- Herring, J. (2014). *Relational autonomy and family law*. New York, NY: Springer.

- Hurst, S. (2008). Vulnerability in research and health care; describing the elephant in the room. *Bioethics*, 22(4), 191–202.
- Jennings, B. (2016). Reconceptualizing autonomy: A relational turn in bioethics. *Hastings Center Report*, 46(3), 11–16.
- Levinas, E. (1961). *Totalité et Infini: Essai sur l'extériorité*. Translation Levinas, E. Totalidad e infinito, Sígueme, Salamanca, 1977.
- Levinas, E. (1972). *Humanisme del'autre homme*. Translation Levinas, E. Humanismo del otrohombre. Ed Caparrós, Madrid, 1998.
- MacIntyre, A. (1999). *Dependent rational animals. Why human beings need the virtues*. Chicago and La Salle, Illinois: Carus publishing company.
- Mackenzie, C., & Stoljar, N. (Eds.). (2000). *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self*. Cary, US: Oxford University Press.
- Mackenzie, C., Rogers, W., & Dodds, S. (Eds.). (2013). *Vulnerability: New essays in ethics and feminist philosophy (studies in feminist philosophy)*. Oxford, New York: Oxford University Press.
- Marsico, G. (2003). *Biética: Voces de mujeres*. Madrid: Narcea.
- Moser, A., Houtepen, R., Spreeuwenberg, C., & Widdershoven, G. (2010). Realizing autonomy in responsive relationships. *Medicine, Health Care and Philosophy*, 13, 215–223.
- Nedelsky, J. (1989). Reconceiving autonomy: Sources, thoughts, and possibilities. *Yale Journal of Law and Feminism*, 1(1).
- Nedelsky, J. (1993). Reconceiving rights as relationships. *Review of Constitutional Studies*, 1(1).
- Nedelsky, J. (2011). *Law's relations. A relational theory of self, autonomy and law*. New York: Oxford University Press.
- Noddings, N. (2003). *Caring. A feminine approach to ethics and moral education*. California: University of California Press.
- Nussbaum, M. (2006). Frontiers of Justice: Disability, nationality. In *Species membership*. Cambridge, MA: Harvard University Press.
- Puyol, A. (2012). Hay bioética más allá de la autonomía. *Cuadernos de Bioética y Derecho*, 25, 45–58.
- Rendtorff, J. D. (2008). The limitations and accomplishments of autonomy as a basic principle in bioethics and biolaw. In *Autonomy and human rights in health care. International Library of Ethics, Law, and the New Medicine*, 36. Dordrecht: Springer.
- Ricoeur, P. (2008). *Lo justo 2. Estudios, lecturas y ejercicios de ética aplicada*. Trotta, Madrid.
- Rogers, W., Mackenzie, C., & Dodds, S. (2012). Why bioethics needs a concept of vulnerability. *International Journal of Feminist Approaches to Bioethics*, 5(2), 11–38.
- Straehle, C. (Ed.). (2017). *Vulnerability, autonomy and applied ethics*. New York, London: Routledge.
- Tauber, A. (2005). *Patient autonomy and the ethics of responsibility*. Cambridge, MA: MIT Press.
- Ten Have, H. (2016). *Vulnerability: Challenging bioethics*. New York: Routledge.
- Timmer, A. (2013). A quiet revolution: Vulnerability in the European Court of Human Rights. In M. A. Fineman, & A. Gear (Eds.), *Vulnerability. Reflections on a new ethical foundation for law and politics. Gender in Law, Culture, and Society*. Farnham: Ashgate.
- Turner, B. (2006). *Vulnerability and human rights*. The Pennsylvania State University Press.
- Varelius, J. (2006). The value of autonomy in medical ethics. *Medicine, Health Care and Philosophy*, 9, 377–388.
- Wendler, D. (2017). A pragmatic analysis of vulnerability in clinical research. *Bioethics*, 31, 515–525.