Factors Conditioning the Autonomy of Patients in Decision-Making Processes in Clinical Settings

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CHAPTER ONE

CONTEXTUALIZATION OF THE DECISION MAKING OF PATIENTS IN THE CLINICAL SETTING

Historical evolution of the conceptualization of ethics of the autonomous subject in decision making

The evolution of ethics is established in a shift from the concept of a substantial subject to that of an individual or ethical subject. This evolution is realized in light of a political understanding of the subject of resistance based on the historical experiences that this subject has had; an ethic as a relationship with oneself and therefore an ethic as self-care (Castro Orellana, 2004). These dimensions open a critique of the current concept of a substantial subject and assert a subjectivity constituted from a space of freedom or an art of living (Molina-Mula, Peter & Gallo-Estrada, 2018; Lanceros, 1996).

One of the fundamental elements of the subject that will determine the patient's autonomy is subjectivity. Subjectivity is the way in which individuals are constituted and produced as subjects, and it is understood as the construction of a concrete subject in different contexts (Sauquillo, 2001). Some philosophers like Foucault reject the theory of the previous subject in terms of a substance or foundation, thus establishing detraction from phenomenology or existentialism (Foucault, 1984).

The subjectivity incorporated into the objectives of productivity, performance, and functionality of the system is a normalized one; subjected to the imperative of inner or psychological truth as an expression of its essence or ultimate foundation (Castro Orellana, 2004). The individual represents a dimension, a constitution of subjectivity in which he takes himself as an object to give his life a certain orientation, to self-shape (Álvarez-Yáguez, 1995).

In this way, the genealogy of ethics is built from three scenes of history that could justify the proposed ethics of our current study:

(1) The first scene places us in antiquity, where morality did not have an articulated code, nor did it depend on universal and authoritarian rules. Morality is etched in the concern to give life a relational and prescriptive articulation. Ethics was contextualized from the concern to define an art that would allow facing the life that pursues freedom: that is, the mode of subjectivation that is deployed aims at the individual to elaborate and preserve his condition of being free in attention to the civic importance that has the ability to exercise authority (Foucault, 1978a; Foucault, 1984).

(2) The second scene is situated in Christianity/Catholicism. The idea of a depth of the soul that should be explored has appeared with Christianity, considering that the truth of a self that is no longer flexible lies in this idea. Now, the relationship with oneself operates under the criterion of the permanent self-observation of an interiority in which the truth hides. For Christianity, there would be a first level of relationship with the truth: the act of faith and submission to an institution, which holds authority over said truth (Foucault, 1978b; Foucault, 1984). The need to generate a pastoral power appears when the logics of ecclesiastical power are introduced into culture.

A series of standardization devices are configured in this scenario. They are understood as instruments at the service of economic and political structures. The way of ordering dormitories of a school or organizing surveillance in a hospital and the determination of the logics of visibility in bathroom design or in regulations of daily work come to replace the indiscreet discourse with which the direction of conscience sought to trap human nature (Foucault, 1978c; Foucault, 2000).

This new perspective of pastoral power produces a shift from a government of individuals to a form of power whose intention responds to mundane purposes such as health and well-being with institutions linked to the State such as the police, family, medicine or hospitals. The new power invades life completely and its exercise can be distinguished in the matter of the force or power of being affected and the function of the force or the power to affect (Deleuze, 1987).

This perspective is what Foucault calls biopower that is understood as the mutation of the power of pastoral care which legitimizes a

system that runs through the entire social body with imperatives of health, safety, hygiene, and normality. Thus, we can recognize an important common element, which is the production of individuality by a network of power relations (Castro Orellana, 2004).

(3) The third scene corresponds to the description of the modern mechanisms of appropriation and control of individuals who block the space of the ethical relationship. Disciplinary processes penetrate more and more into society to achieve the biological dimension of the reproduction of the population, giving rise to biopower.

Biopower describes the uniqueness of a set of knowledge strategies and power relations. The new scenario of power relations appropriates the characteristic phenomena of the life of the human species by structures of knowledge and power (Foucault, 1978d).

The antecedent of biopower is not the pastoral power only. It can also be associated to the sovereign or state power as a key structure of the Western political rationality that legitimizes the authority of the ruler whose fundamental purpose is the achievement of the common good (Foucault, 1978d).

Then, two processes of control of the individuals that make up the construction of the autonomous subject appear:

1) The first is what Foucault calls anatomo-politics as close to the body as a machine to which it is necessary to educate, draw strength to obtain certain advantages, and make its effective integration into control systems docile (Foucault, 1977: 168). This control process consists of monitoring, controlling behavior, conduct, and aptitudes. It establishes how to intensify the performance of the subjects, multiply their capacities, and put them in a place that is most useful.

This anatomo-politics cuts across a series of institutions of the modern society like schools, hospitals, factories, and jails. The same individualization strategy is identified there with space management, time calculation, and movement control; or through surveillance and examination modalities that seek exploration, disarticulation, and recomposition of the human body (Foucault, 1976).

2) The second mechanism or process of control is the biopower, as previously mentioned. It directs the body towards biological processes, proliferation, births, mortality, level of health, duration of life, and longevity, that is, an exercise of power over the population. The population is not only understood as a group of numerous people, but also as living beings traversed and governed by biological laws and processes that can be framed in health and development rates.

   Individuals are available as constituents of a species that produce wealth, goods, and other individuals. Therefore, it reduces to the individual measures and figures that manipulate the political bureaucracy. The distinctive characters of the individualities are lost, and thus the advantage of the abstract of which can easily break off any ethical evaluation is also lost.

   The goal of biopower is to clarify, measure, appreciate, and rank in accordance with the norm. In addition to being understood as a social production, norm is also a constituent function in establishing the dividing lines within social relations. This function of social demarcation is the main characteristic of the norm that governs the anatomo-political and biopolitical levels. Its main effect is the articulation of a normalizing society (Foucault, 1978a).

   Biopower uses scientific knowledge and notions such as human nature for discipline and regularization. Resisting this appropriation of human life by biopolitical forces is reinventing the space of ethics (Molina-Mula, Peter & Gallo-Estrada, 2018).

Power and its relation to the subject's decision-making capacity

Power is all around us operating between individuals or groups or through political and social institutions. It plays an important role in all relationships in this way. Power is the ability to influence or control people, events, processes, or resources. It is the ability to do things (Thompson & Campling, 1998).

On some occasions, the exercise of power is clearly visible through the use of force or coercion against others. At other times, it is more difficult to recognize power since it is exercised in subtle ways when the influence

is realized through persuasion and manipulation or when it occurs at a personal, political or economic level (Finlay, 2005).

Power permeates all layers of society. It is exercised and practiced from innumerable points of support and within a set of relationships (Perron, Fluet & Holmes, 2005; McHoul & Grace, 1993). Thus, Foucault poses how the different and multiple forms of repression are globalized from the perspective of power. Sometimes, this is related to turning the population into repeaters of the dominant discourse under memorization patterns.

These patterns of memorization configure a form of power exercised from the perceptions, cognitions, and preferences of people, which influence and guide their social practices. Knowledge forms are established and institutionalized practices, which are naturally accepted by people (Gilbert, 2005).

When we discuss power relations, we refer not only to politics or those concerning governments or certain groups or elites, but also to all existing relationships among people in order to describe this multi-directionality (Vahabi & Gastaldo, 2003; Fox, 1993; Foucault, 1990).

Power does not operate only from the 'top down' but also from the 'bottom up' through all relationships, and it is diffuse but not concentrated (Cheek, 2004; Manias & Street, 2000). Power must be analyzed as something that circulates unequally and not as a single form or as a place in which it can be assigned (Foucault, 2004; Witto, 2001).

Thus, the network of power relations is not immutable or eternal; it is modified throughout the historical process because 'dynamism' is a distinctive feature of societies, which is translated by the conflicts and ruptures of the existing predominations in search of transformation (Foucault, 2002; Gabilondo, 1990). Power relations are characterized by being mobile, unstable, modifiable, and not prefixed in advance; they can even be reversed in some situations.

Power relations cannot exist except in terms of a multiplicity of points of resistance; where there is power there is rejection and counter-power (Foucault, 1990; Manias & Street, 2000; Peerson, 1995). The power that is claimed needs resistance as one of its fundamental conditions of operation. It is through the points of resistance that power spreads through the social field (Dreyfus & Rabinow, 1992).

Consequently, those who resist or rebel against another form of power cannot be satisfied with denouncing or criticizing this form of violence; what is needed is to question the existing form of rationality (Foucault, 1990). The resistance can be presented in different levels and forms, but it is always present in the contexts where dominant discourses exist and influence or determine the social dynamics (Foucault, 2001).

Oriented power relations lead and influence people's behavior by subjecting the practices and identities to certain specific social norms of each time (Foucault, 2002). The exercise of power is not simply a relationship between the individuals at the individual or collective level. It is a means by which certain actions can modify others (Foucault, 1990).

On the other hand, the articulation of a series of penetration techniques of individuals in the perspective of the act is paramount. The strategies here consist of the determination of the use of time, the regulation of cycles, or the establishment of individual and collective rhythms. The disciplinary technologies, in short, aim to manufacture machines through power as a productive mechanism.

If we situate ourselves in a clinical context, the decision-making capacity of patients according to their power relations is described through three moments:

a) The surveillance, characterized by visibility that gives rise to a strategy of control and produces behaviors that occur automatically in the individual by the action of an absolute coercive look. This leads to the spontaneous reproduction of the power of oneself. The individual becomes the source of his own submission to watch and be watched.

b) The normalizing sanction, as an infrapenality that sanctions everything that does not conform to the rule, reducing the possibility of deviation or difference in quantitative terms and ranking the value of the capabilities of individuals or tracing the limit of the abnormal. This technology is the power of normalization, which forces homogeneity by nullifying everything that escapes the norm, but it is also individualized by allowing deviations, determining levels, fixing specialties, and making differences useful.

c) The examination that is based on a system of objectification that does enter the individuality in a field documentary as if it were a

unit, describable and analyzable. The test becomes visible to the individuals and inserted in the log of the standard by means of knowledge. Moreover, some institutions such as hospitals have needed practices and discourses to be effective in the production of individuals disciplined.

These three disciplinary instruments show that the society of liberties covers the disciplinary society whose power of control is sharpened to the same extent that it is disguised and multiplied, making evident one of the main fictions of the established socio-political order: fiction of freedom (Blanchot, 1988).

The illusion of a society of liberties based on the cutting of a space that apparently monopolizes the deprivation of liberty is modeled. However, that individual who lives in eventual freedom as something that can be stolen or that oppressed individual that is the object of a humanist discourse that encourages liberation already represents in itself a result of subjection.

Foucault (1994) identified four power strategies that affect the freedom of subjects: (1) disciplinary power, (2) pastoral, (3) self-government, and (4) resistance.

(1) Disciplinary power is exercised through mechanisms and strategies, which are used for manipulation and control. The objective of such strategies is to forge a useful and docile subject that can be subjugated, transformed, and re-socialized (Foucault, 2002). This form of exercise of power leads to maintain a status quo and to form new knowledge, practices, mechanisms of subjection and normalization (Varela, 2001). People exercise disciplinary power through a series of mechanisms such as (a) normalization, (b) homogenization, (c) monitoring and control, (d) subjection and subjugation, (e) the clinical look, (f) the control of spaces and the use of time, as well as (g) the rewards and sanctions (Miró Bonet, 2009).

a) Standardization strategies operate by establishing common definitions of objectives and procedures, which take the form of manifestos of how human activity should be organized. The purpose of these strategies is the constitution and identification of people with certain standards, and thus the achievement of compliance within a social structure. Standardization strategies

not only prescribe particular behaviors, but also categorize individuals into groups. This way defines what is normal or deviant, accepted or unacceptable, superior or inferior, and what is good or bad.

b) Homogenization is a mechanism that leads, in a certain sense, to threaten the identity of people in many aspects since it promotes the harmonization of knowledge and the conformity of individuals. Homogenization hinders the individuality and uniqueness of people.

c) Surveillance and control are procedures by which people with strategic positions observe the ones who are at lower levels/positions. Foucault (2002) pointed out how modern society exercises its control systems of power and knowledge through vigilance, whether deliberately or not. He suggested that there exists a kind of "continuous prison" by all levels of modern society from maximum-security prisons, social workers, nurses, doctors, police, and teachers to our daily work and life. Thus, surveillance is permanent in its effects even if it is discontinuous in its action.

d) The strategies of submission and subjugation are mechanisms of imposition, subjection, repression, oppression, dogma, or conquest of individuals or knowledge. Sometimes, they are physical and symbolic strategies that constitute the individuals in such a way that their movements and rhythms respond and are subordinated to the needs of the disciplinary devices. The submission of individuals to certain guidelines, rules, or norms is fundamental for sustaining the power relations that govern modern society (Foucault, 2005).

e) The clinical look is not synonymous with vision. Rather, is a metaphor that Foucault has used to refer to another strategy of power through which events of organic alteration can be read, organized, and interpreted in an anatomo-clinical conception (Foucault, 2001). The clinical look defined by Foucault can be extrapolated to any daily view that is inscribed in the social space and is, at the same time, the effect and the support of certain practices and relationships with others.

f) The control of spaces and the use of time: The control of spaces is the distribution and assignment of individuals to certain spaces, often spaces of closure, or the division of certain groups of individuals from others. The space and the type of relationships occurring in it have an intimate relationship. On the other hand, the use of time is a strategy of exercising power through the fragmentation or division of activities or tasks into fixed schedules and pre-established times, which becomes a new control device.

g) Finally, rewards and sanctions are strategies through which the permanence of an order or a normative power is achieved. Some of the aforementioned mechanisms are achieved through the management of rewards and punishments or threats.

(2) Pastoral power, mentioned earlier, is another form of less taxable power that depends on the obtained information and knowledge based on a relationship of trust that is either emotional or therapeutic. This power is an individualized form of power in which someone acts as a guide for others (Holmes, 2002). The leader exercises power from the fulfillment of duty and self-denial, since everything he does is for the good of the "flock" (Foucault, 1990; Lunardi et al., 2007).

Power is exercised through mechanisms such as intermediation, introspection or, self-examination. Intermediation or representation is a strategy of exercising power in which a person defends the rights, needs, or desires of another before a third person. Introspection or self-examination are ways of exercising power in which one is challenged to verbalize their behaviors, recognize their defects, and explore their true interests and concerns. In most cases, these exercises are carried out in an introspective, passive, or silent way (Miró Bonet, 2009).

(3) The strategies of self-government, also known as subjectivation and self-management, are forms of power to relate to oneself that become part of daily life, not externalized, but in which the relations of knowledge and control are implied (Gastaldo & Holmes, 1999). It is a form of power that is self-applied by individuals and directed towards the control of their own behaviors. This self-government is influenced by dominant social discourses

that have been internalized and incorporated as one's own desire, but which have been socially constituted.

(4) Lastly and as pointed out above, where there is power there is resistance. Strategies of resistance or struggle are present everywhere within the network of power (Foucault, 2005). Resistance is not the inverted image of power, but it is as mobile and productive as power is. The resistance should not be conceptualized in terms of negation, but as a process of creation and transformation. We are not trapped by power; it is always possible to modify your domain under certain conditions and according to a precise strategy. The purpose of this power is to infiltrate ever more deeply human existence, both individually and collectively (Foucault, 2001a).

In the context of health care, power is an integral part of daily activities; it is part of the routine. Both professionals and patients exercise power. On the one hand, professionals can exercise authority, are responsible for people who need care or help, and can make complex decisions. On the other hand, patients can also exercise power relations such as the ability to comply with treatment or to demand specific tasks from professionals (Finlay, 2005).

The ethics of our present: self-care

In the following sections, we will define the ethics of our present after we have already described the subject and subjectivation and analyzed the genealogy of ethics and its core elements.

Ethics begins to appear as an alternative to the dynamic concerns of biopolitics, particularly as a response or a mode of creative resistance that allows us to transform the reality of our lives.

The transformation in the way of being of the individual is equivalent to the change of a plexus of relationships: of oneself, of one with the others and of one with the truth (Lanceros, 1996). The idea is to go beyond a model of individualization, the boundaries that standardization devices draw, to open a space for unprecedented experiences through a relationship that the individual makes with himself and with his limits.

The political dimension of ethics consists of a new policy of the self, which opens a path in the field of power relations (Bernauer, 1995). Ethics is a practice of resistance that reproduces the relationships of strength.

The subject can no longer be considered as the condition of possibility of experience, but rather as the result of a series of conditions that are configured in experience; the subject is a genesis, has a formation, a history (Foucault, 1978a). So ethics is inscribed in the understanding of the subject as a product of self-formation that is in a scenario where it is part of the historically constructed reality in its entirety.

The new proposed ethical situation consists of a field of forces in which relationships of knowledge, power, and freedom unfold. The ethical subject responds to this understanding of the individual as being in perpetual constitution, which causes multiple ways of reinventing and constituting subjectivity. This establishes a continuous tension between power relations and practices of freedom where different forms or modalities of subjectivity.

To be a subject is to belong, that is, to intervene both as an element and as an actor in a global process whose development defines the current field of possible experiences (Macherey, 1995). According to Schmid (2002), the subject is distinguished by mutability and multiplicity. Therefore, ethics implies taking care of one's own freedom, which cannot be done without taking care of others (Schmnid, 2002). In this way, the relationship between power and ethics implies the recognition of the other subject of action at the same time, which, before this relationship, opens a field of responses, reactions, effects, and possible inventions.

The danger posed by any power relationship is the possibility that it solidifies into a form of domination (Foucault, 2000). The real political task at this point is to uphold, reaffirm, and reinvent the sphere where the individual exercises transformations on himself and on the relational universe.

When it is argued that the individual is capable of exercising power of construction and creation over himself, we are witnessing a space of resistance that is etched in the game of power that imposes an identity on us. Ethics could then be defined as the ethics that resists the regime of relations between knowledge, power, and subjectivity (Foucault, 1990).

Ethics as resistance must involve the need to create and innovate in ways of life; a practice of freedom in which the force folds on itself and

opens a new field of relationships. It is thus configured, an ethic that aims to enable the exercise of freedom, an individual who is within a network of power relations. The proposal leads to recognize the value of personal choice in the midst of a situation that threatens the imbalance of domination. The individual does not choose in an empty space. However, he/she acts in a background of historical and biographical experiences, in disagreement with what is current and what is intolerable and in relation to instances of normalization and foci of resistance (Schmid, 2002).

The person who exercises autonomy continues to be a subject constituted by practices and an operative subject within the strategic game. Thus, freedom does not intend to end with the modality of subjection, but rather to make them move and modify permanently.

Rabinow (1999) introduces the notion of biosociability, which describes the new forms of assessment, production of identity, and sociability that emerge in our societies. According to this, there is nowadays a primacy of the medical-physicalist vocabulary referred to health criteria, physical performance, body care, cult of youth, or aesthetics of the image; that acquires an almost moral status and that crosses the understanding that individuals make of themselves, their options, and their relationships with others.

Social medicalization has always accompanied the strategic displacements of biopolitics. Health has become an absolute value to the point of being one of the keys to the configuration of one's identity. You have to self-perfect yourself, be responsible for your own well-being, and endow yourself with health that expresses itself in an image of beauty, strength, and youth.

Our culture of healthy and tanned bodies originates from a narcissistic imperative consisting of individuals who exclusively focus on modeling themselves. Thus, an insecure identity is constituted, placed in disposition, and conditioned by the other. The culture where identities are configured from the fragility of appearance pursues the incorporation of all the elements of a norm (Ortega, 1999).

Thus, the mechanisms of consumption will specifically fulfill the double function of promoting healthy and beautiful lifestyles at the same time, of ordering a menu of acceptable differences. This implies that our culture incorporates a valuation of discipline, renunciation, exercise, and

other mortifications as long as they are in function of the narcissistic imperative.

Self-care, then, implies a movement of the self towards the encounter with the other and the self (Schmid, 2002). The transformation of oneself would be the consequence of this encounter with the other. It thus appears the extroverted connotation of ethical subjectivity turned towards exteriority.

In conclusion, self-care does not equate to the conquest of a definite self, but to an unfinished task with a self-process. When we talk about the work of freedom, it refers to the infinite exercise that the individual deploys, of de-identification and reinvention of himself (De la Higuera, 1999). The creation of oneself does not suppose the modeling of subjectivity truer or more perfect than the previous ones, and that determines the end of the activity of self-formation.

On the contrary, the act of creating oneself needs to be given on the background of a constant detachment from who we are. Once the subject has freed himself from the obstacles saturating the present density, the universal truths or the suprahistoricity and the possibility of a lighter actuality open up, thus allowing the autonomous subject to conceive.

Ethics is the reflective or deliberate form that freedom takes. Ethics focuses on a series of propositions, which are: philosophy has ethics as its central core; freedom is the foundation of ethics; ethics revolves around the techniques of subjectivation or self-care; ethics as self-care can be created with respect to its own existence; self-care enhances the ability of a person for political resistance; self-care also implies a willingness to care for the other human beings; the techniques of subjectivation occur in each culture, are not separated from the games of truth and power, and can be a technique of self, a care of oneself, in a field of freedom.

The ethics of our present arises from the analysis of a series of topics such as the ethical substance, the modes of subjection, the forms of elaboration, and the theology of the moral subject, which will be now explained in more detail.

a) The ethical substance is the part of the individual that must be constituted as the main matter of his moral conduct, which makes up the feelings and the different ways of working the moral subject. The substance of ethics is the subject's own transformation from its historical and social context.

b) Modes of subjection define the relationship of the subject with the rules and how these rules are recognized by the subject as obligations in a certain social and cultural context. From this relationship or modes of subjection, the subject becomes a moral individual of his own behavior. It is what Foucault calls the forms of elaboration or ethical work. This ethical work emanates from the learning of pre-established social norms, from the control of these norms over the behavior of the subject, and from the struggle of the subject himself against these norms when his desires and pleasures are at stake.

c) Foucault refers to the theology of the moral subject as the final consequence of the action of established norms and social rules that give rise to a certain mode of being. However, it is not considered that this consequence implies a strict compliance with the set rules, but rather that it entails a new behavior after establishing a relationship with oneself (Abraham, 1998).

d) In addition, the technologies of the self are introduced as a basic and central element in the development of the ethics of our present. It arises as all societies use techniques that allow individuals to make some operations on their own bodies, souls, thoughts, and behaviors with their own means and to do so in a way that they transform themselves to reach a certain degree of perfection, happiness, purity, and supernatural power.

   The technologies of the self will determine how the acts and behaviors of people will ultimately be related to the rules, norms, or codes that are imposed on them. The code that determines the allowed or prohibited acts is then distinguished from the code that determines the positive or negative value of the different possible behaviors (Hubert, Dreyfus & Rabinow, 1988). This distinction configures the type of relationship that one should maintain with oneself, which identifies how the individual is supposed to constitute himself as a moral individual of his own actions (Foucault, 1994).

This relationship with oneself presents four major aspects: (a) what part of myself or my behavior concerns moral conduct, which in our society configures the main domain of morality, and which are commonly known as feelings; (b) the way in which people are invited or encouraged to recognize their moral obligations; (c) the self-determination of the self,

which refers to what are the means by which we can transform ourselves into ethical subjects. That is, the ethical substance that moderates our actions and deciphers what we are; and (d) what kind of being we aspire to be when we act morally, called "telos", and that relates, on the one hand, the effective behavior of people with the existence of moral codes, and on the other hand the relationship of oneself with these four aspects (Hubert, Dreyfus & Rabinow, 1988).

Therefore, it is not enough to say that the subject is constituted in a symbolic system. The subject is not constituted only in the game of symbols, but it does so in real, historically analyzable practices. There is a technology of the constitution of the self that crosses the symbolic systems while simultaneously using them (Hubert, Dreyfus & Rabinow, 1988).

To end this section, two concepts from self-care should be mentioned in the analysis of the ethics of our present: the culture of self and the care of freedom.

Self-care is a lifelong practice that tends to ensure the continued exercise of freedom (Bernauer, 1996: 254). It is about freeing ourselves from the imposed rules -models of subjection- to access our own behavior or technique of subjectivation, that is, to self-care to one's lifestyle.

Caring for oneself is an attitude towards oneself as well as towards others, and it is even a relationship with the world. It is what Foucault called as forms of subjectivation.

a) The first form of subjectivation responds to the technologies of the self, where self-care tries to free itself from what we depend on and to resituate ourselves in a world as a structure of causes and effects.

b) The second form of subjectivation is the codes. Foucault defines them as historical structures that constitute the individual as the subject of their actions and not as a mere agent. At this point, the requirement of universality in a historical construction of ethics is strongly questioned. It reinforces his conception of ethics not organized as an authoritarian, unified morality, and equally imposed on everyone. A non-universalizing, non-normalizing ethic is proposed without a disciplinary structure and without being based on scientific knowledge.

c) The last form of subjectivation considered by Foucault defines the culture of self, social practices, as practices of oneself (Páez, 1988).

> Foucault talks about independence or relative autonomy of the relationship with oneself with respect to codes. He considers that the individual realizes himself and is constituted as a moral individual, as a form of combat to wage, and as a victory to obtain self-control (Foucault, 1986).

This self-control overflows through many different doctrines, takes the form of an attitude that permeates the ways of living, and is articulated in a set of procedures and exercises that can be meditated and taught. Thus, it constitutes a practice that acquires even interpersonal and institutional forms and gives rise to the development of knowledge (Foucault, 1986).

According to Foucault, taking care of oneself, known as medical care, is the form of an intense attention to the body mainly because of two types of diseases, those of the soul and those of the body, which can communicate with each other. This transference constitutes a point of fundamental weakness of the individual (Páez, 1988).

In conclusion, the ethics of our present appear as the link with oneself and the strengthening of the own personal virtues, transformed from their historical and social context (ethical substance). This represents ethics that are separated from the social position of established norms and codes, but which have a relationship with the subject in the configuration of their behavior-modes of subjection. An ethic is invented by the moral subject itself based on the social, political, and cultural dimensions of ethics – work ethics. It will be understood, thus, the role played by the individual as an autonomous and free subject –teleology of the moral subject. This free and autonomous behavior will be so inasmuch as the subject is capable of understanding how he is supposed to constitute himself as a moral individual of his own actions – technologies of the ego.

All of this constitutes the culture of oneself or the way in which we liberate ourselves from the imposed rules to access our own behavior or subjectivation; that is, our own lifestyle, their own technique of subjectivation. There are no recipes to achieve this (Rojas Osorio, 1999).

New ethical perspective of the autonomous subject in our clinical context

Ethics is the relationship with oneself that takes place in action or "ethics is a practice" (Foucault, 1984: 377). With this ethical proposal, subjectivity is open, plural, and transformable.

The ethical individual is the one who makes an experience of himself that is modified with different criteria and practices. It is not universal or suprahistoric, it is rather a reality that is influenced by structures and experiences with himself, and that is permeable to the changes that affect it by producing self-transformation (Schmid, 2002). Therefore, the ethical individual is an element susceptible to self-constitution and self-conduction.

However, it has further been shown that there is a close relationship between this ethical individual and power. A form of power that acts on the subject appears through a series of control and normalization structures or devices of domination, corresponding to the political technologies of society which indicate the correct behaviors and attitudes.

We are currently observing what has been called as "Medicalization of the Society" by some authors like Foucault in the clinical context. The medicalization of society is articulated as a true technology of the social body, thus fulfilling a decisive role in the biopolitical production of society. The population is not only a theoretical problem but also a technical dilemma that demands intervention and modification procedures such as demographic estimates, the calculation of the age pyramid, morbidity rates, or studies on the relationship between the increase in wealth and the increase in population (Foucault, 1976).

Furthermore, the production of optimal standards in the population is not enough. It is also necessary to properly manage a whole stage of life, which begins within the family and continues into adulthood.

At this point, according to Donzelot (1990), there is a union of medicine and family that reorganizes family life in three dimensions:

a) The family is isolated from all the means or contexts that may cause any potential harm, and the mother is converted into a central element for educational utility. The family is transformed into a privileged field with the intention of biopolitics, the perfect tool in the administration of health. Marriage is promoted then, along with teaching of domestic hygiene and establishment of Sunday rest, but above all, the construction of social housing as a sanitary space. Donzelot calls this ‘a familiarization of society’. In the era of biopolitics, the family functions as a mechanism in the preservation, control, and production of life.

b) Hygiene acquires the connotation of a public problem associated with epidemics, morbidity, average length of life, and mortality. The implementation of a health regime of the population that consolidates the state of collective hygiene is fundamental.

c) There is then the formation of a medical administrative being, which serves as the original nucleus of the social economy and sociology. It also serves as the articulation of a political-medical field of incidence on the population with prescriptions oriented not only to the disease but also to the behavior.

The appearance of the population, the organization of the family as an example of medicalization, and the constitution of a medical-administrative apparatus conducive to social control are the factors that explain the effort to produce a new structural ordering of the hospital.

A series of disciplinary techniques from the army and school are incorporated into the hospital, such as the distribution of individuals, constant vigilance, and continuous recording accompanied by a scientific transformation of medical practice. A therapeutic space is born with a new design of the hospital space consisting of: creation of an individualized space around each patient that is modifiable according to the evolution of the disease; concentration of all power within the hospital organization in the hands of the doctor; implementation of a system of permanent record of everything that happens, which will be decisive for the production of a specific knowledge (Foucault, 1978c).

The use of identification methods, annotations, and circulation of data and information renders the hospital a documentary archive and a place for elaboration of medical knowledge. Modern medicine is a social medicine that is then configured as a technology of the population.

Three models that have been developed in different European countries are described here: State medicine, urban medicine, and labor force medicine.

a) State medicine aims at the comprehensive observation of morbidity and the standardization of practice and medical knowledge. It also aims at the constitution of an administrative organization to control doctors and the creation of medical officers responsible for a region and a sector of the population. The interest of this medicine resides in individuals as a force that constitutes the State and as dynamism in the face of conflicts with other nations.

b) Urban medicine was an improvement of the quarantine scheme that was directed in three objectives: It was studied the places of accumulation of waste in the urban space, which could be agents of disease triggering (Foucault, 1977). Then, it was analyzed and tried to control the circulation processes of water and air. Lastly, the distribution of elements and places essential for life was organized. As a result, the development of the concept of environment and health appears.

c) Labor force medicine consisted of the intervention of poverty that sought to guarantee their health needs and resorted to mass vaccination, the organization of a register of epidemics, and the location and destruction of unhealthy places. The aim was to convert these masses of the population into a more suitable and lasting work force and into a safe political force without risk for the bourgeoisie.

From these models, four modifications are produced on the medicalization of society.

a) First, the State should guarantee the health of individuals for the benefit of the preservation of their own physical strength, their work force, and their production capacity. This ensures the transformation of the right to keep one's body healthy into an objective of the State action.

b) Second, as a consequence of this inversion of the relations between the individual and the State, the preponderance of the concept of hygiene in the literature and in medical administration leaves room for the right to be sick and the legitimate interruption of work.

c) Third, the expenses dedicated to health, the costs of interruption of work, and the calculation of the risks that affect the physical well-being of individuals determine a new horizon of concerns that enter the field of macroeconomics.

d) Fourth, health becomes a focus of political struggles and debates.

Medicine has come to acquire an authoritative power with normalizing functions that far exceeds the existence of diseases and the demands of the patient (Foucault, 1976: 353). Physicians and their knowledge are key players in the invention of the normalizing society. Thus, medicine has

ceased to be a mere instrument of the economic apparatus but has penetrated it and become one of its components.

It is well documented that medicine produces wealth by itself, since health represents a desire for some people and a luxury for others (Foucault, 1976). Health then becomes understood as a consumer good. This means that health is incorporated into the game of the market with its production agents such as laboratories, pharmacists, doctors, clinics, insurers and their consumers as the existing patients and other people as potential future patients.

The introduction of the human body and health into the system of consumption produces a series of perverse effects: (a) first, there is an infinite demand and widespread customer dissatisfaction, since medical consumption does not imply an improvement in the quality of life, nor can the health market act with the same logic as other forms of consumption. (b) Second, Health is treated as a consumer good that produces enormous economic benefits for pharmaceutical companies. The doctors here operate as a link and as mediators of a system of consumption that has the industry at one end and the infinite demand of the client on the other. Doctors become the main agents of medicalization, being simple distributors of medicines within the market of suffering and promised health.

The consequences of this medicalization of society have revealed a growing scientific movement that questions the current way of understanding bioethics as a mere logical instrument or as a set of standardized principles based on criteria of efficiency, consistency, and application (Murray & Holmes, 2009).

In recent years, critical ethics has emerged as detraction from philosophy based on abstract concepts called principlism (Wolf, 1996; Tong, 1996; Fox, 1994; Nicholson, 1994; Bauman, 1993; De Grazia, 1992; Alderson, 1991; Clouser & Gert, 1990; Willians, 1985).

Some authors have defined this principialism as the legitimization of a biomedical discourse or "oppressive status quo" of the principles (Sherwin, 1996: 49). McGrath (1998) affirms that the currently advocated bioethical model uses the principles to create the illusion about the patient's ability to make decisions in an autonomous way, but in reality, the values of a health institution are being given meanings; define, describe, and delimit, what is possible to do and not to do. That is, it raises

the descriptions, rules, permits, and prohibitions of social and individual actions (Davies, 1994: 17).

According to Clouser and Gert (1999), the main problem of the current model of ethics usually appears in the present texts of bioethics as if it were logically derivable from a harmonic dome of ethical theories, when in truth, the principles on which they lean contain internal inconsistencies and theories which are discordant.

This derives that if the principles are not firmly established and justified, people deceive themselves by believing them as providers of moral imperatives. The principles might not be clear, direct, or imperative, but rather a simple collection of suggestions and observations. Therefore, the agent applying them will not know if he is really guiding his action nor will he recognize what facts to consider relevant and how to justify his conduct.

Consequently, the resolution of ethical conflicts has been relegated to expert professionals in this area without giving room for opinion, autonomy, and decision-making capacity of the patient. Therefore, the critical ethic raises a bioethical reflection based on power and its effects in neutralized discourses and supplanted by those considered experts in ethics.

This gives way to a current ethic that argues that bioethics will not be able to examine coherently the social, political, and even economical aspects present in ethical conflicts without an analysis of power and its complexities (Murray, 2008).

Thus, the notion of power arises in the discourse of the ethical-critical reasoning that moves away from the conception of valuing the principles above the context and moves towards a discursive understanding of autonomy. It deals with exploring how personal choice is the reality constructed by different health organizations. Critical ethics states that the substantive rationalism of principlism must be challenged by the process of contextualizing bioethical problems from power and discourse (McGrath, 1998).

Therefore, ethics must start from the point of non-existence of a clear and distinctive idea expressed in the articulation of principles (Jonsen, 1990). The ethical response does not comprise the application of some principles in difficult situations, but it rather consists of an interpretation of the provision of the services where the ethics will express the speeches

of the organization. Ethical practice is directed towards the provision of alternatives for action and respect for individual subjectivity.

Ethics begins to be understood in the clinical setting as the dimension of the relationship with effective behaviors and codes or systems of prohibitions, prescriptions, and valuation. This dimension determines how the individual constitutes himself as a moral individual, thus configuring the forms or modes of subjectivation (Dreyfus & Rabinow, 1985).

This perspective of ethics will allow us to analyze professional relationships based on the codes that currently shape the allowed or prohibited behaviors in professional practice versus non-authoritarian or unified personal choice that opens a new possibility of understanding ethics (McGrath, 1998).

Current context in the decision-making model of the patient in the clinical setting

The literature that deals with the autonomous decision-making of patients is abundant, especially at the international level, although it is viewed with different outlooks and ethical approaches. It is considered as an aspect of importance in the practice of health professionals and is still in an open debate among experts in the field (Molina-Mula, Peter & Gallo-Estrada, 2018; Cribb & Entwistle, 2011; Iliopoulou & While, 2010; Entwistle, Carter, Cribb & McCaffery, 2010; Duke, Yarbrough & Pang, 2009; Calloway, 2009; Ho, 2008; McDemott, Bingley, Thomas, Payne, Seymour & Clark, 2006).

The principle of autonomy proposed by the Belmont report (Beauchamp & Childress, 2009) is discussed in terms of confidentiality, fidelity, privacy, and veracity of the information. All the mentioned aspects are strongly related to the autonomous decision-making ability (Gillet, 2009; Sherwin, 1998), thus emphasizing the value of patient independence (Entwistle, Carter, Cribb & McCaffery, 2010).

Some authors share that the decision-making process of patients is at a crossroads between two ethical positions; paternalism and informed choice (Cribb & Entwistle, 2011; Iliopoulou & While, 2010; Entwistle, Carter, Cribb & McCaffery, 2010; Charles, Gafni & Whelan, 1999; Charles, Gafni & Whelan, 1997)

In paternalistic models, the health professionals decide for the patients based on the discourse that they are doing what is best for them. This can signify a breach of respect for the patient's autonomy and a distortion in the recognition and acceptance of his responsibility.

On the other hand, in models based on informed consent, the professionals provide information to the patients, who make their own decisions. This position raises several ethical dilemmas regarding the patients who want to receive complete information about the health problems before giving their consents and concerning the role of the family in the decision making of the patient. Hence, it is necessary to analyze the position of health professionals regarding the information they provide to patients (Calloway, 2009).

For example, some studies (Antoun, Hamadeh & Adip, 2014; Candib, 2002; Novack, 1979) report a frequent situation among professionals in the United States and Europe in the clinical setting. This is when the patient is not informed directly on the diagnoses of terminal illnesses such as cancer while the family takes the responsibility for such information. This situation reflects the domination of a medical culture that attempts to generate patients according to the medical paradigm.

Other studies (Fiester, 2015; Assche, Capitaine, Pennings, Sterckx et. al., 2015; Rodriguez, Morrow & Seifi, 2015; Tidsskr, 2014; Griffith, 2014; Putnina, 2013; Magnus & Caplan, 2013; Doctor Company, 2012; Cameron, 2012) have argued about different cultural conceptions concerning the informed consent of patients and the role played by the family in decision making. These studies have concluded that depending on the culture, the family can be an element that limits or extends the right of the patients to decide autonomously, and that the non-consideration of the family can generate important conflicts in the relationship with the patient and their informed consent. This consideration about the role of the family will be exposed at the end of this section.

Some authors have classified the different variants in the decision making of patients in restrictive or open-ended conceptions (Cribb & Entwistle, 2011; Moumjid, Gafni, Bremond & Carrere, 2007; Makoul & Clayman, 2006). In this way, it is possible to explore the tensions between the two. Below are some of the advantages and disadvantages from the different perspectives exposed in the literature that include the positions of health professionals and the health management model.

Restrictive conception about the decision-making capacity of patients in the clinical setting

With respect to the most restrictive conception, a clear model of autonomous decision-making of the patient is not proposed according to some authors (Cribb & Entwistle, 2011). These decisions are divided as those that take professional criteria into account and those which are separated from these criteria on the other hand.

Framed within this conception, it is thus alleged that: (a) the patient has preferences about their care and it is the job of the professionals to obtain these references and make decisions; (b) this ensures respecting the autonomy of the informed patient and achieving the best results by making better decisions in this regard; and (c) patients and professionals can, and in some cases must, engage in a discussion about the preferences of the former, but this process must conclude with the choice that is based on the scientific evidence and knowledge of the professionals taking into account the predilections of the patient.

The main defense of this perception indicates that although patients express preferences about interventions and health outcomes, these preferences may put them at risk; therefore, the objective of professionals, to cure and care for patients, is not achieved (Paput, 2014; Dowie, 2002). In addition, it is argued that patients are usually not clear about their preferences and that professionals are the ones who should guide them in decision-making, so a discussion should be established to reach a consensus only in cases where patients have their preferences clearly defined.

Authors such as Joseph-Williams (2014), Epstein and Peter (2007), Nelson, Han, Fagerlin, Stefanek and Ubel (2007), and Sevdalis and Harvey (2006) argue that patients are not clear about their options due to lack of knowledge and understanding of their health status and possible interventions. In these circumstances, it is the professionals who should take advantage to consider the preferences of the patients simply by listening to them and avoiding the potential conflicts. The alternative to this situation states that the professionals should empathize with the patients and build, through information and possible alternatives, the preferences that permit them to make decisions autonomously (Sen, 2002).

This proposal can concurrently be misinterpreted by professionals who can use their privileged situation to frame the patient preferences based on