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Patient autonomy in the therapeutic process as a value for health

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ABSTRACT

This paper presents a critical review of concepts of health and disease in biomedicine, as a contribution to rethinking health in positive terms. We take Canguilhem's epistemology as a starting point in order to highlight fundamental issues in the discussion about health, integrating it with a new understanding of the concept of patient autonomy in the therapeutic process, using an analysis method that takes an approach based on complexity. In this perspective, autonomy is relative, relational and inseparable from dependence. It is also a necessary condition for health, in its broadest meaning, as the self-recovering potential of the human organism. Therefore, autonomy becomes a fundamental value to be reinstated and defended in medical practice, as well as in the social and human sciences' field. A discussion of the implications of the concept of autonomy is presented, if only as a harbinger of a future state, as a precondition for health, citizenship and for life itself.

Key words: physician-patient relation. patient autonomy. health. Canguilhem. complexity.

Introduction

The criticism of the hegemonic biological and naturalistic paradigm of the so-called biomedicine or contemporary western medicine can be considered one of the main contributions from the human and social sciences to the health field. In addition to all the criticism that has been leveraged with regard to the dynamics of the process of institutionalization and socialization of medicine, studies indicate the need to analyze the very concepts of health and disease. In 1999, for

instance, an issue of the journal *Physis* was entirely dedicated to the theme "the meanings of health." In his presentation, Birman (1999) acknowledges that not only new meanings are emerging, but other health practices are also being produced. In the symposia on comprehensive health care that took place at the University of the State of Rio de Janeiro (UERJ), themes such as disease, health and healing perceptions, doctor-patient relations, care and populations health needs were strongly present, as can be seen in the articles by Luz, Pinheiro and Acioli, for instance (Pinheiro & Mattos, orgs., 2001). However, Coelho & Almeida Filho (2002) continued to point out the epistemological difficulty to define health: "*the lack of studies on a properly defined concept of health seems to indicate a difficulty of the dominant scientific paradigm in the most varied fields to approach health in a positive way*." (p. 316). Therefore, analyses on concepts such as health, disease, life, autonomy, continue to be fundamental in our field, although - or perhaps, because - in biomedicine, medical science is still central, and considered as neutral and objective; thus, the social and cultural dimensions also present in the therapeutic process are frequently neglected.

With this displacement from subjectivity to objectivity, from the respect for values to the establishment of "neutral" rules and norms, physicians and patients increasingly grow apart from each other, and patients also lose contact with their bodies. The result is a diminishment of patients' capability to act as subjects in the health/disease process. In other words, within biomedicine we see patients' objectivization, the deterioration of the doctor-patient relationship and the loss of the millenarian therapeutic role of medicine – as an art – giving place to diagnosis and the scientific study of diseases (Luz, 1996). Clavreul (1983) stated that the doctor-patient relation became a relationship between medical institution and disease, especially in the hospital context, due to the exclusion of doctors' and patients' subjectivities.

However the main purpose of this article is to analyze the reductionist conception of health and disease in biomedicine, to consider criticisms that have been made and, hopefully, bring contributions for rethinking health within positive propositions. To do so, our main focus is on Georges Canguilhem's epistemology. From our point of view, this author is essential for the necessary shift from health policies driven by disease towards new proposals driven by health.

Georges Canguilhem's contributions

Le normal et le pathologique (*The normal and the pathological*) has already become a "classic" work. Thus, it has been discussed by many researchers and it has become an obligatory reference in several analyses in the domain of healthcare. In Brazil, the reflections by Coelho & Almeida Filho in 1999 and 2002 are examples, but our focus is on some of the issues discussed in Soares (2000), which bring some important contribution to the theme in question here. Canguilhem's epistemological construction about life hinges on the concept of norm, in a way that life and norm become inseparable (Blanc, 1998). His *démarche* allows an interesting inversion of a fundamental split in a positivist epistemology, in which knowledge occurs on an “absolute reality”, and there is no place for discussion of values. For Canguilhem, on the other hand, knowledge can be relativistic, but there is a fundamental value, ontological, on life itself.

In the first essay of *The normal and the pathological*, the author tries to define the conditions of possibility for a biological individuality starting from the experience of disease. He criticizes medical theory and biology, puts himself against the positivist dogma of disease, and states that there is a qualitative distinction between health and disease, between normal and pathological. The organism is considered a totality and disease is seen as the expression of a new global behavior of the organism, and not only an affected part of it. Disease is an experience lived by an individual, it is creation of a new norm. Every disease refers to a patient who tries to make sense of it. That's why the perspective of the patient is so important for Canguilhem (1995, p. 96):

We consider that medicine exists as art of life because it is the human being, himself, who considers as pathological – thus, to be avoided or corrected – certain states or behaviors that, in relation to the dynamic polarity of life, are apprehended as negative values.

Normativity is, thus, the key concept for the distinction between normal and pathological. Canguilhem's understanding of normativity as life potency to create new forms is seen by authors such as Blanc (1998) as a form of approximation with Nietzsche, who considers that life in itself is creation of value. Vieira (2000) also considers that the nietzschean concepts of the will to power and of eternal return are the expression of the great health. Based on this self-recovering power of

living organisms we can relate Canguilhem's writings with Morin's concept of autonomy (1994, 1996).

Another point to highlight is Canguilhem's rejection of the discourse of scientificity of medicine: he states that normativity - and not science – determines the difference between normal and pathological. In this way, the author refers not only to the issue of the sick person's autonomy, but also to the distinction between medicine and science. We quote:

"Well, medical practice is not a science and it will never be, even if it makes use of means the effectiveness of which are more and more scientifically guaranteed. Medical practice is inseparable from therapeutics, and therapeutics is a technique of establishment or of restoration in the normal, the goal of which escapes the jurisdiction of objective knowledge, because it is ***the subjective satisfaction of knowing that a norm is established.*** *Norms are not dictated to life, scientifically. But life is this polarized activity of conflict with the milieu, which feels normal or not, according to the feeling of being in a normative position, or not"* (Canguilhem, *op. cit., p.* 185-6, highlights in the original).

Because he considers normality and pathology as values, Canguilhem claims a specific field that escapes from the domain of science; therefore, he rejects presuppositions of biomedicine which classifies it as scientific, objective and neutral. His criticism concerning the fragmented vision of biomedicine can be seen in this statement: "(...) *the illness of a living being is not located in certain parts of the organism"* (p. 183).

This conception reinforces our criticism of the way allopathic drugs are being used in medicine, more and more developed to act on specific parts of the organism, with the goal of healing diseases. This fact impoverishes the potential of therapeutics, which should go way beyond a sharply focused action to solve a problem. Pharmacotherapeutics, as it is currently defined, is not intended to act upon the patient, the living being, but on disease, in a conception criticized by Canguilhem. If we consider his concept of cure – *"to cure is to create new norms of life for oneself"* (p. 188) – we can observe that the logic of scientific pharmacotherapeutics used by biomedicine is not aimed at assuring a larger individual normativity. This can lead to an important

inversion: the human being, who should be the target of therapeutics, becomes a mere instrument or middleman of drug action on diseases.

When Canguilhem emphasizes that normal and pathological are concepts of values, he is also rejecting the dominant concept of pathology in biomedicine, *"(...) according to which the morbid state in the living being would be just a simple quantitative variation of the physiologic phenomena that define the normal state of the corresponding function" (p.* 187). For the author, the pathological state is a normal state in the sense that it expresses a relationship with the normativity of life; however, it is a qualitatively different state (and not quantitatively, it is worthwhile to emphasize) from the normal physiologic one, which has different norms. Thus, pathology is not the absence of norm, but the establishment of another norm and a restriction of normativity.

There are not normal or pathological facts in themselves. A normal norm is the one which expresses stability, fecundity and variability of life in an equivalent or superior degree compared to a previously existing norm. Therefore, it is relative, and it can be established by comparison; it cannot be considered absolute, as it is the tendency in biomedicine. This way, "(...) *the anomaly may become a disease but it is not, in itself, disease" (p.* 109). Anomalies and mutations just prove the diversity of life, its multiple possibilities. But in biomedicine anomalies are often considered diseases to be suppressed, therefore reducing diversity, difference, heterogeneity.

A normal man is the normative man, *i.e*., he who is capable of breaking the norms and of establishing new ones, an autonomous man, as we would say. In brief, these are Canguilhem's main contributions: besides the concept of health itself, the concepts of normal and pathological as values, the acknowledgement of the difficulty to determine medically what is normal and what is health, the appreciation of the patients' perspectives in the therapeutic process, as well as their uniqueness.

The acceptance and defense of Canguilhem's vitalist perspective help us think of strategies which may lead to the active, critical, conscious and responsible use of the several alternatives which are present in the contemporary world. This way, we may avoid the acritical consumerism, be it of information, knowledge or technologies.

Concepts of health in question

Berlinguer (1988) had already criticized biomedical definition and evaluation of health as instrumental, based on criteria of productivity or adaptation. Other authors, such as Foucault and Swaan, should also be taken into consideration here, due to their analyses concerning the intervention strategies used in biomedicine.

Based on Canguilhem's thoughts, Caponi (1997) brings interesting contributions too, when she questions the definitions of health by the World Health Organization (WHO) and by the VIII National Conference of Health held in Brazil. The author analyses that the definition of health as *"a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"* may legitimate strategies of control and of exclusion of all those to be considered dangerous or not welcome, because the concepts are not questioned. In the WHO's definition of health, misfortunes and illnesses are not acknowledged as part of life and, thus, should not be seen in terms of crimes and punishments. Nietzsche and Canguilhem have made excellent analyses of this issue. To speak of health involves speaking of pain or pleasure as well, demands the recognition of a “subjective body”, as Canguilhem does. That is why he considers the true doctor an exegete, someone who can help the patient in his search for meaning concerning the set of symptoms that he is experiencing but cannot decipher alone.

In relation to the so-called "broadened" concept of health, defined during the VIII National Health Conference of Brazil and included in our Federal Constitution, Caponi (1997) also presents a quite interesting critique. She acknowledges its merit of focusing on the close relationship between health and society, but criticizes the reduction of the concept into one determinant and absolute dimension in the health/disease process. Any reference to a biological or psychic specificity of the illness is lost, any reference to a vital dimension is excluded, differently from Canguilhem's non reductionist analysis. Besides, just like the definition of the WHO, the broadened concept of health from the VIII NHC may also lead to the idea that all dimensions of the human existence could be medicalized.

Canguilhem understands health in terms of margin of safety, and includes errors as a starting point. He overcomes the concept of health as balance between the organism and the

environment, when he maintains that health implicates the capability to institute new norms, a creative ability. But besides having the self-care capacity as a central element, the concept of health in Canguilhem's thinking contemplates the social determinants as well; this author considers both biological and social values, when he refers to the capability of tolerance to face difficulties.

For us, health as the capability to break norms and institute new ones is a concept that emphasizes diversity, multiplicity, and the creative potential of living beings. This is a crucial issue for those who are looking for new paths, alternative directions, in biomedicine. But what we observe, instead, is the tendency to homogenize, reduce or suppress the ambivalences, the multiple meanings of the diseases, of drugs, of life, after all. In contemporary biomedicine there is no room for this concept of an individual being creator of norms. On the contrary, biomedicine is increasingly directed towards disease, or more precisely, towards organs or fragments presenting some symptoms. How can we think of autonomous individuals, when patients are not even considered persons?

Jonas (1994) discusses the results of the increasingly social regulation, leading to the loss of individual autonomy. Therefore, this author's writings reinforce the analyses done by Caponi (1997) Foucault (1976, 1980), Swaan (1988), among others. Another difficult issue analyzed by Jonas refers to the opposition between technological manipulation and the individual's symbolic manipulation:

"Should we induce learning attitudes in school children through the massive administration of drugs, and ignore the appeal to the autonomic motivation? Should we control aggressiveness through the electronic neutralization of cerebral zones? (...) " (Jonas, 1994, p. 53)

Thus, there is an ethical tension constantly present in the medical practice, which comes from the conflict between the principles of autonomy and beneficence, of the difference among respect for freedom and the concern with what is more convenient to people, and these elements also involve the question about who can and who should make decisions.

New directions for biomedicine

Some alternative proposals have recently emerged, emphasizing the need to rescue values such as democracy, ethics, critical capacity and autonomy in the medical field, values that we also defend as fundamental for overcoming the crisis in biomedicine in a constructive way. Contemporary medicine should shift in order to favor patients' feelings and values, but also those of their relatives and of the health professionals, all of them considered involved in the art of healing. We should stimulate the collective reflection for the necessary decision-making processes or, in other words, the democratization of the doctor-patient relationship, among others, so that we may reassess the concept and practice of humanization in medicine.

Concerning the medical decision models, in particular, there are countless studies (although, in Brazil, this theme can be considered still incipient) defending the democratization of the health professionals and patients relationships, the acknowledgement and stimulus of patients autonomy in relation to the choice of medical treatments and procedures to be followed, of models in which patients and physicians are seen as co-responsible in the process. Such proposals are based on empirical studies which have shown the association between a greater support to patient autonomy and better results, for example, in drug abuse treatments, weight loss and treatment adherence. Quill (1983), Brody (1985), Quill & Suchman (1993), Quill & Brody (1996) and Laine & Davidoff (1996) are examples of researchers who have been studying these models in the USA. Quill & Brody (1996) propose the Enhanced Autonomy Model, centered on the physician-patient relationship and based on competence and dialogue, in which knowledge and experience are shared between patients and physicians. Both of them participate in the decision: the physician is an active guide, is personally involved with the results and is co-responsible with the patient with regard to the consequences of their decisions. From our point of view, despite their validity, such models are based, in general, on a restricted concept of patient autonomy, limited to the context of the patient/physician relationship, without any questioning about the power and knowledge relations socially established, without any questioning on the principles of biomedicine and, consequently, are not concerned with changes.

Dâmaso (1992) criticizes the social health policies, which exercise external control upon the diseases at the expense of autonomy loss and of self-control of vital factors relating to the diseases of individuals, in communities and in whole populations. He proposes a therapeutic process based on the self-recovering potency of the living human organism, rejecting the physical and mental conditioning towards consumption of medicines and other technologies of the medical-industrial complex, consultations, exams, health programs and systems. For the author, any health politics should be educational: *"'Education for life', this would be the most radical health policy project and coherent with the human desire of autonomy"* (p. 222). So, Dâmaso is another researcher who confirms that the discussion of autonomy is crucial to overcome the biomedicine crisis and to move towards a more human, vitalistic medicine, which takes the potential of human beings into consideration. A medicine that would acknowledge its own limits and possibilities concerning its main goal: to contribute to the health of populations.

And we also defend that medical practice should be more and more directed towards people's "care". Science and technology should be just means, facilitative instruments for the final end of any medical system, that is, to take care of human beings. This would improve health and assure the best quality of life possible. Human care should be a crucial element of biomedicine and should also be the focus of any proposal of patient's autonomy. It is through human care that autonomy can be constructed, starting by the recognition and acceptation of the many dependency networks which constitute human existence. Autonomy, as we defend here, also requires a great responsibility in relation to ourselves and to other people. Therefore, to be autonomous does not mean to be independent, selfish, nor individualist, as seems to be a frequent trend in the mainstream conception of patient autonomy.

From different fields of knowledge, within a transdisciplinary approach, we can weave a complexity net for a better understanding of the issues involved in patient's autonomy and the therapeutic process. In the production of this network (c.f. Soares, 2000), we have appealed to authors who use this transdisciplinary or the interdisciplinary approaches in order to integrate micro and macro dimensions, general and particular aspects, interrelationships and interdependencies present in human processes, thinkers who understand the idea of "whole" not as

everything, but as a relative, multidimensional, dynamic complex. In this reassessment of the concept of autonomy integrating knowledge coming from different fields, such as biology, philosophy, sociology, ethics, it is more and more evident that the complex perspective leads to autonomy, as much as autonomy requires complexity:

"the more a system develops its complexity, the more it will be able to develop its autonomy, more multiple dependences it will have. We ourselves build our psychological, individual, personal autonomy, through the dependences that we support (...). Every autonomous life is a web of incredible dependences. (...) the autonomy concept is not substantial, but relative and relational" (Morin, 1996, p. 282).

For a complex concept of autonomy

The first constitutive principle of autonomy in the perspective of the complex thinking is, thus, its relative and relational characteristic, and the acceptance that autonomy is inseparable of dependence. Therefore, it would be necessary to overcome an idea or an objective of achieving an absolute autonomy. When we apply this conception to the health/disease process, it means that arguing for patient autonomy is not the defense of the patient's self-determination *tout court*. On the contrary, we state that to achieve patient autonomy we must strengthen relationships between patients and health professionals, between patients and their family members, because these autonomy/dependency networks are understood as fundamental for care and for health. What is necessary to overcome is the authoritarian or paternalist dimension of those relationships and to move towards the expansion of the autonomy in the therapeutic process.

When we fall ill, we want and we need care of others, be it the specialized knowledge that a professional has to share, be it the affection and emotional support that professionals, friends and/or relatives can bring. This, in itself, doesn't reduce a sick person's autonomy; on the contrary, it may even strengthen it. What should be avoided, however, is the shift into a dependence relationship, in which the person who is more fragile and dependent at a certain moment of life – a moment of an illness, for example – may be subjugated by others. In other words, in the doctor-patient relationship (or in other social relationships), to defend patient autonomy is not to propose

the inversion of the hegemonic relationship we have nowadays, but to recognize that both subjects should have voice and a place in the process, as well as respect regarding the differences in values, expectations, demands, objectives between them. The patient-physician relationship is - and should stay - heterogeneous, plural, diverse; but it should be acknowledged that the main agent of the therapeutic process is the sick person. Pharmaceuticals and medical technologies, as well as physicians and other health professionals must be means, instruments to be used by patients in the health/disease process.

Therefore, patients should be stimulated to become more active, critical, conscious and responsible for the health/disease process, they must be empowered, as several activist groups in the field of health, notably the AIDS NGOs, increasingly demand.

It is worth pointing out that to consider the patient "responsible" for his/her disease, as we put it, does not mean that we agree with the discourse in which the disease is considered a punishment and the patient a "loser" or "guilty", who can, thus, be stigmatized, isolated socially. Absolutely not. We also strongly reject the policies that manipulate this idea of a responsible patient in order to justify reduction of government expenses with health, and/or try to liberate governments from their responsibilities concerning population health care, as we often observe in neoliberal politics.

It is necessary to review the basic assumption of modernity, that is, the existence of a rational individual. This is a myth. We are *Homo sapiens/demens* as Morin puts it, conscious and unconscious, rational and emotional, objective and subjective, and not purely rational individuals. One cannot speak of individuals as isolated from societies either. Both Morin and Elias (1994a, 1994b) have shown that this dichotomy must be overcome and we must think in terms of complex relationships, *i.e.*, complementary and antagonistic, between individual and social groups; both affect and are affected by each other, they make and are made by each other. Plastino (1996), in his criticism on the illuminist conception of man and of modernity, also denounces the reductionism of these conceptions.

So, when we think about patients in their relationship with health professionals, we must consider them as unique human beings, individuals and yet members of the human species, who

cannot be considered out of the society and of the culture to which they belong. The same applies to the health professionals. And when these relationships take place in public or private health institutions, as it is increasingly the case, this is one more element to be considered in the analysis. These relationships are also challenged by the limits given by those organizations. Authors like Illich (1975) have made important contributions through the analysis of the medical nemesis, which helped expropriate the potential of people to live in an autonomous way.

Autonomy, even as a potential that can come into being, deserves to be reassessed as a condition for health and for citizenship, for life itself; thus, it is a fundamental value, but it is not, nor should it be, absolute. It is relative and relational, as argued above, and it should be built in a process of continuous production in a network of dependences, which is quite flexible, but which is necessarily reduced in cases of illness. Autonomy must be built in a continuous way in its interrelationship with dependence in daily life. As a consequence, it is very difficult to think about autonomy in health if there is no autonomy in the most general areas of politics and of life. The autonomy/dependence relationships are present during the whole life of living beings, at the individuals' level, the level of societies, of countries and even of the planet. Thus, we agree with Castoriadis (1986), when he maintains that autonomy is a fundamental value within a project of a democratic and responsible society.

In this reassessment of the concept of autonomy within the approach here proposed, to affirm it as a value entails seeking the democratization of relationships between health professionals and patients, the democratization of knowledge and information, acknowledging, respecting and appreciating multiplicity, diversity and singularities, a greater responsibility and participation of citizens, valuing subjectivity and, above all, an ethics of solidarity and responsibility. This leads us to ask especially in the case of countries such as Brazil, how to assure minimum autonomy of subjects regarding their health-disease process? Is it possible to speak of an autonomous patient, free and conscious of his/her choices, when the social and economic constraints are of such magnitude, when there is ignorance due to lack of access to information, in such a highly unbalanced knowledge/power relationship between physician and patient as is the case, for instance, in the Brazilian public health institutions? What are the minimal conditions that

should be assured in terms of social justice, of life conditions, equity, knowledge and information, in order to assume the existence of a possibility of autonomy?

From our point of view, information, democratization of knowledge and of physician-patient power relationships, State – through governmental institutions – and civil society power relationships, ethical issues and a larger citizens' autonomy in relation to their choices and decisions become crucial. However, autonomy is not to be mistaken for individualism, nor freedom to be taken as an abstract idea, apart from the social, cultural and political context. As we have been arguing, the possibility of management of one's own life entails consciousness of limits, of existing alternatives, of a democratic and ethical perspective. In other words, autonomy requires respect for others, appreciation of subjectivities, knowledge and values, as well as the acknowledgement of interdependence. An autonomous human being is he/she who acknowledges his/her need of others in every human aspect – affective, intellectual, emotional…

Another implication of the assertion of autonomy as a fundamental value in a democratic and responsible society refers to the formulation of policies. These should not be rigid, but more general guidelines stating their assumptions and goals, leaving a wide margin of flexibility so that adaptations to particular situations can be made. But in order to achieve that, there should be many cultural and educational changes, a *"reform of thinking"* (Morin, 1998) that overcomes the disciplinary perspective, the Cartesian thinking, and dichotomies such as macro/micro, specific/general, cause/effect, individual/collective, rational/irrational, objective/subjective. We must understand processes of knowledge construction and of critical capability empowerment. That is, we must move towards education of conscious, responsible, informed citizens, capable of debating, questioning and choosing projects, proactive in their implementation and who refuse to be subjugated by technologies and institutions. These are to be used by the citizens themselves as a tool for an enhanced autonomy.

Another important issue is the need of a deep transformation in the concepts of health and disease/ illness. This is due to a second constitutive principle of autonomy in the perspective of the complex thinking: autonomy as a necessary requirement for health, understood in its widest

meaning, health as life, as self-recovering potency of living human organisms (Dâmaso, 1992), as the capacity to face new situations and institute new norms (Canguilhem, 1995).

This understanding entails the acknowledgement and appreciation of diversity, of multiplicity, of the creative capabilities of living beings, of their need of autonomy/dependence interrelationships as a very condition of life itself (Morin 1977, 1980, 1994, 1996). There is no life without autonomy. This is a characteristic of all living beings, it is part of the comprehension of life and death phenomenon. Therefore, therapeutics should have the stimulus to our self-cure and autonomy capability (cf. Canguilhem), as its main goal, so that it can be considered, indeed, a therapeutics for health.

The rationale which rules drug use in biomedicine must be radically changed. We must overcome this distrust in nature's capacity, in the faith on man's power to control nature, characteristics of the illuminist thinking. As stated above, pharmacotherapeutics is still pretty much developed within the mechanist scientific rationale, in which the main search is through stimulation or inhibition of biochemical or physiologic human functions, in order to alleviate or to eliminate symptoms, or to favorably alter the course of a disease. To what extent have pharmaceuticals been used as a means of stimulating human beings' own capabilities of self-recovery or instituting new life norms?

So, that leads us back to the importance of revaluing autonomy in the therapeutic process and in social life, in general. It is worth repeating Castoriadis (1986): autonomy is in the core of human singularity; therefore, the construction of a new form of society should be based on a project of autonomy.

In conclusion

The main goal of this paper was to revalue and reinterpret the concept of patient autonomy in the therapeutic process. To conclude, we summarize the ideas developed here and highlight a series of proposals for health policies.

We defend autonomy as essential for human beings and, therefore, a precondition for health and citizenship. A health policy should not be considered as such if it does not take

autonomy into consideration. The search for patient autonomy in the health/ disease process becomes fundamental, from our point of view. It must be developed on a day-to-day basis, continually, in its interrelationship with dependency, even when autonomy is limited as in the case of a disease. For us, an autonomous being is he/she who recognizes his/her necessity of another being in every dimension of life.

Having these principles as a starting point, many implications for different levels of health policies can be considered. In relation to the therapeutic process itself, we have highlighted:

- The need for strengthening relationships between patients and health professionals, between patients and their relatives, but not in paternalistic or authoritarian ways;
- Acknowledgement of heterogeneity and diversity in relations, as well as of the patient as subject of the therapeutic process;
- Recognition that the different medical systems and technologies, as well as physicians and other health professionals, are only means in the therapeutic process;
- Stimulus to empowerment and responsibility of patients, based on an ethics of solidarity, respect and accountability in the process;
- Relationships and knowledge in the health field should be democratized;
- Revalue of subjectivity and care in medicine;
- The need for profound changes in the concepts of health and disease.

When drug policy is considered from the point of view sustained here, it should allow for therapeutics that stimulates the creative and curative capabilities of the ill persons. Policies should be more general and flexible, built in a democratic way, instead of the rigid and reductionist ones we see at present. Rational drug use should not be a goal, as reason is only one of the elements at stake. No one uses medicines only for rational reasons… Decisions should not be made only by experts, but we do not defend medicalized self care either. Medications should be used creatively and critically by autonomous citizens.

More general implications of the rethinking about the value of autonomy are the need of construction of the conditions for a real expansion of autonomy in politics and life.

Democratization of information, knowledge and power relationships, construction of an ethics of solidarity and responsibility, deep changes in education and culture are essential to achieve autonomy. Thus, there is still a long and hard way to go, but it is absolutely necessary in order to have health in its mostly comprehensive and concrete value.

References

BIRMAN, J. Os sentidos da saúde. **Physis,** RJ, 9(1): 7-12, 1999.

BLANC, G. **Canguilhem et les normes.** Paris: PUF, 1998.

CANGUILHEM, G. **O normal e o patológico**. 4ª ed. revista e aumentada, Rio de Janeiro: Forense Universitária, 1995. [1ª ed. em francês: 1966]

CAPONI, S. Georges Canguilhem y el estatuto epistemológico del concepto de salud. **História, Ciências, Saúde – Manguinhos,** IV (2): 287-307, jul./out. 1997

CASTORIADIS, C. **A instituição imaginária da sociedade.** 2ª ed., Rio de Janeiro: Paz e Terra, 1986.

CLAVREUL, J. **A ordem médica:** poder e impotência do discurso médico. São Paulo: Brasiliense, 1983.

COELHO, M.T.A.D.; ALMEIDA FILHO, N. Normal-patológico, saúde-doença: revisitando Canguilhem. **Physis,** RJ, 9(1): 13-36, 1999.

COELHO, M.T.A.D.; ALMEIDA FILHO, N. Conceitos de saúde em discursos contemporâneos de referência científica. **Hist. cienc. saude Manguinhos,** 9(2): 315-333, mai-ago, 2002.

DÂMASO, R. Saúde e Autonomia: Para uma política da vida. *In*: FLEURY, S. (org.). **Saúde: Coletiva?** Questionando a onipotência do social. Rio de Janeiro: Relume-Dumará, 1992. p. 213-231.

ELIAS, N. **El proceso de la civilización.** Investigaciones sociogenéticas y psicogenéticas. 1ª reimpresión, México: Fondo de Cultura Económica, 1994a.

_____ . **A Sociedade dos Indivíduos**. Rio de Janeiro: Jorge Zahar, 1994b

FOUCAULT, M. La crisis de la medicina o la crisis de la antimedicina. **Educación médica y salud (OPAS),** 10(2): 152-170, 1976.

_____ . **O nascimento da clínica**. 2ª ed., Rio de Janeiro: Forense Universitária, 1980.

ILLICH, I. **A expropriação da saúde:** nêmesis da medicina. Rio de Janeiro: Nova Fronteira, 1975.

JONAS, H. Técnica e Responsabilidade: Reflexões sobre as novas tarefas da Ética. *In*: _____ . **Ética, medicina e técnica**. Lisboa: Veja, 1994. p. 27-61.

LUZ, M.T. **V Seminário do Projeto Racionalidades Médicas**. Rio de Janeiro: UERJ, IMS, outubro 1996. (Série Estudos em Saúde Coletiva, n° 136)

MORIN, E. **La Méthode.** 1. La Nature de la Nature. Paris : Éd. du Seuil, 1977.

_____ . **La Méthode.** 2. La Vie de la Vie. Paris: Éd. du Seuil, 1980.

_____ . **La Complexité humaine**. Paris: Flammarion, 1994.

_____ . **Ciência com consciência**. Rio de Janeiro: Bertrand Brasil, 1996.

_____ . La democratie cognitive et la reforme de la pensée. *In:* **I Congresso Inter-latino do Pensamento Complexo** (Cilpec), Universidade Cândido Mendes e *Association pour la Pensée Complexe*, Rio de Janeiro, set. 1998. Mimeogr.

PINHEIRO, R.; MATTOS, R.A. (orgs) **Os sentidos da integralidade na atenção e no cuidado à saúde.** RJ: UERJ, IMS: ABRASCO, 2001. p. 157-166.

PLASTINO, C.A. **Os horizontes de Prometeu: considerações para uma crítica da Modernidade.** Rio de Janeiro, UERJ, IMS, 1996. (Série Ests. em Saúde Coletiva, n° 141)

SOARES, J.C.R.S. A autonomia do paciente e o processo terapêutico: uma tecedura complexa. 2000. **Tese (Doutorado)** – Instituto de Medicina Social, UERJ, Rio de Janeiro.

SWAAN, A. Conclusion: the collectivizing process and its consequences. *In:* _____ . **In care of the State.** Health care, education and welfare in Europe and the USA in the Modern Era. Cambridge: Polity Press, 1988. p. 218-57.

VIEIRA, M.C.A. **O desafio da grande saúde em Nietzsche.** Rio de Janeiro: 7 Letras, 2000.

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