



Patient Autonomy in Health Care Ethics-A Concept Analysis

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Abstract

The four principles approach has been one of the most used methods of healthcare ethics. Various moral principles can and do conflict in the moral life and it can be difficult to justify between the principles. The paper reports that whilst respect for autonomy is as important as the other principles, but, being a prima facie value, it also has some parameters. The paper elucidates the important concept of paternalism that deemed sufficient justification in health care decision-making.

Introduction

The four principles namely principles of beneficence, non-maleficence, justice and respect for autonomy, sometimes referred to as principlism, were first introduced by two American healthcare professionals, Beauchamp and Childress in the 1980s. In addressing ethical dilemma, it has been argued that each of these principles has a prima facie value or obligation whereby an obligation is

always binding unless a competing moral obligation overrides or outweighs it in a particular circumstance.

Case Studies

The first case describes Maimunah, 74 years old, was found to have progressive cancer and it is not aware as yet. She has repeatedly said to the doctor that she would rather die than suffer the pain. The doctor decided not to tell her the diagnosis, fearing that it could harm the patient.

The second case refers to Kamariah, aged 30, refused to have her blood taken,

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for various tests, even though, through the test, a diagnosis can be made and further treatment can be prescribed. She refused because her fears of needles.

The third case shows Basri, who was having an irreversible illness, has insisted on having his life prolonged as long as possible by all available means. He demanded aggressive treatment, although the staff considered the treatment futile.

Discussion

The first case describes the disclosure dilemma in health care practice. The notion “to tell or not to tell” has been around for many years. This is particularly relevant with what is regarded as “bad” news for the patient. It is not a problem if the patient has expressed the wish not to know the information, but it is a major problem if the patient who wishes to know, who expects to be told the truth, or who says nothing at all.

In disclosure standard, there are three types (Beauchamp and Childress, 2013) however here it is only beneficial to mention two. First, the *professional practice standard* is where the disclosure

is decided by the health professionals because of their professional expertise and commitment to the patient’s welfare. Thus, in Maimunah’s case, the minimal harm resulting from the nondisclosure outweighs the benefit of the disclosure of the information. However, it may need further justification, because patient’s subjective beliefs, fears, and hopes need to be treated sensitively and individually (Beauchamp and Childress, 2013). Meanwhile, the second standard is the *subjective standard*, which is a preferable moral standard of disclosure, because it alone acknowledges a person’s specific informational needs. However, this can be argued as inadequate because patients are often uncertain what information would be relevant for their deliberations, and in fact, it is quite difficult for a healthcare professional to determine what information is relevant to the patient (Beauchamp and Childress, 2013).

In Maimunah’s case, the doctor paternalistically assumed that more harm might result from the information disclosure, even though respect for autonomy demands the healthcare professionals to disclose information

(Beauchamp and Childress, 2013). It is arguable that we cannot know what the autonomous decision of the individual would have been, had she been given a chance to know the truth. The fear of the detrimental effect from telling the truth is perhaps not a sufficient justification for general policies of non-disclosure, which would deny the autonomy of many. Nonetheless, in relation to terminal illness, a mortal diagnosis and prognosis, information may be withheld from the individual if it is deemed in their best interests not to know, that is, if there is risk of harm. This is known as therapeutic privilege and requires the careful exercise of clinical judgment (Dimond, 2015).

The second case accentuates an answer whether Kamariah's autonomy in decision making should be respected. For medical and nursing practitioners bound by a duty of care, the principle of nonmaleficence is important because it asserts an obligation not to inflict harm on others. In medical ethics, it has been closely associated with the maxim *Primum non nocere*: "First (or above all) to do no harm" (Beauchamp and Childress, 2013). In this case, the

uncertainty requires further deliberation on the consequences of the various courses of response and action. Should the irrational decision be sufficient to establish the patient's incompetence? Is it justifiable to override such decision? Furthermore, should the nurse pursue with the procedure, Kamariah would be harmed by having to be restrained in order to insert the needle. On the other hand if the blood tests are not done now, it may cause her more harm, for instance, a diagnosis cannot be made and this would delay her intended treatment. Therefore, the question is which course of action would result in the greatest harm? Difficulties usually occur when a rational, competent adult decides to refuse any medical treatment and this potentially poses a considerable dilemma for health care professionals.

It is nonetheless important that Kamariah is making an informed decision, that is, she understands the benefits and risks that may result from the decision. Whilst this may seem to be an irrational decision, but one has to remember that, patients are entitled to make decisions which seem irrational to others, if the patient understands what their decision entails. Furthermore, to

regard others as irrational because they do not share the same view of a morally good life predisposes to paternalism (Maclean, 2013). Paternalism in healthcare is the idea that doctors and nurses know what is best for the patient. They subsequently make choices about treatment, claiming that it is in the patient's best interests. Traditionally, paternalism has been well accepted and seems to work well too. But, with the emphasis on respect for autonomy, the paternalistic approach has been widely criticized (Beauchamp and Childress, 2013). Equally, this act of paternalism reflects the principle of beneficence which emphasizes the moral importance of doing 'good' to others and, in particular in a health professional context, doing good to patients. Following this principle, it raises the question of who should be the judge of what is best for the patient. Arguably, one human being cannot judge what is best for another, even though one may have more knowledge. There is a danger that one may make a judgment based on personal values and beliefs that are not the same of another (Banner, 2013). To exercise the principle of beneficence, unfortunately some form of paternalism may be inevitable. Harris (2015)

maintains that the only thing that makes paternalism morally respectable is its claim to be an essential part of what it is to respect people. Harris further contends that, in most cases our concern for the welfare of others poses no problems and is non-paternalistic. The problem arises where a health professional and patient disagree about what is conducive to their welfare or where a health professional does not disagree but they happen not to want to maximize their own welfare.

The third case contends that the principle of nonmaleficence can be overshadowed by the futility of treatment. Futile or pointless treatment is used to cover many situations of predicted improbable outcomes, doubtful success, and unacceptable benefit-burden ratio (Beauchamp and Childress, 2013). This raises a question as to the extent that "do no harm" can be applied in Basri's case. By continuing the treatment as requested by him, the healthcare professionals may be ethically right in exercising the principle of nonmaleficence, however, this notion can be challenged in the view of others' best interests, especially in terms of the futility of treatment and the

limited health resources. Furthermore, healthcare professionals are not obligated to continue what is deemed to be futile treatment (Beauchamp and Childress, 2013). This is to say that, if the action of one, can impact on another's wellbeing, for instance, scarce resource, then respect for a patient's autonomy is unjustifiable. Therefore, whilst there is a convincing argument for upholding and promoting autonomous choice, there is clear evidence emerging that such a principle is not always absolute.

Reflecting on these three cases, whilst having autonomy means someone has the ability to decide, to choose and to act without the interference from others, it could be argued that it is not possible for one to be fully autonomous because there are many factors that can influence in decision-making such as culture and religion. However, it is presumed that it is not as straightforward as this. In healthcare practice, respect for the autonomy entails the health professionals to help patients to come to their own decision after they have been provided with important information, and to respect and follow those decisions

even when the health professional believes that the patient's decision is wrong (Hope et al., 2008). Meaning to say, that if the patient understands the benefits, risks, costs and implications from making the decision, then their decision must be respected. But, for those who have impaired or restricted autonomy, it may mean that someone has to make a decision for them, which is in the best interests of the person. For instance, babies, prisoners, people with mental illness are amongst this group of people (Beauchamp and Childress, 2013).

Furthermore, respect for autonomy has only a prima facie standing and can sometimes be overridden by competing moral considerations. Therefore, primarily, respect for autonomy does not extend to persons who cannot act and decide for themselves because they are immature, injured, uninformed or badly informed, coerced or exploited. Infants, irrationally suicidal individuals, and drug-dependent people are examples (Beauchamp and Childress, 2013). Of course, the problem about incompetence is to determine the patient's capacity to decide, based on their ability to

understand the amount of information given. This can be seen in emergency cases where treatments that are carried out are deemed for the best interest of the patient, and there is no means to know the patient's wishes. This act of beneficence seems to justify the overriding of the autonomy of the patient. The consequences of the various courses of action need to be considered. If the patients are not treated, then they are likely to die. This would mean that there is a need to balance the harms and benefits of the various options, in order to determine what would be in the patient's best interest (Murray, 2012). Nonetheless, treating an autonomous patient in a paternalistic manner may indicate that the patient's autonomy has not been respected. But at the same time, whenever we try to help others we inevitably risk harming them, and for that reason, health professional must therefore consider all the four principles particularly of beneficence and nonmaleficence together and aim at producing a net benefit over harm (Ashcroft et al., 2007).

Conclusion

In conclusion, the above discussion reflects the four principles in health care ethics can come into conflict and overrides each other principle. The cases highlight that when moral conflict arises, there is a need to consider the equal importance of all the four principles in health practice. The conflict does not necessarily mean that one principle is more important than the other. It further demands that some ethical considerations and justifications to come to some possible resolutions.

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