# ETHICAL ISSUES IN MEDICINE

## Respect of Autonomy

Some of the ethical issues in contemporary medicine include respect for autonomy. Autonomy can be defined as the personal rule that is free from the controlling interferences by others from personal limitation preventing meaningful choices. An autonomous person acts intentionally, with understanding and without any controlling influence. When it comes to clinical applications respect for autonomy is among the major guidelines of clinical ethics. In this case, autonomy is not merely permitting patients to make their decisions; the physician has to create a condition that is necessary for autonomous choice in others. For the doctor, respect for autonomy involves respecting a person’s right to self-determination and creating the condition required for the autonomous choice (Balducci & Innocenti, 2017).Respect for autonomy is mainly associated with enabling and allowing patients to make their decisions concerning the health care intervention they will or will not receive. The principle of respect for the autonomy is also invoked in discussions concerning privacy, fidelity, confidentiality as well as truth telling. However, it is mostly associated with the idea that patients should be allowed to make autonomous decisions as those made intentionally and with substantial freedom and understanding from controlling influences (Kious, 2016).

The idea that every patient should be provided with options and allowed to make some voluntary decision concerning some potentially life-changing health care intervention is paramount. It discourages inappropriate paternalism while protecting the patient from unwanted interventions (Lending & Dillon, 2007).For instance, through the autonomy, the patient can decline a surgery which they consider to be more burdensome than beneficial. For example, in the first case study, the patient has the right to make the decision whether he or she will go to the hospital or will wait until the appointment date. The caregiver should not make the decision for the patient. In most cases, the family of the patient who is given a chance to exercise the right to autonomy is left in a dilemma wondering if they should go by the patient’s decision or their ideas (García, 2015).

Some people have argued that the patient autonomy model fails to give enough attention to the effects of the disease on the patient’s capacity for autonomy. Medicine should restore a person’s autonomy, but it would be wrong to assume that autonomy is restorable or preservable when it comes to serious ailments. A sick person can be anxious, fearful, angry, guilty or hostile so much so that they can make judgments which they would not make when they are calm. This is so because they are mostly preoccupied with their disease and body. This mainly leads to beneficence which is an action done for the benefit of others. Beneficent actions are taken to prevent or remove harm and to improve the situation of others. For instance, if the elderly person were not in a position to make a decision following the degree of the disease, then the clinician would be forced to make the decision on behalf of the patient. The clinician is supposed to avoid causing any harm, but he or she has an obligation to help the patient (Holloway & Galvin, 2016).

Lastly, the relational understandings of a patient’s autonomy can underpin the enriched specification of the principle of respect for autonomy. The concern about the autonomy of patients is relevant in most of the health care contexts (Łuków & Różyńska, 2015).

## Beneficence and Non-malfeasance

Non-malfeasance is a medicinal term which means doing no harm or inflicting the less harm possible with aims of reaching a beneficial outcome. Harm and its effects are considered as part of the ethical decision-making process. Every physician must refrain from offering ineffective treatment or acting in malice towards the patient. However, the principle offers very little useful guidance to physicians as many beneficial therapies also have serious risks. Physicians should avoid providing ineffective treatments to patients as these leads to risks with no possibility of benefit and so have a chance of harming patients. They must avoid any action that would purposely harm the patient without the action being balanced by proportional benefit. Following the fact that many medication, interventions, and procedures cause harm as well as benefits this principle offers little concrete guidance when it comes to the care of patients. For instance, in the second case study, the physician should not listen to the woman who insists on euthanasia (Luce, & White, 2009).

The most common ethical dilemma in this situation is balancing between beneficence and non-malfeasance. This is a balance between the risks and benefits of treatment and plays a critical role in almost every medical decision such as whether to order a medication, particular test, operation or procedure. The case study can also include some aspects of beneficence ethical principle. This is the action that is mainly done for the benefit of others. The actions are done to improve the situation of others. For instance, in the case study, the physicians should not stop the CPR. Instead, they should do everything possible to help the man (Guido, 2001).

Those who argue against beneficence in such a situation maintain that physicians have no general obligation of beneficence. They only have duties to what is right that come from specific roles and assignments of duty that are not part of the ordinary morality. The beneficent actions are therefore virtuous as well as commendable moral ideals but not obligations. However, all professionals are obligated to always with no exception favor the interests’ as well as the well-being of the client (Gallagher et al., 2002).The understanding of this ethical principle compels the physician to consider his or her calling to the high standards of professionalism. The health professional is always required to act in a beneficent manner and always to do good when it comes to the patient. Additionally, the physicians have a duty to of care that mainly extends to the patient, professional colleagues as well as the society at large. Anyone who neither understands nor accepts the duty will be at risk of acting malevolently while violating the fiduciary principle of protecting and honoring the patient (Hanssen, 2004).

## Confidentiality and privacy

Any conversation between a doctor and a patient should remain confidential. The physicians are therefore supposed to safeguard personal as well as health information learned in the context of the client-nurse relationship (Pirani & Badruddin, 2015).The information can only be disclosed with the consent of the client or when there are specific legal or ethical obligations to do so. In the third case, the nurse was not supposed to disclose the information concerning the girl. Patient confidentiality is among the most important pillars of medicine. It is not only a matter of moral respect to protecting a patient’s information, but it is also important in retaining the important bond of trust between the patient and the doctor (Blais, 2015).

Patient confidentiality is vital in treating ill-health and without it would be hard for patients to disclose information about themselves as well as their families for fear that the information would leak thus affecting their reputation, employment as well as personal relationships (Amini et al., 2016).

Nurses are mainly faced with the challenge of respecting the confidentiality of patients in the present world where information is quickly shared and where information concerning illnesses can be sensitive. The physicians have a duty to care for every patient who involves maintains privacy as well as confidentiality (Barnett & Johnson, 2008).

Respecting the patient confidentiality starts with a clear understanding of different terms like the duty of care which maintains that the nurse has a duty of care towards the patient. Additionally, every patient has the right to information concerning their health circumstances.

The principle of confidentiality maintains that once the patient has shared personal information, the patient entrusts it to the nurse for safekeeping. In most cases, the information represents the individual who is not in a position to constantly monitor how the nurses use the information. Sharing the information would expose the patients to different people who should not be the case (Chua & Pitts, 2015).

The patient information may include information relating to injury, illness, disability as well as the background and demographic information concerning the patient. Confidentiality also includes other medical staffs who are not supposed to disclose any information they overhear from their colleagues (House et al., 2015).

However, in some few cases, health care worker can share personal information without the consent of the patient. This only occurs when in the public interest. This includes circumstances where availing the information would be necessary to preventing serious harm to other people (Jacobs, 2016). Through considering the possible risk of harm to other people if the information is not availed, the health care provider will decide whether or not to offer information to a third party. This type of instances is only set out in guidance from the General Medical Council. Maintaining confidentiality as well as communicating with patients is valuable in themselves as they assist in improving the standards of healthcare.

## Reference List

Amini, K., Negarandeh, R., Ramezani‐Badr, F., Moosaeifard, M., & Fallah, R. (2015). Nurses’ autonomy level in teaching hospitals and its relationship with the underlying factors. *International journal of nursing practice*, *21*(1), 52-59.

Balducci, L., & Innocenti, M. (2017). Quality of Life at the End of Life. In *Dying and Death in Oncology* (pp. 31-46). New York: Springer International Publishing.

Blais, K. (2015). *Professional nursing practice: Concepts and perspectives*. New York: Pearson.

Barnett, J. E., & Johnson, W. B. (2008). *Ethics desk reference for psychologists*. New York: American Psychological Association.

Chua, S. J., & Pitts, M. (2015). The Ethics of Prescription of Placebos to Patients with Major Depressive Disorder. *Chinese medical journal*, *128*(11), 1555.

García, F. A. (2015). Chapter Six-Respect and Autonomy in Children's Observation and Participation in Adults’ Activities. *Advances in child development and behavior*, *49*, 137-151.

Gallagher, E., Alcock, D., Diem, E., Angus, D., & Medves, J. (2002). Ethical dilemmas in home care case management. *Journal of Healthcare Management*, *47*(2), 85-97.

Guido, G. W. (2001). Legal and ethical issues in nursing. Hanssen, I. (2004). An intercultural nursing perspective on autonomy. *Nursing Ethics*, *11*(1), 28-41.

Hanssen, I. (2004). An intercultural nursing perspective on autonomy. *Nursing Ethics*, *11*(1), 28-41.

Holloway, I., & Galvin, K. (2016). *Qualitative research in nursing and healthcare*. New York: John Wiley & Sons.

House, J. B., Theyyunni, N., Barnosky, A. R., Fuhrel-Forbis, A., Seeyave, D. M., Ambs, D., & Santen, S. A. (2015). Understanding ethical dilemmas in the emergency department: views from medical students' essays. *The Journal of emergency medicine*, *48*(4), 492-498.

Jacobs, B. B. (2016). Respect for human dignity in nursing: Philosophical and practical

perspectives. *Canadian Journal of Nursing Research Archive*, *32*(2).

Kious, B. M. (2016). Respect for autonomy: deciding what is good for oneself. *Journal of medical ethics*, medethics-2015.

Luce, J. M., & White, D. B. (2009). A history of ethics and law in the intensive care unit. *Critical care clinics*, *25*(1), 221-237.

Łuków, P., & Różyńska, J. (2015). Respect for Autonomy. In *Encyclopedia of Global Bioethics*

(pp. 1-12). New York: Springer International Publishing.

Lysaught, M. T. (2004). Respect: or, how respect for persons became respect for autonomy. *Journal of Medicine and Philosophy*, *29*(6), 665-680.

Lending, D., & Dillon, T. W. (2007). The effects of confidentiality on nursing self-efficacy with information systems. *International Journal of Healthcare Information Systems and Informatics (IJHISI)*, *2*(3), 49-64.

Modra, L., & Hilton, A. (2016). Ethical issues in resuscitation and intensive care medicine. *Anaesthesia & Intensive Care Medicine*, *17*(1), 35-37.

Olsen, J. C., & Sabin, B. R. (2003). Emergency department patient perceptions of privacy and confidentiality. *The Journal of emergency medicine*, *25*(3), 329-333.

Pirani, S., & Badruddin, S. (2015). Euthanasia: A fight for respect and autonomy. *International Journal of Nursing and Midwifery*, *7*(6), 104-107.

Racine, E., Larivière‐Bastien, D., Bell, E., Majnemer, A., & Shevell, M. (2013). Respect for autonomy in the healthcare context: observations from a qualitative study of young adults with cerebral palsy. *Child: care, health and development*, *39*(6), 873-879.

Smebye, K. L., Kirkevold, M., & Engedal, K. (2016). Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study. *BMC health services research*, *16*(1), 21.

Tagin, M., Zhu, C., & Gunn, A. J. (2015). Beneficence and non-malfeasance in treating neonatal hypoxic-ischemic brain injury. *Developmental neuroscience*, *37*(4-5), 305-310.

van Thiel, G. J., & van Delden, J. J. (2001). The principle of respect for autonomy in the care of nursing home residents. *Nursing Ethics*, *8*(5), 419-431.

Weiss, L. (2016). Autonomy Versus Beneficence Versus Non-malfeasance in a Patient With Limited Cognitive Function.