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# Introduction

Nursing ethics is a domain of inquiry that focuses on the moral problems and challenges that nurses and midwives face in the course of their work. It involves an exploration and analysis of the beliefs, values, attitudes, assumptions, disagreements, emotions and relationships that underlie nursing ethical decisions. Since moral problems and challenges for nurses occur in institutional environments, nursing ethics takes seriously the quality of the ethical climate of these environments.

In some ways, nursing ethics can be viewed as one area of healthcare ethics alongside others such as medical ethics and dental ethics. Like these, nursing ethics focuses on ethical issues that arise in patient/professional relationships, such as autonomy, consent, veracity and confidentiality. It also considers obstacles to good care that health professionals must grapple with, such as a failure to achieve respectful and ongoing communication between families and nurses, patients and physicians. The power of such communication lies in mitigating the negative consequences of moral disagreements that can readily impact on good patient care. Nursing ethics can also be understood as distinct from other fields in healthcare ethics in important ways. Nursing ethics is connected with the unique history, goals and practices of nursing. In addition, many nurse ethicists pay particular attention to the quality of the relationship the nurse has with patients. This relationship can provide a type of ‘embodied knowing’. In nursing, it is part of the everyday work of nurses to care for people whose bodies elude their own control.

*Proximity created through physical intimacy gives rise to an important source of ethical knowledge that is uniquely available to nurses. . . . [M]oral understanding of health experience derives not only from rational thought but also from the bodily cringes we feel within ourselves when we touch another in pain. These cringes are a way of knowing that is crucial to sound ethical decision making and cultivated uniquely by nurses because of the nature of the work that they do.*

(Wright and Brajtman 2011:26)

In the past thirty years, the field of healthcare ethics in general has expanded rapidly in order to try to address the moral and metaphysical seismic shifts that have occurred as a result of technological advances at the beginning and end of life. Today, human beings can create life, modify life and prolong life in ways that make the wildest of science fiction stories sound tame. Professional association guidelines, clinical ethics committees, research ethics committees and commissions are instituted to attend to the moral uncertainty and moral challenges that go along with such rapid changes. Nursing ethics can be seen as part of a process of development that, similarly, addresses

these challenges. To meet these challenges, Janet Storch speaks of 'ethical fitness'. Such fitness includes reflecting on and practising ethics daily, engaging in ethical discussions and forums and discussing barriers to ethical practice (Storch 2010).

While nursing ethics has also expanded rapidly in response to change, it is well to remember that it is not just a recent phenomenon, the 'Josephine come lately' or 'poor relation' of other fields in healthcare ethics. In fact, according to Marsha Fowler's doctoral research, nursing ethics has a long and distinguished history, which demonstrates that nurses have for decades been profoundly and intimately concerned with good nursing practice and the welfare of society as a whole (Fowler 1984). The first documented nursing textbook, for example, was Isabel Robb's *Nursing Ethics: For Hospital and Private Use*, published in 1900 and reprinted several times. In addition, the first journal of nursing, *The Trained Nurse*, which began in 1888, published a six-part series of articles on ethics in nursing. From its inception in 1900 to the 1980s, the *American Journal of Nursing* (AJN) published over 400 articles on ethical issues (Fowler 1997:31).

At the beginning of the twentieth century, the language of obedience, vocation and service dominated the nursing ethics discourse. Today, in the twenty-first century, writers place emphasis on good judgement, autonomous decision-making and professional and personal accountability.

What is common to both early and recent discourse, however, is an understanding of the ethical life as one that is most deeply lived in relationship with others. In this view, to be ethically alive is to be aware, attentive, and understanding of the ethical obligations and responsibilities we share with and for others.

We offer this nursing ethics text in recognition of the long-standing ethical engagement of Irish nurses and midwives in improving the lives of people in their care. In the following chapters, we explore and analyse situations drawn from the everyday practice of nurses in Ireland and elsewhere, as well as some exceptional situations in which life and death issues arise. This text does not view ethics solely as an academic or theoretical subject but as an engaging, challenging activity that demands the development of a range of skills and intelligences. (See discussion of skills in Appendix 4.)

We use different moral frameworks to draw out a variety of ethical features in diverse situations. We focus on traditional ethical frameworks such as principle-based approaches, but also draw on more contemporary perspectives such as narrative ethics in order to foreground different ethical dimensions that may arise in healthcare settings, and in discussing each of these theories we ask the question: how ought we to live?

We believe that, given the international and multicultural nature of nursing practice, there should be a variety of moral frameworks to support ethical understanding and development. As with all other areas of inquiry, the development of nursing ethics has not occurred in a vacuum. History, culture, gender relations, political and economic forces, healthcare policies and organisational hierarchies all contribute to the often vastly different roles and responsibilities that nurses assume locally and globally.

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Included in the lexicon of healthcare today is ‘cultural competence’ and ‘transcultural nursing’. Leever explains that the high profile of these concepts is a:

*... reflection of the diversity of western societies and healthcare’s commitment to provide care that is responsible to the values and beliefs of all who require treatment. ... [R]especting patient autonomy and promoting the good of the patient ... provide the ultimate moral foundation for cultural competence.*

(Leever 2011:560–1)

This text is the second edition of *Nursing Ethics: Irish Cases and Concerns* (2005), which was the first book of its kind for teaching nursing ethics in Ireland. The text introduces the reader to the process of ethical reasoning and resolution through interactive learning, with the goal of engaging the reader through an exchange of cases, analysis and questions. Many of the cases are concrete narratives drawn from everyday experiences of nurses in Irish hospital wards, operating theatres, hospices, clinics and community health centres. Where relevant, we also include cases drawn from other countries. The narratives highlight a number of ethical questions and issues that are then explained and discussed in the text. In each chapter, a range of activities and suggestions are offered to the reader to encourage them to tease out the moral questions raised in the text. Each chapter offers Summary Learning Guides to facilitate a revision of concepts and definitions that aid in the project of developing greater ethical literacy for nurses in practice. A new feature of this second edition is ‘Suggested Professional Responsibilities’ offered at the conclusion of each chapter. These suggested responsibilities leave room to encourage discussion among colleagues that might add to the list offered by the authors of this text.

The overall aim of the book is to provide Irish nurses with a resource that will support and empower them in the challenging role they have in Irish healthcare. Specifically, we intend this book to provide the critical, reflective and imaginative skills to enable nurses to become more informed and more confident decision-makers.

The book is divided into three sections with a brief introduction before each section. The first two sections explore and analyse different case narratives as the basis for consideration of the patient–nurse relationship, and decision-making at the beginning and end of life. The third section turns the lens on the ethics of healthcare research and moral disagreement and distress. We believe that, because Irish nurses work in very different kinds of healthcare settings, they need to be able to draw on a variety of moral paradigms in order to expand their agency. For this reason, when considering topics and accompanying life narratives, our discussion draws on a range of different ethical frameworks that are more fully explained in the final two chapters of Section 3.

# SECTION ONE

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## The Patient–Nurse Relationship

Section One focuses on moral values that are central to the patient–nurse relationship. These values are also key conditions of the empowerment of individuals to make important decisions in relation to their healthcare and well-being. They include autonomy, truth telling, confidentiality and informed consent.

Chapter 1 explores and analyses the notion of patient autonomy as involving self-determination and self-authorship. The chapter explains why the freedom of the individual to make their own life choices is considered so important, particularly in western democracies. Not all countries and cultures prize autonomy equally. Social and cultural differences, particularly in many countries in Southern Europe and South Asia, privilege family and communal decision-making over individual autonomy. Chapter 1 also discusses the notion of paternalism and the challenges that arise when respect for autonomy seems to conflict with the need to protect vulnerable patients from harm. The limits to the exercise of autonomy are explained and can offer guidance to nurses and midwives in their efforts to promote autonomy in the professional–patient relationship. A related principle, beneficence, is defined and some of the tensions that can arise between beneficence and autonomy are detailed.

Chapter 2 assesses the requirement of informed consent, underlining the differences between express, tacit and implied consent. Chapter 2 draws attention to the tensions inherent in the role of the nurse who is working to empower patients to achieve valid informed consent in encouraging the autonomous decision-making of patients. Informed consent is shown as more a process of understanding and deliberation than a single act of assent or compliance. A number of pertinent legal instruments and relevant cases are presented to show the legal importance of determining capacity for informed consent. The legal instruments recognise that capacity may fluctuate over time, which calls for special attentiveness to such fluctuations. Exceptions to the requirement of informed consent are clarified and, as in all chapters, cases provide human narratives that illustrate the challenges in nurturing a positive nurse–patient relationship.

This understanding of informed consent will be central in a number of subsequent chapters, but especially Chapter 7, where the focus is on challenges that the requirement

of informed consent pose to nurses who undertake research involving human participants.

In Chapter 3, Case 3.1 tells the story of an autonomous patient who is very aware that her consultant is withholding information about her serious medical condition. A nurse who is party to this feels morally compromised and yet feels powerless to ameliorate the situation. Case 3.2 illustrates the narrative of a gentleman who unambiguously does not wish to be told information about his medical condition. The two cases highlight the dual rights of competent patients to know or not to know details of a diagnosis or prognosis. Chapter 3 explains and evaluates two different moral theories on truth telling, emphasising the values promoted in truthful conversations and the potential harms of deception. The centrality of communication as an ethical imperative receives emphasis in both case narratives. Arguments for and against truthful conversation with patients are offered and assist in reflecting on concrete situations that nurses meet in their professional role. Chapter 3 also echoes the discussions on informed consent in Chapter 2, since understanding of and information about one's condition are prerequisites for patient consent.

Chapter 4 refers to professional codes of practice in determining the scope of confidentiality and points out those circumstances where an exception to confidentiality might be made. The discussion of confidentiality is developed through an analysis of two cases which raise the troubling tension between the duty to protect one patient and the duty to warn another. The chapter explains the importance of the therapeutic relationship as itself a source of moral concern. In this chapter, complex situations are illustrated in the case narratives, which show that diverse cases call for different kinds of ethical skills and sensitivities. The chapter argues that to be ethically engaged in the fullest sense is to be alive to the world of the patient from the patient's point of view, while acknowledging that there are others whose voices and interests must also be heard and served.

# Chapter 1

## Autonomy and Beneficence

### Objectives

At the end of this chapter, you should be able to:

- Define **autonomy**.
- Discuss why autonomy deserves respect.
- Consider different ways in which autonomy can be respected in healthcare settings.
- Distinguish between negative and positive obligations of autonomy.
- Delineate and discuss the limits on autonomy.
- Define and discuss the principle of **beneficence**.
- Distinguish between **weak** and **strong** forms of **paternalism**.

## INTRODUCTION

Autonomy is a notion that is deeply embedded in western culture. It represents political and legal ideals that are associated with liberalism. At the heart of these ideals is the idea that the expression of uniquely individual beliefs and values should generally trump other values and goods.

The term ‘autonomy’ derives from the Greek words *autos* (‘self’) and *nomos* (‘rule’, ‘law’, ‘governance’) and originally referred to the self-rule of Greek independent city states. Today, however, we associate autonomy not just with nations but also with persons, acts and decisions. In addition to self-rule, it has acquired meanings such as self-governance, liberty, self-authorship, freedom of the will and self-determination.

An autonomous person is usually taken to be someone who is capable of making important decisions about their own lives on the basis of their own beliefs and values. An autonomous decision is usually considered to be a decision that is carried out freely (in the light of an individual’s own thoughts, feelings, desires or intentions), is informed, and is the result of considered deliberation about the likely consequences.

Describing a person as autonomous does not mean that they are the single originating source of all of their decisions; neither does it imply that they have complete control over all of their desires, intentions and deliberations.

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*To restrict adequate decision-making by patients and research subjects to the ideal of fully or completely autonomous decision-making strips their acts of any meaningful place in the practical world, where people's actions are rarely, if ever, fully autonomous. A person's appreciation of information and independence from controlling influences in the context of healthcare need not exceed, for example, a person's information and independence in making a financial investment, hiring a new employee, buying a house, or selecting a university. Such consequential decisions must be substantially autonomous, but not necessarily fully autonomous.*

(Beauchamp and Childress 2001:59–60)

Setting a minimum standard of this kind for autonomy makes sense because it includes the decisions that most ordinary people make. The significance of setting such a standard will become even more clear in Chapter 2 when we examine the concept of **informed consent**.

## RESPECT FOR AUTONOMY

Because of the significance attached to autonomy, respect for autonomous choice is considered to be an important moral and legal right. It is a core element of many different philosophical and political theories. Two philosophers, the eighteenth-century German, Immanuel Kant (1724–1804), and the nineteenth-century Englishman, John Stuart Mill (1806–1873), have greatly influenced the way in which we understand what respect for autonomy involves.

### Kantian Autonomy

Kant appealed to **deontology** – the belief that some things are intrinsically or inherently good, that each person is intrinsically valuable or has unconditional worth because they have the capacity to be autonomous. For Kant, human dignity resides in the fact that each person has a **free will** which they can follow independently of their passions or desires. In his view, human beings can be distinguished from many other sentient creatures because, unlike them, they are not wholly determined by their own immediate desires.

Believing that human beings are able to act freely and independently of personal desires, loves and hates, Kant argued that they are capable of prescribing general moral rules or principles for themselves to follow. They can legislate for their own conduct. The neo-Kantian Thomas Hill takes this to mean that:

*[T]he autonomy of a moral legislator means that, in debating basic moral principles and values, a person ideally should not be moved by blind adherence to tradition or authority, by outside threats or bribes, by unreflective impulse, or unquestioned habits of thought . . . must try not to give special weight to his or her particular preferences and personal attachments. . . . In other words, at the level of deliberation about basic principles, morality requires impartial regard for all persons.*

(Hill 1991:45)



## Autonomy and Beneficence

In the Kantian view, human beings have a capacity for free, **rational** and **impartial** decision-making. This means that they are able to decide a course of action on the basis of careful reflection and in the absence of coercion from authority or custom. In addition, they can decide the best course of action independently of their own personal preferences or inclinations.

The fact that human beings are the kinds of creatures who can act, or refrain from acting, on the basis of their own deliberative capacities enables them to take responsibility for and account for their decisions in a way that has been recognised throughout human history. For example, in the West, religious stories might bemoan the decisions of Lucifer, Adam and Eve to turn away from God, but their ability to make such a choice is nevertheless a central feature of the Christian belief system. In addition, classic plays and novels such as *Hamlet* and *Pride and Prejudice* focus on and appraise the choices and the subsequent lives of their main protagonists. Popular music also celebrates those who can say ‘I did it my way’ or who ‘can shout out, I am what I am’. From the sublime to the ridiculous and from the traumatic to the trivial, the ability of human individuals to choose on the basis of their own ideas of what is the right thing to do has been lauded down the centuries by very many cultures across the world. Whether individuals choose to conform, to reform, to rebel or to refuse, individual creativity is everywhere honoured.

## Millian Autonomy

In his well-known thesis in *On Liberty* (1859), John Stuart Mill also promoted respect for individual autonomy (or liberty) but on different grounds from those of Kant. Mill viewed each person as worthy of respect, not because of their rationality or impartiality, but because of their unique individuality. He appealed to the **utilitarian** view – that an action is morally good if it gives rise to more good than evil – to support his position. For Mill, respecting individual autonomy gives rise to more good than evil: society ought to respect autonomy because in the long term, society benefits from doing so:

*The worth of a State, in the long run, is the worth of the individuals composing it ... a state which dwarfs its men in order that they may be more docile instruments in its hands even for beneficial purposes – will find that with small men no great thing can really be accomplished.*  
(Mill 1981: 187)

In other words, in the Millian view individual freedom is compatible with and contributes towards the good of society as a whole. It follows that a person ought to be allowed to act according to their own life’s plan, their own beliefs and values, whether or not their actions are considered wise or good or foolish by everyone else. (One needs to read Mill’s text as referring to both genders when he uses the language of ‘small men’, etc.)

For Mill, autonomy is not an absolute right, i.e. we are not always obliged to respect it. On his view, the state or an individual is justified in interfering in individual

liberty when a person's action causes harm to others (this is known as the **harm principle**). He distinguishes between public and private morality, between those of our actions which affect others in society — other-regarding actions — and those which affect only ourselves — self-regarding actions. This is a classic liberal position which holds that the freedom of the individual can be compromised only when it is in competition with the rights and freedoms of other individuals. Respect for autonomy requires, in Mill's view, that we not interfere with the self-regarding acts and decisions that people make.

*[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he does otherwise.*

(Mill 1981:68)

## RESPECT FOR AUTONOMY IN HEALTHCARE

Drawing on the insights of both Kant and Mill, some healthcare ethicists have suggested a **principle** or **rule** of autonomy to guide all health professionals in relation to their care of patients. Such a principle obliges health professionals to behave in certain ways toward patients. Tom Beauchamp and James Childress, for example, are two ethicists who have given an important role to the concept of autonomy in healthcare. They delineate the principle of autonomy in the following way:

*This principle [of autonomy] can be stated as a negative obligation and as a positive obligation. As a negative obligation: Autonomous actions should not be subjected to controlling constraints by others. . . . As a positive obligation, this principle requires respectful treatment in disclosing information and fostering autonomous decision-making. . . . Respect for autonomy obligates professionals in healthcare and research involving human subjects to disclose information, to probe for and ensure understanding and voluntariness, and to foster adequate decision-making.*

(Beauchamp and Childress 2001:64)

Negative autonomy — the patient's right to refuse treatment — means that health professionals are obliged not to interfere with or constrain a patient's autonomous decisions in relation to their health. Positive autonomy — the right to be facilitated as much as possible in directing one's medical treatment and care — places more substantive obligations on healthcare workers. It obliges health professionals to recognise, support and enable the unique values, priorities and individuality of patients. Both negative and positive obligations place a duty on health professionals as long as the exercise of patient

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autonomy does not substantially infringe on the autonomy and/or well-being of others. (Refer to Mill's harm principle, above, and the section on 'Limits to Autonomy in Healthcare', below.)

In Ireland, recent government policy requires health professionals to respect patient autonomy in different ways. In particular, it draws attention to their positive duty to promote autonomy. One of the goals of the Health Service Executive (HSE) Strategic Plan for 2008–13 is 'to develop the role of the "expert patient", especially those with long-term illnesses, in developing their own care plan and in looking after their own condition' (p.14). Two of the related actions to achieve this goal are: the promotion of patients as 'partners with health professionals'; and the education of staff on the 'importance of patient involvement in their care' (HSE 2008). The National Strategy document defines 'involvement' as:

*A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.* (HSE 2008:6)

The focus of this HSE strategic plan on patient-directed and patient-centred care gives expression to patient autonomy and brings Ireland in line with international efforts to change the way in which illness is managed in the twenty-first century by health professionals and, increasingly, by patients themselves.

## LIMITS TO AUTONOMY IN HEALTHCARE

In healthcare, the right of autonomy may sometimes be limited for a variety of reasons. The foremost of these concerns the **duties that are owed to other people**. For example, it may be morally acceptable to interfere with a person's right to refuse treatment if the person has a contagious disease, such as tuberculosis. In such cases, a degree of interference with his or her rights (to refuse treatment, to freely interact with others) may be justified on the basis of the harm which would be caused to others who might well become infected with the disease if the person's right of autonomy were respected.

McCarthy, Donnelly, Dooley, Campbell and Smith (2011) refer to an unusual understanding of duties owed to others that is implied in one Irish case, *Re K* (2006):

*Here, a woman was not permitted to refuse a blood transfusion on the basis of her religious beliefs (she was a Jehovah's Witness) because, if she died, her infant son would be left without a parent. Judge Abbott held that the child's welfare should take priority over the woman's right of autonomy. This case was later reconsidered by the Irish courts under the name *Fitzpatrick v K* (2008). Judge Laffoy found that the woman had, in fact, lacked the necessary capacity to make the decision to refuse the blood transfusion and for this reason, her decision was not an autonomous one. This meant that there was no need to consider the*

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*question of whether or not the child's welfare should take priority over the woman's right of autonomy and Judge Laffoy did not consider the matter.*

(McCarthy *et al.* 2011:176)

A **second limit** to patient autonomy derives from the **just entitlements of others**. In short, given that medical procedures and healthcare services are scarce resources in great demand, patients cannot demand whatever they want. Countries differ on the commitment they give to fairness in the distribution of scarce health resources but, generally, any democratic society will provide a minimal public health system which tries to ensure that professional time, medication, clinical procedures, care, etc. are equally available to all who need them. In such a system, individuals cannot randomly demand more than is deemed fair and clinically indicated. In these systems, any additional requests bear additional costs.

A **third limit** to patient autonomy derives from the right of the health professional to her or his **moral integrity**. Such a right on the part of health professionals is not absolute and can only be exercised in well-justified circumstances. For example, health professionals are generally not obliged to provide treatment that they consider futile or harmful: if a patient asks to have a (healthy) limb removed because they consider it ugly or evil, a health professional is not obliged to perform the surgery. A more commonplace but more contested example might be that of a terminally ill patient who insists on very invasive, burdensome and risky treatment that the healthcare team deem futile. The issue of professional integrity is considered in greater detail in Chapters 5 and 8.

### Summary Learning Guide 1.1

#### The concept of autonomy refers to:

- such capacities as self-rule, self-governance, liberty, self-authorship, freedom of the will and self-determination;
- a person who is capable of making important decisions about their own lives on the basis of their own beliefs and values.

#### Autonomy deserves respect because it:

- is an expression of the rational and impartial nature of human beings (Kant);
- contributes to the good of society as a whole (Mill).

#### The limits of autonomy

The right of an individual to autonomy may be limited when its exercise conflicts with:

- the duty owed to other people;
- the just entitlements of others;
- the moral integrity of health professionals.

**The principle of autonomy obliges the health professional to:**

- refrain from interfering with or constraining the autonomy of patients (except where that autonomy might seriously limit or harm others);
- enable and promote the autonomy of patients.

**Activity**

- a) Can you think of any examples from your practice where you felt obliged to constrain the autonomous decision of a patient in your care?
- b) Can you think of any examples from your practice where you supported and enabled the autonomy of a patient in your care?
- c) Based on what you have learned about the concept of autonomy so far and on the definition of the principle of autonomy provided by Beauchamp and Childress, briefly define the principle of autonomy in your own words as a guide for your practice.

The following case illustrates the kind of demands that the principle of respect for autonomy, in its negative sense, places on a nurse who is working in a hospital setting. The case is concerned with the ways in which a patient's autonomy can be constrained.

**CASE 1.1 THE PATIENT WHO WANTS TO GO HOME**

Sean Ó Murchú is 72 years old and has been living alone since the death of his partner five years ago. He is in the early stages of Alzheimer's disease and is currently in the city general hospital recovering from a minor operation. Until recently, he has lived a very active and independent life, devoting himself to charity work and to his beloved garden.

During the day, Sean is generally fine, good humoured and co-operative with staff and fellow patients. However, as the evenings draw on, Sean is inclined to become agitated and distressed. He insists, often loudly and aggressively, to staff and other patients that he wants to go home to tend to his flowers and vegetables. He has taken to wandering the corridors of the hospital trying to leave and, on a few occasions, he has managed to get as far as the hospital car park.

The staff have tried various strategies to reassure Sean. They have told him that his neighbour is caring for his garden and they have also tried some mild sedatives. However, even when asked during his most lucid periods in the day, Sean tells staff that he would prefer to go home, whatever the risk, and that he misses his house all the more when night draws on.

Most recently, Sean managed to leave the hospital altogether and was found by an off-duty hospital porter wandering in a very busy shopping area looking for a bus to take him home. This has prompted the team to meet to decide on what can be done to ensure Sean's well-being and safety and the welfare of other residents on the ward. The

resident doctor suggests that they give Sean a stronger sedative in the evening, while the ward manager suggests that they use an electronic tag so that staff are alerted and the door of the ward is closed when Sean tries to leave the hospital.

## DISCUSSION

Sean's story will strike a chord with many nurses, health professionals and carers who look after people with varying degrees of dementia and it illustrates some of the key ethical issues that arise in relation to their care, for example:

- the obligations, if any, of the healthcare team to respect Sean's wishes;
- the obligations of the team to ensure Sean's safety and well-being;
- the obligations of staff to respect Sean's wishes and, at the same time, ensure the well-being of all the patients in their care.

You might think of other issues that are relevant here, but we will focus our discussion on respect for Sean's autonomy and concern for his welfare.

Through general conversation, or as a result of applying a relevant clinical assessment tool, it might be established that Sean's dementia is sufficiently advanced to seriously cloud his judgement. Staff might determine that Sean's stage of dementia is increasingly undermining his ability to make autonomous decisions. In short, Sean's wishes to go home and his actions that follow are viewed as resulting from his confused state rather than the outcome of his informed reflection and understanding.

On the other hand, staff might determine that Sean's desire to go home is substantially autonomous because he is only in the early stages of Alzheimer's. Because Sean is generally lucid, his choice is based on a clear understanding of the risks at stake and a consideration of the reasons for and against his hospitalisation.

However, whether Sean is considered to have substantial autonomy or no autonomy, his safety and welfare is an issue. Concern for his safety might lead the team to appeal to a second principle, that of beneficence, in order to help them in deciding what to do. We will briefly explain this principle before considering its application to Sean's situation.

## The Principle of Beneficence

Since the time of Hippocrates (460–377 BC), healthcare professionals have been advised to act for the benefit of their patients. This advice is often conceived in terms of the principle of beneficence, which minimally requires that health professionals avoid harming patients and ideally requires them to promote patient health and well-being. (The twin tasks of avoiding harm and promoting good are often cast as two principles in the ethics literature: **non-maleficence** – do no harm; and **beneficence** – do good; but for the purposes of this chapter, we take the principle of beneficence to incorporate both meanings.)

The parable of the Good Samaritan in the New Testament, Luke 10:34, is a good example of the *ideal* form of beneficence (Beauchamp and Childress 2001:167). In that story, a man travelling from Jerusalem to Jericho is beaten and robbed and left for dead.

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His plight is ignored by two other travellers but he is eventually found by a stranger who, moved to pity, pours oil and wine on the man's wounds, bandages them and brings him to the nearest inn to care for him there.

### Activity

- a) Write a list of three acts of kindness in ordinary life that might be considered ideal acts of beneficence.
- b) Write a list of three acts a nurse might perform in the course of her work that might be considered ideal acts of beneficence.
- c) Do you think that it is possible for nurses to live up to the ideal of beneficence in all aspects of their professional lives?

Many ethicists and many ethical codes accept a less than ideal notion of beneficence as a requirement of professional conduct. Even so, while health professionals are not expected to be extremely altruistic and self-sacrificing, they are nevertheless required to prevent and remove the conditions that cause harm and to promote good. Many professional codes of conduct for nurses implicitly appeal to the principle of beneficence to guide the professional conduct of nurses: for example, the code of conduct of An Bord Altranais, the Irish Nursing Board, claims:

*The aim of the nursing profession is to give the highest standard of care possible to patients. Any circumstance which could place patients/clients in jeopardy or which militate against safe standards of practice should be made known to appropriate persons or authorities.*

(An Bord Altranais 2000a)

and according to the American Nurses Association (ANA):

*The nurse's primary commitment is to the health, welfare, and safety of the client.*

(ANA 1985: Section 3.1, p.6)

Because the patient in Case 1.1 is at risk of harm if he leaves the hospital, the healthcare team have an obligation under the principle of beneficence to take this into consideration. The issue that arises for them is one of balancing their obligations to both respect Sean's wishes and, at the same time, protect him from harm. This might mean that the team will have to make what is called a **paternalistic** decision in relation to Sean. The concept of paternalism and its implications for Sean's care are discussed in the following section.

## Paternalism

Paternalism involves an action that overrides a person's decision or controls their actions in the interests of what is considered to be their own good. As the word suggests,

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to act paternally towards a person is to act in a fatherly way towards them. Drawing on the traditional role of the father in a family, this conjures the idea of someone who makes most of the decisions for his children without consulting them and who is motivated in doing so by his conception of what is in their best interests.

For Beauchamp and Childress, the analogy of the responsible father translates easily to reflect the role of the health professional:

*A professional has superior training, knowledge and insight and is thus in an authoritative position to determine the patient's best interests. From this perspective, a healthcare professional is like a loving parent with dependent often ignorant and fearful children.* (Beauchamp and Childress 2001:178)

### Weak Paternalism

In healthcare, many paternalistic actions on the part of health professionals and healthcare organisations are considered to be morally acceptable. **Weak, or justified, paternalism** overrides a *non-autonomous* person's decision or controls their actions in order to protect them from harm or promote their own good. An individual may be considered *non-autonomous* for a variety of reasons, for example their capacity to decide is compromised because they are unconscious, demented, ignorant, psychotic, fearful, depressed or severely emotionally stressed.

On this understanding of paternalism, which is accepted as obligatory by ethicists and health professionals generally, the object is to protect individuals from self-inflicted harm.

*Intervention in the life of a substantially non-autonomous dependent became and remains the most widely accepted model of justified paternalism. That is, the paradigmatic form of justified paternalism starts with incompetent children in need of parental supervision and extends to other incompetents in need of care analogous to beneficent parental guidance.*

(Beauchamp and Childress 2001: 177)

Examples of acts of weak paternalism are:

- raising the rails of the bed of a post-operative patient;
- preventing a patient from removing their IV tube while they are asleep or unconscious;
- controlling the flow of information to a patient whose capacity to understand what they are being told is limited;
- restraining an individual who is experiencing a psychotic break and is in danger of self-harm;
- performing the Heimlich manoeuvre in an emergency without permission;
- ?



## Autonomy and Beneficence

Looking at the case study of Sean in the light of this discussion of weak paternalism, we can see that if the healthcare team conclude that Sean is substantially non-autonomous, their decision to intervene, albeit paternalistic, would be morally acceptable. In this situation, Sean's freedom of movement could, justifiably, be restricted, because his decision to go home would not be considered to be an autonomous one.

In short, constraining Sean does not disrespect his autonomy. He is not exercising autonomy in this instance. However, one might say more positively that the healthcare workers are respecting Sean in his substantially non-autonomous state. The task that would then remain for the team would be a practical one of deciding what is the most appropriate, least restrictive and effective course of action to take in order to ensure Sean's safety.

## Strong Paternalism

Strong paternalism overrides an *autonomous* person's decision or controls their actions in order to protect them from harm or promote their own good. In effect, strong paternalism elevates the principle of beneficence over the principle of autonomy when the two are in conflict.

Many contemporary ethicists argue that acts of strong paternalism are morally unacceptable because they interfere with autonomous choice. For example, Isaiah Berlin (1992) draws on the liberal philosophy of John Stuart Mill to reject paternalistic interventions in cases of substantial autonomy. For him, the authority to make decisions resides in the individual.

*I wish to be an instrument of my own, not other men's acts of will. I wish to be a subject, not an object . . . deciding, not being decided for, self-directed and not acted upon by external nature or by other men as if I were a thing, or an animal, or a slave incapable of playing a human role, that is, of conceiving goals and policies of my own and realising them.*  
(Berlin 1992:131)

This position also finds support in the arguments of the Irish legal medical expert Mary Donnelly, who suggests that it is the patient who is the most appropriate person to make healthcare decisions because patients are the ones who are immediately and directly affected by the consequences of any decision made:

*This in no way denies the importance of the doctor's [and nurse's] expertise but it acknowledges that the patient is an expert too in relation to how she lives her life and the consequences and risks she is prepared to make.*

(Donnelly 2002:17).

For Donnelly, patients and health professionals do not necessarily have the same values concerning what constitutes benefit or harm to them. Unless there are exceptional

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circumstances where they might be self-deceived or ignorant, Donnelly argues in favour of assuming that people are best placed to know their own desires, values and beliefs. They are also the ones who are likely to be most directly affected by the consequences of their decisions.

In healthcare settings, strong paternalism is viewed as disempowering and typically involves one or more of the following: lying, deception, manipulation, coercion, non-disclosure of information. Examples of acts of strong paternalism are:

- not providing a client with an intellectual disability who has the capacity to understand with adequate information about a diagnosis, medication or procedure;
- manipulating an autonomous patient in order to ensure their compliance with a nursing procedure;
- putting a do not resuscitate (DNR) order in place without informing or consulting with an autonomous patient;
- ignoring the birth plan of a woman in labour;
- overriding an autonomous patient's refusal of treatment or care;
- ?

Returning again to Sean's situation described in Case 1.1: if the healthcare team consider that Sean is substantially autonomous, they are not justified in interfering with his decision. They may disagree with it, they may consider that it is imprudent and foolish and they may advise him that in going home, he is putting his health and welfare at serious risk. However, respect for Sean's autonomy requires that the team do not interfere with his choice.

So far, in analysing Sean's situation, we have only suggested two possibilities; that Sean's decision to go home is either non-autonomous or substantially autonomous. But there is at least one other alternative.

Staff might determine that Sean's decision to go home is *partially* autonomous. For example, they might agree that it is uncoerced, purposeful and adequately informed, but they might also consider that Sean has not sufficiently thought through the risks inherent in going home.

Notice that this situation highlights the fact that the task of determining whether someone possesses, or lacks, the capacity to decide autonomously is neither easy nor clear. (See Chapter 2 for further consideration of autonomy understood as a legal capacity to consent.) What is important for health professionals, however, is that autonomous capacity can be enabled and enhanced. In addition, the important point here is that it should not be presumed that if Sean is found to lack substantial capacity his views should simply be ignored or discarded. Sean's participation in decisions being made about him should be enabled as far as possible.

### Activity

- a) How would you suggest that the healthcare team might proceed in Sean's case?
- b) Many public health nurses, midwives, mental health nurses and nurses caring for individuals with an intellectual disability describe the people they care for as *clients* rather than *patients*. However, for the purposes of this text, we have generally used the more traditional word 'patient'. Take a few moments to reflect on what these different terms conjure up for you. Do you think that labelling someone in a particular way changes our behaviour toward them?

### Summary Learning Guide 1.2

#### The principle of beneficence:

- obliges health professionals to protect patients from harm and to promote their health and well-being;
- is explicitly stated in many professional codes of conduct.

#### Paternalism:

- describes actions that are carried out for the good of patients;
- can be *weak*: intended to prevent harm or promote the good of patients who are non-autonomous;
- can be *strong*: intended to prevent harm or promote the good of patients who are autonomous.

## Promoting Autonomy

As we indicated in the first half of this chapter, the principle of autonomy has negative and positive implications for nurses. So far, we have been exploring the negative obligation that the principle places on nurses – not to interfere with or constrain a patient's substantially autonomous decisions in relation to their health.

The following section explores the different ways in which a nurse might promote and enable the autonomy of patients in her care. This positive obligation on the part of the nurse is underlined by An Bord Altranais in their document *The Scope of Nursing and Midwifery Practice Framework*, which states that:

*Nursing care should be delivered in a way that respects the uniqueness and dignity of each patient/client regardless of culture or religion. (An Bord Altranais 2000b:3)*

The document also lays stress on the duty of the nurse to promote the 'active involvement' of an individual and their family, friends, and community in all aspects of their healthcare and to encourage 'self-reliance' and self-determination'. It goes on to cite values that underpin the delivery of nursing care:

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*Fundamental to nursing practice is the therapeutic relationship between the nurse and the patient/client that is based on trust, understanding, compassion, support and serves to empower the patient/client to make life choices.*

(An Bord Altranais 2000b:3).

(Note that An Bord Altranais's code of professional conduct is currently under review. We expect that when it is published in 2012 it will focus in greater detail on the nurse's obligation to respect patient autonomy.) Promoting the autonomy of individuals who lack capacity because of their age or cognitive ability is particularly challenging for professionals. As one professional, interviewed in a recent Irish study, acknowledges:

*A child who is on the cusp of having their own autonomy, you're looking at teenagers, and we see children here from premature babies up to 18, 19 and sometimes 20. We see children with intellectual disabilities as well and the whole role of autonomy for somebody with an intellectual disability and the challenges that poses, in terms of can they be autonomous? Are they allowed be autonomous? Whether that is from their parents' side of things or from the medical point of view or the child's own abilities. That's a huge challenge.*

(Quinlan and O'Neill 2009:54)

According to Donnelly (2009a), there are ways in which patient participation can be facilitated notwithstanding the fact that a patient lacks capacity. She refers to the Code of Practice to the English Mental Capacity Act 2007, which provides a useful resource in setting out ways to facilitate participation by adults lacking capacity. These include using simple language, speaking at the appropriate volume and speed, using appropriate words and sentence structure, breaking down information into smaller points, and using illustrations and/or photographs to help the person understand the decision to be made. Where a person has communication or cognitive problems, possibilities are offered by the use of picture boards, Makaton, signing or technological aids. In addition, for some people who are restricted to non-verbal methods of communication, their behaviour and, in particular, changes in their behaviour may provide indications of their feelings.

The case study that follows focuses on the issues involved in promoting patient autonomy in a familial context. Specifically, it looks at the challenges faced by a public health nurse in relation to a family in her care.

### **CASE 1.2 THE PATIENT, THE CARER AND THE PUBLIC HEALTH NURSE**

Eibhlín Ní Chásaigh is the local public health nurse for a small rural community in the west of Ireland. As part of her caseload, she regularly visits Mr Michael O'Leary, who is at the end stages of lung cancer and is expected to die within the next three months. During her visits, Eibhlín has developed a friendly relationship with Michael's daughter, Anne.

Anne, who is now 52, had a job in the local post office until the death of her mother two years ago. At that stage she took unpaid leave from work in order to stay at home

and care for her father. On one of Eibhlín's recent visits to the Murphy home, Anne told Eibhlín about a painful sore that she had on the nipple of her left breast. She seemed very embarrassed to show Eibhlín her breast but when she eventually did, Eibhlín became immediately concerned. She thought that this could well be a simple reaction to some skin product or detergent or some form of dermatitis. However, she was also concerned that it might be a rare form of breast cancer that affects one breast and usually starts out as a rash that develops into a painful lesion.

Anne confided to Eibhlín that she had been to her local GP two months previously and had been given an antibiotic cream. However, the condition had not cleared up and, on her second visit, the GP suggested that she go to the regional hospital for tests. Anne told Eibhlín that she had refused point blank to do this for a number of reasons: she did not want to leave her father at this crucial time, she did not think that she could cope with the idea that she herself might be ill and she felt that she would not be able to hide any bad news from her father. In short, while she was worried about her own situation, she did not want to know: she had left the doctor's surgery and had made no further appointment. She reckoned that she might be able to address the situation after her father died.

Eibhlín did now want to alarm Anne any further, but she knew that if Anne did indeed have some form of cancer, time was of the essence. She wondered how much information the doctor had given her about her condition and if he had actually told Anne that she might have some form of cancer. She wondered how she might best help Anne to make the right decision.

## **DISCUSSION**

The case of Anne and Michael is an example of a situation where there is conflict and uncertainty. It would seem that Anne must decide whether to delay treatment for a possibly serious condition in order to spend more time with her father, or have treatment and risk losing time and companionship during his last few weeks with her.

The case raises a number of ethical issues, such as the right of the nurse to interfere with Anne's apparently autonomous decision not to know her condition and the scope of the public health nurse's duty to protect the well-being of carers and their families as well as patients. However, because we want to explore the positive requirements of the principle of autonomy we will try to answer one specific question in this section: How best might Eibhlín understand her obligation to promote Anne's autonomy in this situation?

## **The Nurse–Patient Relationship**

In this case, Eibhlín could decide that her moral obligations to Anne are fulfilled if she provides her with more information about her possible condition. This approach casts the relationship between the nurse and the patient as a contractual one, where there is a provider and a consumer or an expert and a lay person. On this view, the task of the

nurse is to make sure that the patient is informed of the nature of their illness, the risks and benefits of any proposed treatment and any alternative procedures. In this **contractual model**, both nurse and patient are perceived as distinct parties with distinct tasks and obligations. To promote autonomy, in this model of the nurse–patient relationship, means to fully inform the patient and allow them to make their decision. The nurse is the informer or the one who ensures that information is provided, and the patient is the decision-maker.

However, it could be suggested that this understanding of the nurse–patient relationship does not fully capture what goes on in situations where a person is often extremely vulnerable and does not at all fit the picture of someone capable of making substantially autonomous decisions. When people are ill, their values, beliefs and desires are often unclear and there is far more uncertainty as to how these might be realised. Importantly, people very often want to revise or modify their preferences in the light of their illness. The situation of Anne and Michael is certainly one where illness contributes to vulnerability and uncertainty as to what to do, and this reality needs to be addressed.

We want to suggest an alternative, more **dialogical** or contextual, approach to the promotion of autonomy than the contractual model. This approach recognises that decision-making can involve both *independence* and *interdependence*. It acknowledges both the vulnerability of the patient and the dynamic nature of decision-making (Parker 2001:304–11; MacKenzie and Stoljar 2000).

Where there is this kind of vulnerability, we suggest that the role of the nurse expands. Her or his task is not simply to provide information to enable decision-making but to support the patient to identify and articulate their values and intentions so that they are better able to choose whatever treatment (or non-treatment) might be consistent with their core desires and values. On this view, the patient may not yet know what they want or may want different, even conflicting things.

The emphasis here is not on confirming the separateness of nurse and patient – one informs and one decides – but on acknowledging the interdependence of patient and nurse. In our case study, Anne is dependent on Eibhlín to help her consider her options in the light of her concerns about her father and her own health and in relation to her overall goals, beliefs and values. Eibhlín is dependent on her relationship with Anne in order to fulfil her obligations to both Michael and Anne. This is a **dialogical view of autonomy**; it sees information as shared information, something that runs in both directions. It views decision-making as a mutual process in which the emphasis is on communication as dialogue, listening and attention to body language, not only on communication as information provision.

This understanding of the obligation to promote patient autonomy is also consistent with the role of the nurse as patient **advocate**. Specifically, Fry and Johnstone describe the nurse's advocacy role as one that emphasises communication skills and support in a way that is similar to the dialogical approach. Their account of advocacy 'views the nurse as the person who helps the patient discuss his or her needs, interests, and choices consistent with the patient's values and lifestyle' (Fry and Johnstone 2002: 38).

### **Activity**

Take a few moments to reflect on the challenge that faces Eibhlín in relation to her obligations to Michael and Anne. In the light of the dialogical approach to promoting autonomy, how do you think Eibhlín might proceed?

The idea of dialogical communication is particularly pertinent to the situation facing the public health nurse in Case 1.2. This is because effective nursing care in community situations such as this is dependent on a partnership existing between the nurse (Eibhlín) and patient (Michael) and carer (Anne). Unlike nurses working in acute care settings, for example, it is likely that public health or community nurses have long-term relationships with individuals and families that last over a number of years.

At the outset, both Anne and Eibhlín need to gather more information. For example, is there a family history of such lesions/carcinoma on the breast? Anne's age is also a consideration. Eibhlín will also need to establish what, for Anne, is the most difficult aspect of the situation as it currently stands. Telling her father, perhaps? At present, there is insufficient evidence of anything sinister to tell Michael and thereby worry him unnecessarily. Eibhlín may reflect with Anne as to what might be the worst case scenario – that indeed she has a malignant lesion/lump in her breast – and they may consider the alternative – that this is a benign lesion. Either way, through a process of elimination Eibhlín could empower Anne to give consideration to a possible course of action that would not necessitate her being away from her father for any length of time. For example, Anne might make an appointment for a mammogram in the knowledge of a four- to six-week waiting period. In the interim, she has the opportunity to cancel the appointment and has time to reflect on and become more familiar with the situation. Anne might also ask the GP to take a swab of the lesion and send it for analysis to test the appropriateness of the antibiotics used in the first instance. Eibhlín might offer to accompany Anne to the mammogram and suggest that a relative visit Michael while Anne attends her appointments.

In guiding and supporting Anne, Eibhlín is able to take a more contextual or situation-based perspective that makes links between Anne's health status and Michael's health status and the goals and values of all concerned. Moreover, Eibhlín's approach acknowledges that, for Anne, her relationship with her father and his ill health is central to her decision-making in relation to her own condition. Neither Michael nor Anne can be viewed as isolated individuals who are simply choosing for themselves. They are deeply involved with each other, so the question of their well-being extends far beyond their own immediate state of health. This perspective understands that, for many people, their personal autonomy is one value that is realised alongside others, such as deep familial attachment and solidarity (Barclay 2000:60). This view is supported by recent research in Irish healthcare settings, which indicates that the decision-making process for many dying patients is a social rather than a medical exercise and that many

patients often prioritise the interests of their loved ones over their own (Quinlan and O'Neill 2009; Weafer, McCarthy and Loughrey 2009).

The approach to decision-making, as we have just outlined it, seems very attractive and practical. However, we can think of two concerns that might arise when a nurse adopts it in relation to a vulnerable patient.

1. One difficulty with this approach is that the nurse may not have time or the skill for this kind of dialogue. Eibhlín is no doubt a hard-pressed public health nurse with a heavy case load and many demands on her time; she may feel that Anne's situation is an additional drain on her resources that distracts her from her professional obligations to Michael.
2. In addition, given the long tradition of paternalistic practices in the Irish healthcare services generally, Eibhlín may well mistake her own values for those of Anne's. She may, unwittingly and with the finest of intentions to empathise, impose her own values on Anne.

One understanding of empathy that is central to the **dialogical model** is useful here; it is articulated by the ethicist Howard Brody:

*In a culture that prizes autonomy and independence, we may fondly imagine that most people are whole and intact, unlike those who suffer from disease. . . . Charity tends to assume that I start off whole and remain whole while I offer aid to the suffering. Empathy and testimony require a full awareness of my own vulnerability and radical incompleteness; to be with the suffering as a cohuman presence will require that I change. . . . Today I listen to the testimony of someone's suffering; tomorrow that person (or someone else) will be listening to my testimony of my own. Today I help to heal the sufferer by listening to and validating her story; tomorrow that sufferer will have helped to heal me, as her testimony becomes a model I can use to better make sense of and deal with my own suffering.*

(Brody 1987:21–2)

In Brody's view, the demand of empathy does not require us to 'step into another's shoes' in order to understand their pain. It does not presuppose that it is ever possible to fully understand another's pain. The other person is always 'other' to us, their difference persists, resisting assimilation under the umbrella of mutual understanding. Instead, empathy demands that we bear witness to our own vulnerability and lack so that we stand, not as whole to part, or healthy to ill, but as a 'cohuman presence'. On this view, the nurse cannot offer patients the reassurance that they know and understand them; only the acknowledgement that they have listened and heard. On this view, too, no nurse is untouched by a patient's pain and vulnerability; there is professional engagement, not detachment.

Different situations demand different responses. Autonomy and its protection and promotion demand different responses. Sometimes a patient may explicitly ask for



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information and support, sometimes they may need the nurse to decide with them or for them. Sometimes they may only need time to reflect. Sometimes, and this can often be the hardest thing of all to provide, they may need a 'cohuman presence', a person who is strong enough in her or his own vulnerability to be able to recognise and bear witness to their pain (McCarthy 2003:65–71).

If we apply the dialogical approach to the first case in this chapter, Case 1.1, it might change the way in which the healthcare team approach Sean's requests and attempts to go home. Following Brody, they might take the time to listen to and validate Sean's own story: they might try to explore with him what it is about home that Sean particularly misses. Might his love of gardening find an outlet in the hospital setting? Might his worries about home mask other concerns? They might begin by acknowledging and making space for Sean's wishes, whether or not they determine that it is appropriate to fulfil them.

### *Summary Learning Guide 1.3*

#### **The contractual approach to promoting autonomy involves:**

- recognising the patient as an independent decision-maker;
- conceiving of the nurse as a provider and the patient as a consumer of a health service;
- informing patients of the nature of their illness and the risks and benefits of proposed treatments;
- professional detachment.

#### **The dialogical approach to promoting autonomy involves:**

- recognising the vulnerability of the patient as a decision-maker;
- conceiving of the patient as an interdependent decision-maker;
- viewing information-giving as shared communication;
- professional engagement.

### **Activities**

- a) The ethicist Donna Dickenson (2001), herself a strong advocate of patient autonomy, points out that while the ethics literature and laws in the United States and Europe are dominated by what she calls a 'liberal, rights-based' approach in which the patient is seen as having the right to override medical opinion, this is not universally the case. Citing Ireland and some southern European countries such as Italy and Spain as exceptions, she suggests that the prevailing view in Ireland is a paternalistic one where 'The patient has a positive duty to follow the doctor's instructions and to maximize his or her own health and well-being . . .' (Dickenson 2001:285).

Take a moment to reflect on Dickenson's perspective on the patient's position in Ireland. Do you think that she captures the real situation for patients (such as Sean) in Irish hospitals and other healthcare settings? Is talk of patient autonomy merely aspirational, the preoccupation of idealistic academics (such as ourselves), rather than a realistic possibility?

- b) If we conclude that the term 'paternalism' is an unhelpful way of capturing some of the decisions that health professionals have to make on behalf of their patients, can you think of an alternative term? Would 'maternalism' be more useful? Or do you think we might run into similar difficulties with this term?
- c) Not everyone would agree with privileging autonomy over other human values. There are many who believe that personal autonomy and, in turn, individual rights, has been afforded far too much weight in western democracies and that the lives of vulnerable groups and of communities as a whole have suffered as a result. In Indian and Chinese society and in many countries in southern Europe and South Asia, family and communal decision-making is privileged and individuals are encouraged to place the interests of their family and community above their own. List any merits that you see in this approach to decision-making.

## CONCLUSION

This chapter has defined the concept of autonomy and explained two philosophical views of why autonomy deserves respect: Kant's argument that respect for autonomy recognises the human capacity for rational and impartial decision-making and Mill's argument that a society which respects individual autonomy is ultimately a better society than one that does not.

We introduced the idea of a principle of autonomy and explained some of the limits to the exercise of autonomy that might serve to guide nurses and midwives in their practice. In addition, a related principle, beneficence, has been defined and the tensions between autonomy and beneficence explored. Finally, the chapter suggested two different ways in which the nurse–patient relationship and the task of promoting autonomy can be conceived.

The following chapters continue to discuss autonomy and its scope in healthcare decision-making. Specifically, respect for autonomy requires the health professional: to ensure the informed consent of patients to accept or refuse treatment (Chapters 2 and 6); to tell the truth (Chapter 3); and to respect patient confidentiality (Chapter 4).

### *Suggested Professional Responsibilities*

- 1 **Assume autonomy:** nurses should presume that patients are free and capable of making decisions on the basis of their own beliefs and values.
- 2 **Respect patients' autonomous choices** in a way that is fair and free from prejudices such as those based on age, mental illness or intellectual disability.

### *Autonomy and Beneficence*

- 3 **Engage with patients:** consider their capacity to communicate, understand information, deliberate and weigh information in the light of their own beliefs, values and goals.
- 4 **Distinguish between honest persuasion and manipulation and force:** while persuasion is legitimate, the use of manipulation and force is not (unless the person lacks autonomy and there are reasonable grounds to act in their best interests).
- 5 **Promote and support participation:** consider how a patient's ability to participate in decision-making about their treatment and care might be enhanced. Nurses should seek to facilitate people of borderline autonomous capacity in participating in decisions affecting them insofar as this is possible.

**The following terms are explained in the glossary:**

advocacy	principle
autonomy	rational
beneficence	rule
deontological	strong paternalism
free will	substantial autonomy
impartiality	utilitarianism
informed consent	weak paternalism
non-maleficence	
paternalism	