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Modernized Bioethical Principle of Autonomy

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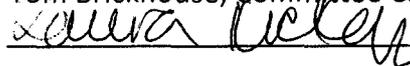
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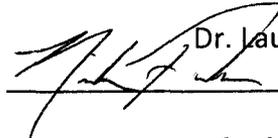
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Melissa A. Micek

Philosophy Thesis

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Dr. Brickhouse

Introduction

In 1978, Mary C. Northern was admitted to Tennessee Nashville General Hospital for an infection in both of her feet. It was discovered that Ms. Northern was suffering from untreated and severely gangrenous frostbite, which is deemed fatal if left untreated. The healthcare professionals agreed that in order to prevent the gangrene from spreading, both of her feet would need to be amputated. However, Ms. Northern strongly refused the life-saving operation. Ms. Northern posed no threat to anyone; however, it is questionable what the most ethical course of action is when a patient refuses treatment. This raises the question, should a patient be able to refuse a life-saving treatment, or should a healthcare professional force treatment upon the patient? A philosophical dilemma arises between the healthcare professionals' interest to benefit the patient's well-being and the interest of the patient to receive preferred treatment and express self-determination. The traditional bioethical principles are inefficient to allow the most ethical decision. The most ethical decision is one which modernizes the dated principle-based philosophy and highlights the need for an enhanced approach to patient autonomy.

Bioethical principles form the cornerstone for ethical medical decisions; however, a modern interpretation takes into account the increasing complexities which create dense ethical questions. The ability to make one's own medical decisions, promote wellness, relieve pain and suffering through medicine, to do no harm, and the values of equality and fairness in medical treatments are all important principles when considering medical decisions; however the most crucial aspect of ethical decision-making is patient autonomy. Especially in light of ever-increasing medical advancements, it is the healthcare professional's moral duty to fully inform the patient of all medical information and alternatives to enhance patient autonomy.

The fundamental bioethical principles were formulated in the 1960s to resolve increasingly complex ethical and legal issues resulting from modern western technologized

medicine (Jonsen 1990, 57). The historical influence of these emerging principles are now widely accepted as the standard for ethical decision-making. The 1974 Belmont Report identified important ethical principles that ought to be upheld in biomedical research.¹ Tom Beauchamp and James Childress reformatted the ideas into the four cardinal bioethical principles, known as the “Georgetown Mantra,” including the principle of autonomy, beneficence, non-maleficence, and justice. Although there is strong influence, principlism is inefficient as a “predominantly abstract, rationalistic mode of reasoning in bioethics,” especially in the context of modern medical advancements (Dawson 1998, 516; Traphagan 2013, 31). The bioethical principles should not “be used in a deductive way, where principles were merely applied to specific cases” (Wolf 1996, 16). Despite modern medical achievements, the discussion of bioethics has relatively remained stagnant (Dawson 2010). Modern medical advancements call for modern interpretations of bioethical principles. Patient autonomy is the focus of modern ethical decision-making with Beauchamp and Childress’s original proposals to understand the complexity of decision-making. The two cases studies presented exhibit the need to uphold patient autonomy for ethical decision-making. Furthermore, these two cases reveal disparities among decisions based on false beliefs and the cultural influences of medical decision-making.

Case Studies

When 72-year-old Mary C. Northern was admitted to the Tennessee Nashville General Hospital, she adamantly refused to have the surgery to amputate both her feet. The conflict arose when Ms. Northern expressed no desire to die, yet insisted her strong belief that her condition would improve without the surgery, regardless of the medical advice. It was recorded that “she

¹ The Belmont Report emerged from the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (Paola 2010, 39).

tends to believe that her feet are black because of soot or dirt.”² Ms. Northern was “unable to unwilling to recognize” her condition would result in death if gone untreated and did not “appreciate” the consequences of her decision (Arras and Steinbeck 1999, 171). The court argued that Ms. Northern did not have the ability to refuse treatment and assigned Ms. Northern a legal guardian to override her medical decision and consent to the amputation. However, there are moral complications Ms. Northern as incompetent for refusing treatment because in this specific case, there was a largely lacking evidence of general incompetence. There was a lack of any neurological disability, as it was recorded that Ms. Northern as “lucid, shows no evidence of dementia, possesses good memory and recall, and is coherent and intelligent” about general information.

In the same year, 77-year-old Mrs. Rosaria Candura was hospitalized at Symmes Hospital, Massachusetts also for gangrene in her leg. Mrs. Candura’s daughter sought a probate court order to have temporary guardianship over her mother in hopes to give legal consent for the surgery to amputate her mother’s leg. Mrs. Candura was stubborn in her unwillingness to consider other points of view and persistent in her wish to not have the surgery.³ However, the court’s decision for Mrs. Candura diverged from Ms. Northern’s court case and it was decided Mrs. Candura could legally refuse the amputation, despite similar grim odds of survival. The court stated, “We hold that Mrs. Candura has the right under the law to refuse to submit either to medical treatment or a surgical operation, that on the evidence and findings in this case the decision is one that she may determine for herself, and that therefore her leg may not be amputated unless she consents to that course of action.”⁴ Mrs. Candura understood that without

² State Dept. of Hum. Serv. v. Northern 562 S.W.2d 197(1978) State of Tennessee.

³ Lane v. Candura. American Journal Of Law & Medicine. Fall 78 1978;4(3):289. Available from: Legal Collection, Ipswich, MA. Accessed February 19, 2016.

⁴ imdb.

the surgery there would be a low chance of survival. However, Mrs. Candura had lost her husband shortly before this diagnosis and this loss deeply affected her desire to continuing to live. Although Mrs. Candura was adamant about not contemplating other choices, she ultimately expressed her contentment with death and expressed her lack of desire to survive. Furthermore, Mrs. Candura described that she did not want the sense of burden to her daughter, Grace R. Lane. The court decided that Mrs. Candura could deny the potentially life-saving amputation (Davis 2004).

The moral differences between these two cases is that Ms. Northern is arguably acting out of a false belief and the healthcare professionals did not act to enhance her autonomy. These two cases are supportive of the argument that patient autonomy ought to be upheld for ethical medical decisions. These two cases are strikingly similar, as both cases of elderly women had identical cases of gangrene, as well as the well-being and survival of the patient was determined to have amputation. However, there was a contrasting decision to pursue the amputation with Ms. Northern and not with Mrs. Candura. The decision to allow Mrs. Candura to deny the amputation was morally sound and upheld patient autonomy; however, it was morally dubious to force the amputation upon Ms. Northern. There is insufficient evidence that healthcare professionals upheld their moral duty to enhance the patient autonomy with her refusal of treatment.

The four main principles set forth by Beauchamp and Childress are the traditional foundation for ethical decision-making; however, in this case, are insufficient for the most ethical choice. The principles of justice, beneficence, and nonmaleficence have minor relevance to informed refusal, especially in these cases. The primary focus to make these decisions the most ethical would be an updated principle of autonomy. The general principle of autonomy

does not signify a coherent or clear identification of when a patient is able to refuse treatment. The Curve of Competency clarifies to what extent one ought to deem incompetent about a specific topic, but otherwise generally competent.

The bioethical principle of justice more readily applies to the equality and fairness of distributing treatment rather than refusing treatment. Beauchamp and Childress identify justice as the fair distribution of benefits, risks, and costs (2009). The principle of formal justice in relation to bioethics, based upon John Rawls' 'justice as fairness' egalitarian theory, regards entitlement, equality, and allocation of scarce resources and treatment (Paola et al. 2010). The principle of justice in relation to medical treatment is the moral standard to treat all patients with equal and fair treatment regardless of any external factor, such as socioeconomic status. In both cases presented, the healthcare professionals offered the same treatment because it was presumed that amputation was the best medical treatment. There was no prevalent bias or unfair treatment from the healthcare professionals in these scenarios; therefore, no injustice is clearly visible. The patients were offered the same solution of amputation to their gangrene, despite being states apart. Further ethical dilemmas arise when there is unequal access to medical treatment as well as a discussion of the justice aspects to offer necessary versus unnecessary and periphery uses of medicine. However, the discussion of the ethics of the necessary medical treatment and is beyond the scope of this paper.

The bioethical principles of beneficence and nonmaleficence are two minorly relevant principles when discussing patient refusal of treatment. The principle of nonmaleficence is formulated from the medical doctrine, the Hippocratic Oath.⁵ The Hippocratic Oath has become the maxim *Primum non nocere*: "Above all [or first] do no harm" and has been reformatted to

⁵ The Hippocratic Oath is referred to as a principle for all healthcare professionals; however, the actual document is more of a ritual than a binding doctrine.

the role of “bring benefit and do no harm” has been reformatted to the role of “bring benefit and do no harm” (Paola et al., 2010 43,52). This principle sets forth the moral obligation for healthcare professionals to avoid harm, but also their duty to promote beneficence towards the patient.

General beneficence is the obligation to do good towards all persons, regardless of a specific relationship and sets forth moral guidelines (Beauchamp and Childress 2009, 199). Within the bioethical sphere, beneficence specifically relates to the moral guidelines of the physician-patient relationship. Healthcare professionals are morally obligated to advocate for the best interest of the patient and to refrain or limit harm (Paola, et al. 2010, 55). Harm is identified to have an “adverse effect on one’s interest” (Paola, et al. 2010, 86). However, harm can be more complex depending on who is defining harm. From the perspective of the healthcare professional, the best interest of the patient is to advocate for health benefits or prolong life and acting adversely to these interests would promote harm. Thus, in the context of the case of Ms. Northern and Mrs. Candura, the best course of action in the eyes of the healthcare professionals is to advocate for amputation to save the patient’s life. However, from the perspective from the patient, the quality of life may be deemed of higher importance rather than prolonging their life. This conflict of interest is imminent when patients refuse treatment because of the direct contradiction of what the physician would recommend and what the patient will accept for medical treatment. The notion of personal “good” is predicated on the patient’s and his or her family’s interpretation of what is in their best interests are while “notions of truth of biomedicine are seen as an unqualified “good” that should take be balanced with the individual’s autonomy. (McGrath 1998, 527). This is exemplified in Mrs. Candura’s case, where her interest was not to prolong her life, but to express her right for self-determination. She expressed awareness and

contentment with the consequence that refusing treatment would likely result in death. Ms. Northern had conflicting interests where she did not want to pursue the surgery, yet had no desire for the consequence of death. This contradiction results from her false belief, which is addressed in a future section. The principle of nonmaleficence “involves considering alternative routes,” for all types of procedure considered. In this particular case, amputation surgery may appear to be an obvious benefit in regards to save their life, there is also the consequence of not being able to walk. There are modern prosthetics that may be considered in order to ensure the principle of nonmaleficence is honored. If the patient, such as Ms. Northern or Mrs. Candura, still refuses the amputation, they must be presented with other options with full disclosure. Other options may be to have palliative care, pain relief, discussion if amputation is considered about artificial limb options, hyperbaric oxygen therapy to increase oxygen in the blood supply. As medical technology advances, there are increasing alternatives to promote the good ongoing antibiotic treatments to prevent the spread of the disease, or future options as medical technology advances. The ethical responsibility of the physicians is to “collect information regarding patient and surgical outcomes to *enhance* the informed consent dialogue with patients and maximize safety” (Arora et. al. 2014, 1200).

The informative role of a healthcare provider is to simply provide information. However, it must be useful and understandable for the patient. Also, there is an interpretive role to explain and define medical information. Ms. Northern received only a third-grade education; therefore, she would have a difficult time interpreting dense medical information. Any patient would have a different interpretation of dense information, let alone the increasing medical technology. The patient has their perspective, considered as the “voice of the life world,” where only the patient knows what it would be like to live through treatment and handle the aftermath. On the other

hand, the healthcare professional would articulate their perspective as the “voice of medicine” (McGrath 1998, 521). Another role of healthcare providers is to be deliberative, which requires healthcare professionals to avoid dumping technical information, rather encouraging conversations with the patient about values, cares, and concerns. The decision-making process is not which is not “based on a static risk-to-benefit ratio that is the same for each patient, but rather a candid, back-and-forth conversation between patient and physician regarding values, risk factors, goals...and medical information” (Arora et. al. 2014, 1200).

Although healthcare professionals have the best interest to benefit and prevent harm to the patient, this does not generally justify paternalistic acts to override a competent patient’s choice in medical decisions. Paternalistic acts involve the “intentional overriding of one person’s preferences or actions by another person” and dictating medical action (Beauchamp and Childress 2009, 208). Until about twenty years ago, paternalism was the standard for physician-patient relationships. It was assumed that all patients ought to follow every physician order (Kelley 2005, 189). Traditionally, patients seek medical treatment and care from healthcare professionals, creating a hierarchical relationship and are referred to as “gatekeepers” (Holmstrom and Dall’Alba 2002). The healthcare professional’s knowledge of medical information and the care flow from the healthcare professional to the patient in a top-down system and creates a higher fiduciary duty for the healthcare professional. There is also an assumption of trust that the healthcare professional will disclose relevant and accurate information. The Supreme Court of California declared in *Truman v. Thomas* that “it is the duty of a physician to disclose to his [or her] patient all relevant information to enable the patient to make an informed decision regarding the submission to or refusal to take a diagnostic test” (Ryan 161). There is complexity regarding paternalism based on how well the patient is informed. Soft paternalism applies when

the patient is poorly informed or may be in an emotional state that inhibits the rationale while hard paternalism occurs when the patient is fully capable of making the rationale, but the healthcare professional intervenes (Beauchamp and Childress 2009, 209-10). There is larger grey area within soft-paternalism due to the uncertain levels of rationality and good intentions to intervene to prevent future harm. Although it was once seen as the norm, there are now moral reconsiderations and patient autonomy has emerged to have greater importance. The “acceptance of even limited paternalistic intervention [could] open a Pandora’s box which could substantially threaten personal freedom” (Faden 1977, 135).

There is a lack of evidence in Ms. Northern’s case that the healthcare professionals conversed or deliberated with her about her choices. The order for a state appointed legal guardian for Ms. Northern is paternalistic without fulfilling the obligation to discuss, converse and deliberate with Ms. Northern about her choice. The healthcare professionals should have

The principles of beneficence and nonmaleficence underline the importance of self-determination and autonomy. Autonomy is formed from the Greek word self, *autos*, and governance, *nomos* (Beauchamp and Childress 2009, 99). Autonomy directs the “protection for patient rights” through the decision-making process and the patient “is still situated within the awesome power of the biomedical discourse” (McGrath 1998, 524). The Council of Ethical and Judicial Affairs and the American Medical Association state the respect for patient autonomy requires “physicians respect a competent patient’s decision to forego any medical treatment” (Beauchamp and Childress 2009, 193). Based on this notion, a patient must have apt mental capabilities to be considered competent for decision-making. The threshold competency can be difficult to determine in some situations, based on the seriousness and complexity of the consequences of the decision. In this principle, there is ambiguity in *how* healthcare

professionals ought to rightfully respect patient autonomy. Peter Murphy identifies this difficulty of determining autonomy as a choice that is processed through freely and without external or internal pressures and the ability to determine an autonomous decision is of “admit of degree” (Murphy 195).

There is an influx of influencing a patient’s decision, including preconceived notions, false beliefs, cultural norms and familial values. The danger of a purely principle-based approach is that there is “little awareness of the complex ways in which people in other societies conceptualize the nature of being human...and lack a cross-cultural perspective” (Traphagan 2013, 28). Other cultures, such as Japanese or Indian “do not really see each human as a morally autonomous locus of decision-making - at least not in the relatively isolated sense common in Western moral philosophy” and view the heads of family or community leaders to have the cultural justification of paternalism (Peterson 2011, 63). This highlights the importance of the moral obligation of the healthcare professionals to consider and discuss all options with the patient as an independent case that has unique influences. The traditional model of autonomous decision-making as a recipe: “: clinicians contribute the ‘facts’ (the projected risks and benefits of the available medical options), while patients provide the ‘values’ (based on their preferences and ethical commitments). When these are combined, medical decisions emerge.” (Truog 2015, 13). However, the bioethical principle of autonomy is significantly improved by the new modern models, which extends upon Quill and Brody’s enhanced autonomy and implements what is the original formulation of the curve of competence.

Enhanced Autonomy

Quill and Brody propose a mix of the traditional paternalistic and autonomous choice called “enhanced autonomy,” that encourages patients and healthcare professionals to “actively

exchange ideas, explicitly negotiate differences, and share power and influence to serve the patient's best outcome" (765). This method promotes a method that the patient can autonomously make decisions of their care that are informed by both their personal values and their physician's experience and knowledge. This aligns with the conclusion that a patient can ultimately decide to accept or deny treatment; however, "enhanced autonomy" provides patients with a dialogue that allows them to make a fully informed decision. The role of the healthcare professional is to provide the ideas of beneficence and respect the patient's values that can influence their decision. This would promote trust within the relationship to have active listening and regard to weigh all the patient's positions and perspectives (Murphy). One can easily imagine a case where a hypothetical homeless man needs treatment for gangrene, yet refuses treatment because he might be under the impression that the treatment is too expensive for him; however, through further communication with his healthcare professionals, he can be provided with the correct information and consider the best option. The concept of "enhanced autonomy" allows for the assurance of patient's power and control over their course of action. The non-compliant patient can create an adversarial relationship between the healthcare professional and patient rather than collaborative (Hill 2004). The healthcare professionals "know that their patient's functional ability and quality of life depend on their success at self-care" and the existing relationship between the healthcare professional and the patient can be advanced through the concept of "enhanced autonomy" (Quill and Brody 1996). Also, the possibility if a physician overuses their power to influence a patient's decision is balanced with the concern of a physician underusing power as a healthcare professional (Murphy 766). This means that on one hand paternalism could promote a highly-involved physician, while on the other hand; an irrelevant or disengaged physician could not provide the patient with the best

outcome. The principle of enhanced autonomy strikes a balance to allow the patient to have full competence to make decisions about their own health. Enhanced autonomy also encourages the involvement of the unique qualities of the individual case that are important to the patient's decision. One could also foresee a case of a Jehovah Witness refusing blood transfusions would allow them to make that choice, but being fully informed of the consequences of their deeply held belief. Once again, patients do have the right to refuse treatment, given the considering they ought to be fully informed about that choice. It is acknowledged that this active engagement and trust building within the physician-patient relationship is not currently happening and must be improved upon to focus on autonomy.

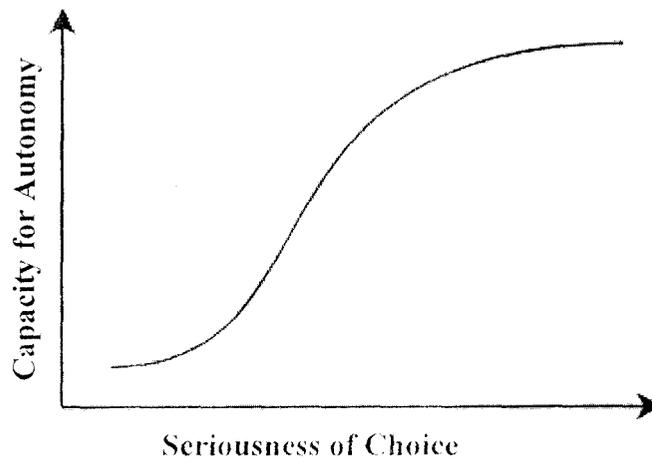
Curve of Competence

Competence means the "ability to perform a task" (Beauchamp and Childress 2009, 112). Incompetence is usually a legal term to express when a person is found incapable, due to physical or mental capacity, to make autonomous choices about a particular matter in that particular time (Davis 2004; Beauchamp and Childress 2009, 112). There are several precedent standards and examples of how to determine competency. A concern of Beauchamp and Childress of trying to adequately measure competence is that "competence itself varies with risk," shown by a continuum, "ranging from partial proficiency to complete ineptitude" rather, it is that certain decisions require higher levels of abilities, including the ability to understand the consequences (2009, 117). Grisso and Appelbaum present a "competence balancing scale," which attempts to balance protection against autonomy (Beauchamp and Childress 2009, 116). The initial balance is weighted more towards autonomy; however, the final balance depends on "the patient's mental abilities in the face of the decisional demands, weighed against the probable gain-risk status of the patient's treatment choices" (116). The precedent formulations to

measure competence; however, there is severe inadequacies of precedent formulations. There is no focus on enabling autonomy with regards to an individual choice. The original formulation of the Curve of Competence significantly improves upon previous notions to modernize the principle of autonomy.

The ability to determine if a patient is deemed competent enough for decision-making can be supplemented by the formulation of the "Curve of Competency." This original term assists complex ethical dilemmas when a patient may not be deemed fully competent to make a serious choice, but autonomy still ought to be respected. On the varying levels of competency, even general competence or a specific competence regarding a particular subject, autonomy ought to be upheld to its fullest extent. In regards to denying treatment, there can be a scale of how important the treatment is for a patient, roughly based on necessity for survival. At the lowest on the scale can be the ability for a patient with a headache to refuse treatment of painkillers. On the other end of the spectrum, there is the dire situation that a patient with a ruptured spleen refuses the life-saving surgery. It is not that serious if someone refuses Ibuprofen for their headache compared to if someone refuses the surgery to save their life. On the other axis of the Curve of Competency is the ability to make rational, autonomous decisions. This spectrum ranges from no ability to make autonomous decisions to full capability. It is widely accepted that young infants and children are unable to make decisions; therefore, they would be on the low end of the spectrum. As children grow older, they are able to choose what they wear, eat, do with their free time, all leading to a more autonomous life. A fully rational adult would be placed at the top of the spectrum, fully autonomous and able to make important decisions. Thus, this relationship results in a curve where the ability to make decisions matches how important the decision, as pictured in Graph 1.

Graph 1. Curve of Competency



It is argued that the curve can slightly plateau on the right-hand side, meaning that the most serious of choices may not need an increase in capacity for autonomy. For example, cases of the extremely elderly and tremendously sick, some individuals may not want to exercise their autonomy to make end-of-life decisions (Beauchamp and Childress 2009, 105). In these cases, the patient would decide to trust and follow the healthcare professional's wishes rather than express their own opinions. Once again, this identifies the importance of trust and communication within the physician-patient relationship. The most ethical decision is one which is freely chosen; however, the ideal philosophical argument is never as complex as the practical issue at hand. There is always the question of how a healthcare professional ought to assure the choice of refusal of treatment is autonomous.

The ability to promote a fully autonomous choice must be with the determination that the patient is able to rationalize the choices given and comprehends the complete array of risks and benefits of the choice. The patient that is given a consent form to sign is not enough to assure the understanding of the decision and its consequences at hand. Without the complete comprehension of the benefits and risks, the patient may not make a fully-autonomous

decision. This indicates that the healthcare professional must explain the benefits and risks of each option of treatment. Without such understanding, there can be a misconception of what might happen when the patient refuses treatment. The continuum of decision-making capacity and the ability of a patient to make a specific decision also varies at a specific time . If precedent autonomy, or advance directives, conflict with present decisions, then a resolution autonomy ought to be followed (Cooper 2010).

Furthermore, an important aspect of respecting autonomous choices is that an individual is allowed to make decisions even if someone else disagrees or dislikes the decision. A healthcare professional is able to tell a patient the best recommended course of action, but they cannot force or coerce the patient into that decision. This leads to determine that the patient is also responsible for their decision after the healthcare professional has given them the adequate information. There is also the instance where a patient might hold a falsely held belief. The patient must be fully informed and be able to comprehend the provided information, yet still hold the false belief. It must be certain that there is an informed refusal, even after being fully informed and adequately comprehends the information (Beauchamp and Childress 2009, 130). The responsibility of the healthcare professional to ensure the patient to understand the information provided as well as understands the patient's point of view is essential to provide adequate medical care.

Patient Refusal Based on False Beliefs

Most people make decisions based on their preconceived notions or biases that are able to not be recognized or highly reflected upon. These notions can influence a patient's decision to accept or refuse treatment. What should be done if a patient has false belief? There are some people that do not reflect upon their values and do not deliberate over their preconceived

notions. "Most of us are first-time players with no training" in making difficult ethical decisions, therefore, difficult decisions are influenced by past experience, or emotions, rather than reason (Dresser 1995, 15). The difficulty of making medical decisions is the ability to understand and accept the medical facts as the truth.

There is a distinction between if a patient refuses treatment based on their beliefs about medical facts versus other relevant beliefs. If the refusal of treatment is based on misinformation, miscommunication, or ignorance, there is in a sense not that the patient is not given the full ability to make a rational decision. Based on Aristotle's argument that an act is involuntary if "ignorance of the circumstances of the act and of things affected by it" (Faden 1977, 133-4). Therefore, a false belief based on ignorance or false information is not truly a voluntary decision. For example, if a patient refuses chemotherapy because they believe they don't have cancer, then the patient is ignorant about the circumstance. There is another scenario that the patient refuses based on other beliefs based on their personal values. If the patient is refusing treatment based on competing values, it must be decided by the individual rather than the HCP. For example, an individual might value the quality of life over the quantity deems the choice to refuse treatment. Religious convictions would fall under this category of refusing treatment based on beliefs. However, this refusal must be informed that the refusal of treatment will result in the end of life. If a patient states their desire to keep living and extend their life, but refuses treatment, this conflict seems unwarrantable and unable to be resolved at the current level of understanding of the circumstance and consequences.

Healthcare professionals "have a moral obligation to attempt to change a patient's false belief. This obligation is both justified and limited by the liberty principle" to enhance a fully informed decision (Faden 1977, 136). This moral calculation on to try to change a false belief

should be based on how probable the belief is false and how probable the severity of consequent pursuant to holding this false belief (Faden 1977, 134). The healthcare professional should also take into consideration that the context, including the severity of the consequence, may justify if a healthcare professional intervene to try to change the false belief. However, the same liberty principle that obligates the healthcare professional to try to change the false belief also limits, or restricts the healthcare professional of intervening in medical decisions. Faden argues the moral calculation that “intervention is justified only if the amount of freedom lost through the intervention does not outweigh the gained increased freedom of choice” (1977, 134). For example, it is preferable if a healthcare professional tries to inform the patient’s false belief about having cancer and successfully change their false belief would give the patient greater liberty to make an informed decision rather than keeping them in the dark trying and not having that liberty. The view is that the clinicians contribute facts, including the projected risks and benefits (Truog et al. 2015, 13) but it is ultimately the patient’s ability to choose. Overall, a patient might have an informed refusal that is unwise or unreasonable, but the healthcare professional is never justified to force treatment. “It is important to distinguish false beliefs as grounds for incompetency,” especially if the decision is simply deemed of ill-preference or irrational (Faden 1977, 135).

The models of enhanced autonomy and curve of competency work hand-in-hand to modernize and better utilize autonomy for ethical decision-making. There are levels of competency that can relate to the levels of choices that one can fully utilize their autonomy for. The healthcare professional ought to talk and discuss patient values, to express compassion and lay out all options. The combination of enhanced autonomy and curve of competency allow a patient to choose from options, even if those options are limited. For Ms. Northern’s case, she

should have had further discussions with her healthcare professionals. Another example, if a patient has dementia, which implies there is no competence for refusing treatment due to neurological disability, patients ought to still have preference over some decisions. This would be the preference of there are conditions in which the time or method which the patient has treatment. This exemplifies the essence and spirit of respecting and maintaining human dignity and upholds patient autonomy. Patients may feel a loss of control over their own lives during medical emergencies or any treatment; therefore, any option that can be implemented to the patient wishes then ought to be respected.

Implications

One implication if healthcare professionals honor the wishes of the patient, there might be “significant unnecessary suffering and even death can result” (Murphy 189). A patient may choose to refuse treatment that goes against the purpose of medicine; however, paternalism cannot justify reaching beyond the competent patient’s wishes. Peter Murphy attempts to mend this consequence by promoting that patients are able to decide again if they want to have treatment to reduce their pain, that a patient has the ability to re-decide without being universally bound to their original position (189). The second implication is that a physician might be justified in discontinuing the relationship with the patients that do not conform to the best patient care. For example, almost 40% of clinicians say they would discontinue their provider relationship with families that refuse *all* vaccines and 28% would refuse if a family refused *some* vaccines. However, the Academy’s Committee on Bioethics advises healthcare professionals listen to the family’s concerns and “share honestly what is and what is not known about the risks and benefits of the vaccine in question” (deHart, Halsey, Omer, Oresenstien, Salmon 1982).

There are the tangible consequences of patient responsibility, including reprimanded, censured, or referred to another physician (Kelley 190). There is the possibility that healthcare professionals will reach beyond the patient's autonomy in order to protect the overall societal health. For example, if a person refuses to be treated for an epidemic. It is only in cases of direct and immediate harm that a healthcare professional is justified to step in and override the informed refusal. An extreme example is if a patient enters the hospital and creates harm to other patients or to the staff, intervening for the protection of others may be necessary, showcasing there are exceptions to the general rule of respecting patient informed refusal.

It is interestingly noted that Mary Northern never received the surgery due to concerns of the serious surgery and Ms. Northern died on May 1, 1978 after a blood clot from the gangrenous tissue. Her adamant belief about the medical necessity for surgery was due to her cultural background only having a third-grade education and that she did not believe the African American doctor informing her (Arras and Steinbeck 1999).

Conclusion

This argument modernizes principle-based philosophy and highlights the need for enhanced patient autonomy. There is a balance between the healthcare professional look out for the benefit of the patient with the paternal role and the patient making an autonomous decision about their care. Healthcare professions ought to strive for the ability to enable the patient to have the autonomy and allow the patient can refuse treatment. A medical decision cannot be made alone and it is proposed that through a strong relationship between the healthcare professional and the patient that a fully autonomous choice can be made. The modern interpretation of the bioethical principles addresses how to respond to ethical dilemmas after they

arise in the context of clinical practice” in the certain context when patients refuse treatment (McGrath 1998, 522).

Works Cited

- Arora, Kavita Shar; Monique Spillman, Magdy Milad. 2014. “Bits and Pieces: The Ethics of Uterine Morcellation.” *Obstetrics & Gynecology*. American College of Obstetricians and Gynecologists. 124(6 December)1199-1201.
- Beauchamp, Tom L., Childress James F. 2009. *Principles of Biomedical Ethics*. Oxford University Press: New York and Oxford.
- Collopy, B.J. 1988. “Autonomy in Long Term Care: Some Crucial Distinctions.” *The Gerontologist*, 28(Supplement), 10–17.
- Cooper, Stephanie. 2010. “Taking No for an Answer - Refusal of Life-Sustaining Treatment.” *Virtual Mentor*. 12:6 (June) 444-9. Web 6 Feb 2016. <http://journalofethics.ama-assn.org/2010/06/ccas2-1006.html>
- Damasio Antonio.1994. *Descartes' Error: Emotion, Reason, and the Human Brain* (New York: Penguin).
- Davis, John K. 2004. “Precedent Autonomy and Subsequent Consent.” *Ethical Theory and Moral Practice* 7: 267–291. Kluwer Academic Publishers. Netherlands.
- Dawson, Angus. 2010. “The Future of Bioethics: Three Dogmas and a cup of Hemlock.” *Bioethics* 24(5): 218-25
- Dresser R.2011. “Bioethics and Cancer: When the Professional Becomes Personal,” *Hastings Center Report* 41, no. 6 (2011): 14-18, at 15
- Epstein R. M. and E. Peters. 2009. “Beyond Information: Exploring Patients’ Preferences,” *Journal of the American Medical Association* 302 (2009): 195-97; P. Slovic, “The Construction of Preference.” in *Choices, Values, and Frames*, ed. D. Kahneman and A. Tversky (Cambridge: Cambridge University Press, 2000).
- R. M. Epstein, D. N. Korones, and T. E. Quill. 2010. “Withholding Information from Patients—When Less Is More.” *New England Journal of Medicine* 362 (2010): 380-81.
- Hill, Joal. 2004. “Non-Compliance: Conduct and Compassion.” *Lancet*. Vol 363 No. 9425. Web. 1 April 2015.
- Holmstrom, Inger, Dall’Alba. Gloria. 2002. “Carer and Gatekeeper’ – Conflicting Demands in Nurses’ Experiences of Telephone Advisory Services” *Scandinavian Journal of Caring Services*. 16:2(142-8), Web. 20 Jan 2016.
- Jonsen, A. 1990. *The New Medicine and the Old Ethics*. Harvard University Press, London.
- Kelley, Maureen.2005. “Limits on Patient Responsibility.” *Journal of Medicine and Philosophy*, 30: 189-206. Web. 8 April 2015.
- Komesaroff, P. A. 1995. “From Bioethics to Microethics: Ethical Debate and Clinical Medicine,” in *Troubled Bodies: Critical Perspectives on Postmodernism, Medical Ethics, and the Body*, ed. P. A. Komesaroff (Durham, NC: Duke University Press), 62-86.
- Lane v. Candura. 1978. *American Journal Of Law & Medicine*. Fall78;4(3):289. Available from: Legal Collection,Ipswich, MA. Accessed February 19, 2016.
- McGrath, Pam. 1998. “Autonomy, Discourse, and Power: A Postmodern Reflection on Principlism and Bioethics.” *Journal of Medicine and Philosophy*. 23(5):516-32.

- McGrath, Pam. 2011. "The 'Real World' Of Ethical Decision-Making: Insights From Research." *International Journal Of Ethics* 7.3(4): 183-196. *Humanities International Complete*. Web. 7 Feb. 2016.
- McHale, Jean, Ann Gallagher, and Isobel Mason. 2001. "The UK Human Rights Act 1998: Implications for Nurses." *Nursing Ethics*. 8(3)223-33.
- Murphy, Peter. "Are Patients' Decisions to Refuse Treatment Binding on Healthcare Professionals?" *Bioethics*: Vol 19 No. 3.np. 2005. Web. 1 April 2015.
- Nagel T., 1986. *The View from Nowhere* (Oxford: Oxford University Press).
- Nalpathanchil, Lucy. 2015. "Can Connecticut Force a Teenage Girl to Undergo Chemotherapy?" *National Public Radio*. 8 Jan 2015. Web 20 Jan 2016.
<http://www.npr.org/sections/health-shots/2015/01/08/375659085/can-connecticut-force-a-teenage-girl-to-undergo-chemotherapy>
- N.P. "Mental Capacity Act 2005: Code of Practice Office of the Public Guardian, United Kingdom Stationery Office, Department for Constitutional Affairs. Published by TSO 2007 Birmingham, UK
- Paola, Frederick Adolf, Robert Walker, and Lois LaCivita Nixon. 2010. "Principles of Biomedical Ethics" 39-64. *Medical Ethics and Humanities*. Jones and Barlett Publishers, Sudbury, Massachusetts.
- Petersen, Alan. 2011. "The Politics of Bioethics." "Beyond Bioethics." *Routledge Studies in Science, Technology and Society* Routledge Ny: NY 132-49.
- Quill, Timothy E, and Brody, Howard. 1996. "Physician Recommendations and Patient Autonomy: Finding a Balance between Physician Power and Patient Choice." *Annals of Internal Medicine*. No. 125. pp763-769. Web. 1 April 2015.
- Ryan, Joanne M. 1981. "Expansion of Physician's Duty to Warn – An 'Informed Refusal Malpractice Action: Truman v. Thomas.'" *Bridgeport Law Review*. Vol. 2: 155-15. Web 8 April 2015.
- Schneider, C. E. 1998. *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (Oxford: Oxford University Press).
- Simmons, Paul. "Aging and Human Dignity: The Future of Autonomy." *Wayne Dales Institute: A Learning Community for Spiritual Care*. Web. 8 April 2016.
<http://www.drewdmin2010.net/index.php/library/hvhc-2000/379-simmons-hvhc-03>
- State Dept. of Hum. Serv. v. Northern 563 S.W.2d 197 (1978) STATE of Tennessee, DEPARTMENT OF HUMAN SERVICES, v. Mary C. NORTHERN. Court of Appeals of Tennessee
- Traphagan, John W. 2013. *Rethinking Autonomy: A Critique Of Principlism In Biomedical Ethics*. Albany: State University of New York Press, *eBook Collection (EBSCOhost)*. Web. 28 Jan. 2016.
- Truog, Robert D, et al. 2015. "Microethics: The Ethics Of Everyday Clinical Practice." *The Hastings Center Report* 45.1: 11-17. *MEDLINE*. Web. 28 Jan. 2016.
- Veatch R. M.. 1995. "Abandoning Informed Consent." *Hastings Center Report* 25, no. 2 (1995): 5-12.)

Wolf, S.M. 1996. "Introduction: Gender and Feminism in Bioethics," in S.M Wolf (ed)
Feminism and Bioethics: Beyond Reproduction. Oxford University Press: New York and
Oxford.