Autonomy *versus* beneficence

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Abstract

This work discusses the principles of autonomy and beneficence. It sets the relationship between these two concepts by means of a bibliographical assessment, whose proposal is to point out the Historical evolution of medical ethics, from Hippocratic age to present. In face of new moral, bioethical and ethical perspectives, arising from contemporaneousness, the discussion indicates that a medical decision-making model based on respect to autonomy seems to be ideal, in spite of its difficult articulation with the classical parameters that guides the doctor-patient relationship, as highlighted by the domestic and international literature. Finally it concludes that one lives a paradigmatic transitional situation, in which the governing model does not provide effective answers and its substitute has not been established yet, suggesting adoption of strategies in order to stimulate the debate within the Academy, prioritizing patient's autonomy.

Key words: Bioethics. Professional autonomy. Personal autonomy. Paternalism.

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The principle of beneficence, associated with non-maleficence, has oriented medical practice over two thousand and five hundred years. Since its inception, the relationship between physicians and patients had as a reference the Hippocratic Oath, by which the physician established a commitment to use medicine for the benefit of patients, among other obligations.

Over the centuries, the application of these principles in daily professional practice has been based often in paternalism, given the undeniable difference in knowledge about diagnosis, treatment, and cure between physician and patient. The incorporation of scientific rationality into medicine at the end of the nineteenth century provided the physician with technical autonomy for decision making, legitimating his decision-making power by the domain of the specific knowledge [1].

If these two principles remain central to the physician-patient relationship, guaranteeing the necessary confidence essential to the relationship, how those moral assumptions are applied has been widely questioned in the past three decades. In view of the formulation of the *Universal Declaration of Human Rights* in 1948 and subsequent regulations targeted to patient's rights, among which in particular the self-determination, new challenges were brought to medical practice. Within such context, the principle of respect to the patient's autonomy has assumed a growing importance in current bioethical discussions. Such principle derives from the recognition that everybody is capable of determining his own faith and, therefore, the right to act freely, according to his own conscience and moral values. The right to self-determination has deeply questioned the so-called physician's paternalist attitude, which, at first sight, would know what is better to the patient [2].

Individual autonomy, however, is subject to several ethical, moral, cultural, and religious rules imposed by society, since the individual, due to the need of promoting patient's autonomy, recognizes them as legitimate. The physician should provide information, assure understanding, and guarantee his free adhesion to the proposed treatment. The assumption that associates the respect to the patient's autonomy is called informed consent and the tool used for its application is identified as free and clarified consent term (FCCT).

The standards and limits of such principles remain undefined and open to several interpretations. As a result, this study seeks to present the different versions of the literary representatives who have approached the subject, to enable the deepening of the search for answers to the problem, i.e., the definition of the limits and benefits of patient's autonomy and the physician's beneficence. For this, the development of bibliographical study established a temporal period of 16 years, selecting and analyzing the published literature on the subject in the period between 1983 and 2009.

From Hippocratic medical ethics to contemporary medical ethics

The fundamentals of ethical basis in traditional medicine were ordered by the Hippocratic Oath and in the deontological and normative books contained in the *Corpus Hipocraticum*. The oath included physician's commitment to use medicine to the benefit of patients; to maintain medical knowledge under secrecy, except to his peers; not maintaining sexual relations with patients and not administering substances that could led to death or cause harmful effects [3]. Since it represented a code of norms of conduct, it became a parameter for the very physicians to evaluate their practice.

With the Christianization of the West, the oath underwent adaptations targeted at Christian morality without, however, changing the fundamental structure of the code of ethics. The premise incorporated by the Christian thought

was the spirit of charity. The priestly character of the doctor was kept and the Hippocratic ethics was perpetrated over centuries, as medical ethics was converted into the paradigm of all priestly ethics [4].

Human charity influenced social organization in medical practice with the establishment of several institutions by religious organizations that provided charity by assisting the sick. Nevertheless, in that period they had the priority purpose of sheltering, dedicating themselves more to the exclusion of the sick person from social life to avoid contagion than to the cure [5]. From the beginning of the Middle Ages to 19th century, three beliefs guided interactions between physicians and patients: patients should respect physicians, since their authority comes from God; patients should have faith in their physicians and should promise obedience [5].

From the 12th century, upon the rebirth of Greek *rationalism*, after the Catholic Church crisis period, with the opening of colleges of medicine at the medieval universities and the promulgation of the first laws ruling the exercise of medical practice by candidates, emerged the beginning of the professionalization process in medicine. Through such statutes, the medicine was legitimated before the society, since physicians relied on a knowledge that only the *initiated* could acquire and they were assured the State protection, assuring them the professional monopoly.

At the end of the 19th century, social legitimacy of medicine acquired reinforcement due to the incorporation of the scientific rationality and by the change of the medical paradigm with the establishment of medicine based on the identification of diseases, signs, and symptoms according to the anatomic lesions [1]. As a result, the medical system was consolidated, strengthening the Idea that the layman was not only capable of understanding his own health problems but particularly of remedying them. Therefore, the historical development of medicine provided to the physician technical autonomy for the decision-making with the patient, which was based either on the grasp of the specific knowledge and on the social legitimacy consented by such professional class.

The original principle of the physician-patient relationship is established in the relationship of trust and respect between them, a fundamental condition for the cure [5]. Patient's trust is based on the conviction that the physician has the knowledge required to solve his problem and the respect by the physician to the patient is based on the ethical principles of beneficence and not-maleficence. The principle of beneficence, according to the Hippocratic tradition, it did not admit shared relationships of decision with the patient. According to Katz, the idea of patient's right to share responsibilities of decision with his physicians never made part of the essence of medicine [5].

However, it should be recorded that the questioning of such paternalist relationship between the physician and the patient and the emergence of the

principle of respect to the autonomy and the free and clarified consent is rather recent. It may be pointed out its emergence in 1914 when the North-American courts started to interpret the cases of intervention in the patient's body without his consent, as a violation of the individual right to self-determination [3]. Dumont defined the term *individual* with two possible meanings. The first is the empirical subject manifested by the word, by thought and by the willingness, represented as an indivisible part of human species: the social being. The second one relates to the moral, independent, autonomous being and, therefore, non-social. The notion of individual with moral rights represents a construction of modernity [6].

John Locke initially proposed the fundaments of modern theory of human rights in 1690, to which men would be equal, independent and governed by reason. Such initial proposition defines the contents of each one of the rights man must have in society. The first ones are the civil and political rights, such as the right to life and health, freedom of conscience and property. Secondly, are the individual rights, i.e., those depending exclusively on the individual's initiative; lastly, duties imposed by him [4]

The modernization project assigns to the subject the affirmation that each individual creates freely his own identity – without meaning, however, individualism or centrality of the individual with lack of public sphere or social representa-tiveness. The movement has the intent of incorporating the rights of the individual in the process, as well as the affirmation of the possibility of democratic convenience in societies based on freedom and autonomy of its members [7].

In the middle of the 19th century, fifty years after the French Revolution, a new generation of human rights started to be modeled centered on the idea of equality and justice. It meant thinking the State or political power in the function of protecting the fundamental rights of individuals and considering that modern democracy only exists when the recognition of the basic citizenship right occur [7].

The *Universal Declaration of Human Rights* promulgated by the United Nations in 1948, as a reaction to the horrors perpetrated during the Second World War serves as basis to the protection and promotion of human rights. Such declaration was promulgated by the Nuremberg Court three years after the end of the trials for war crimes committed by the Nazi Germany after the conviction of twenty physicians due to brutal experiments performed on human beings. The Declaration became the basis for a system of conventions, instruments, mechanisms, and guarantees intended for protecting and promoting human rights. It was also created and disseminated the document known as the *Code of Nuremberg* – which, for the first time, provides recommendations at the international level on ethical aspects related to research involving human

beings. The self-determination of the individual was the first criterion enunciated and the judgment is considered as the milestone in the adoption of scientific practice normalizing principles. On the other hand, actions against physician's negligence began to reach the American courts in the middle of the 19th century. It was deflagrated the movement of constitution of the patient's rights to information and to co-feeling when he relates with the physician and the health services [3].

The term *free and clarified consent* appeared only in 1957, after the rulings on the case *Salgo versus Leland Stanford Jr. University – Board of Trustees* when, the merit of the quality of information and physician's duty to provide it was considered for the first time. It based on the allegation of negligence in performing the surgical act and for not having alerted on the risk of paralysis [8].

In Brazil, the promulgation of the 1988 Constitution, which incorporates health as citizen's right and duty of the State, associated to the full participation of society in the 7th National Health Conference, were established the rights by the population not only to the access to the different levels of health care, but also to its participation in the formulation of health priorities by legal mechanisms. Within that context, the Medical Code of Ethics is reformulated and the Brazilian Code of Consumer Protection is established, both important to affirm patient's right to free information and consent [3].

The beneficence model begins, gradually, to open space to the autonomy model. In the process of developing patient's autonomy, three stages are distinguished: in the first, the legal image of professional negligence or lack of ability stands out; in the second dominates the idea of aggression, understood by the intervention on the body of a person without his consent; in the third, the concept of clarified consent is defined more precisely. Generally, the disrespect to the principle of clarified consent is typified as the lack of ability or medical negligence. Since then, the North-American law recognized the right to self-determination by the patient [4]. According to Faden and Beauchamp, the informed consent doctrine did not cause great changes to the physician-patient relationship, adding that such clinical practice should be an ethical problem, more than a legal issue [8].

Principle of autonomy

Conceptually, autonomy is a word derived from the Greek, composed by *autos*, which means *own, the same, by himself*, and *nomos*, with the sense of *rule, government, law, norm* - and was first used with reference to people and states' self-management. From then on, the term autonomy acquired different meanings, extending itself to individuals, with the meaning of rights to freedom, self-government, individual choice, freedom of will. The term acquires, therefore, a specific meaning according to the context of a theory [9].

Etymologically, the concept of autonomy means the condition of a person or an autonomous collectivity; that means it itself determines the law which it submits[10].

The identification between will and reason makes man a completely free being and gives origin to the notion of autonomy. The autonomous individual acts freely, according to the plan chosen by him [11]. In sociological terms, the emphasis on the principle of autonomy may be understood as the consequence of the changes occurred at western countries, to wit: the replacement of the concept of family society by individual, hereto understood as the free individual; the recognition of the moral pluralism at the social level, with repercussion on the decline of moral regulations imposed by the State; and the process of decision on health targeted to an increasingly legalist model [12].

It is worth mentioning that to the autonomous person are included the capacities of reasoning, comprehension, deliberation and independent choice. However, it is interesting the act of decision that leads to the autonomous choice, which represents the act of governing effectively and not the capacity of governing. Autonomous persons with self-government capacity may fail when governing themselves in their choices, due to temporary restrictions imposed by disease, ignorance, coercion or other restrictive conditions [9]. Similarly, those persons who are not autonomous may sometimes make autonomous choices. One person with reduced autonomy is controlled by others somehow, and is incapable of deciding or acting based on his wishes and plans.

In order for an action to become autonomous, it requires a certain level of understanding and freedom from any coercion, and not full understanding and complete lack of influences. It would be the capacity of the individual acting intentionally[9]. In the practical world, the limitation of the patient's decision to the ideal of fully autonomous decision may cause the deprivation of the required health care. What is or not substantial is separated by a tenuous line, but a limit should be established to determine autonomous decisions based on the specific objectives.

Such principle recognizes the importance of the patient's free will and the respect the physician must keep for his moral, physical and legal dimensions. Such will qualified by the freedom must be grounded on the information and truth[11]. Therefore, in the patient-professional relationship both must act with knowledge, freely and with intent to reach the *status* of moral subject - what demands mutual respect to the other's autonomy [13].

However, no one is free from external influences such as the family or the moral community to which he belongs. The context itself of getting sick brings limits, at different levels, to the exercise of autonomy. Such concept assures that the principle of autonomy should be based on the patient's free decision, even with limitations, taking into consideration that individualism, since people live in a society and are, therefore, subject to several ethical,

moral, cultural and religious rules imposed by such society and recognized as legitimate by the individual [9].

The requirements of authority of one institution, once accepted, will influence the autonomy of decision. As an example, a Jehovah's Witness refusing to have a recommended blood transfusion. Individuals do not live isolated from society and the moral principles of a given social and cultural organization have authority and influence over their lives and autonomous choices. Thus, forms of victorious conduct, charitable behavior, responsibility in the performance of duties are moral notions accepted by individuals, but derived from cultural traditions that interfere in autonomous decisions. However, the fact of sharing principles does not hinder that they be considered individual parts of the person, since they do not mean factors. The respect to the rules of professional ethics codes is compatible with autonomy [9]. The respect to autonomy derives from the recognition that everybody has unconditional value and capacity to determine his own faith. Beauchamp and Childress [9] teach that *the act of violating one person's autonomy is the same as treating him as a means, without considering his objectives*.

The self-determination right is correlated to the obligation of not causing harm to others. The respect to autonomy has, therefore, p*rima facie* validity and may be surpassed by concurrent moral considerations. The obligation of respecting autonomy, though ample, does not apply to non-autonomous persons, since they are immature, ignorant, and coerced or explored. Examples are children and patients with mental problems, who have reduced competence. Therefore, autonomy is not limited to the sick, but is extended to the family[9].

In practice, the principle of autonomy implies promoting, as much as possible, autonomous behaviors by the patients, informing them, assuring the understanding and the free adhesion, proven by means of the signature of free and clarified consent. The practice of consent implies assessment of capacity or competence of the individual which should be analyzed not only according to the capacity of receiving information, but also in getting data judged and listened and express a coherent answer.

Informed, free, and clarified consent is the mean used to assure the patient's autonomy, where the physician or other health professional uses the required prudence to accomplish his duty of informing, under an accessible language, the relevant facts for the competent patient to decide with full awareness.

There are modalities as the tacit, passively expressed, by omission, i.e., in the absence of objection it is presumed acceptance. This is only acceptable for procedures with risk less than the minimum. The presumed consent is the one which assumes that the patient would have nothing against the procedure such as, for example, urgent assistance in which the physician presumes that the patient looked for him so he could do the best for him and who would oppose to his conduct. The assumption bases in a general theory of the human good or the rational will.

The prospective consent is that in which the patient shows future wish, such as donating his organs after his death[9]. Although there is an obligation of requesting the decision making by the patients based on the respect to autonomy, one should be alert to the many interferences suffered on such situation. Autonomy reflects a relative value, since it is submitted to individual fragilities and ambiguities. Therefore, the principle of autonomy keeps important issues open and it should be considered only as a key principle within a system of moral principles.

Principles of beneficence/non-maleficence

Beneficence, in common speech, means acts of compassion, kindness, and charity. Beneficence derives from the Latin *bonum facere*, which means do the good, i.e., perform the action or manifestation of good. It distinguishes from benevolence, which means to be available to do the good [3].

The principle of beneficence has a large tradition in Hippocratic medical ethics, which manifests the interest in not prejudicing people (*primum non nocere*) [14]. Not causing prejudice or harm was the first great norm of ethically correct conduct of physicians [15]. Beneficence represented the landmark to the development of knowledge and techniques aiming at assisting the patient to overcome certain situations in his life [3].

Many acts of beneficence are not mandatory, but the principle of beneficence affirms the basic question existing between the obligation and the philanthropy or charity still remain confusing [16], requiring an assessment of its limits.

Beneficence is, on the other hand, an ideal of action that surpasses obligation; and in the other limited by moral obligations. It is evident that physician and other health professionals cannot exercise the principle of beneficence on an absolute way. It has limits, such as the individual dignity inherent to the human being. The principle is conditioned to or depends on the situation to which it is inserted. The more generalized the obligations of beneficence are, the lesser is the probability of the primary responsibilities being accomplished [9].

The reciprocal one is the reference to the ethics of health care in which the physicians would have great debts to the society (for the education received and privileges) and to the patients (through research and *practice*, for example).

The principle of beneficence attempts, in a first instance, to promote health and prevention of diseases; secondly, it weights the good and the bad seeking for the prevalence of the first one [15].

Many authors believe that the principle of non-maleficence is an element of the principle of beneficence, since not causing the intentional bad is doing good. On this respect, David Rossi,

in his work 'The right and the good', of 1930, established the concept of duty, proposing that in the cases of conflict between beneficence and non-maleficence the non-maleficence shall prevail [17]. Still, according to Frankena [18], *we should promote the good and avoid the evil*.

The Belmont Report, published in 1978, includes the non-maleficence as part of beneficence understood as double obligation: not causing damages and maximizing the number of possible benefits, minimizing the damages. Such approach is not supported by Beauchamp and Childress [9], who consider that the principle of beneficence requires more, since the agents must assume positive attitudes to assist the others and not simply refrain from practicing harmful acts. Causing harm or damages to others is forbidden normally and, thus, the non-maleficence becomes a possible action regarding all persons. In parallel, Morality does not obligate beneficence; therefore, its manifestation is casual. Thus, the non-maleficence obligations are more severe that those of beneficence, but cautions should be taken as to the priorities, since they suffer changes according to the situation. The severity of non-maleficence is feasible if the act of benefitting involves the practice of something morally wrong.

Paternalism

The term paternalism derives from the model of the patriarchal family, where the father exercises the Power of making all choices, especially those regarding the children.

Throughout the history of medical ethics, the principles of non-maleficence and beneficence established the bases of the physician-patient paternalist relationship. Paternalism may be understood as the conduct the physician has with the intent of benefitting the patient, but without his consent.

Legally, paternalism has been defined in terms of coercion by the State through laws that interfere in individuals' freedom of action. However, such paternalist attitudes have been discredited by the western political ideologies, even though they still are perceived in the areas of social policies legislation, in medicine and health care [19,20].

Philosophically, Beauchamp e Childress [9] present the individual's autonomy, giving emphasis to two lines of thinking. The first one understands autonomy as a value by itself, where all forms of control would be immoral and paternalism would be a form or coercion, constraint and violation to autonomy. There is a liberal view of paternalism which classifies it according to the degree of restriction to autonomy, establishing two types: soft and hard.

Soft paternalism consists in an action that does not violate the person's autonomy such as, for example, the mandatory vaccination of children. The strong or hard paternalism violates the principle of autonomy and may be subdivided into weak and strong. The first one is morally justifiable in predetermined situations such as group

of people who do not have autonomy developed or have lost such capacity. The second one is morally unjustifiable since it involves intents with the purpose of benefitting one person despite the fact that its choices are informed. On the hard paternalism, there is a refusal to consent the wishes, choices and autonomous actions of a person, with the purpose of protecting it, restraining the available information and despising the volunteer choices [9].

In the daily physician-patient relationships limits are not noticed between such forms of paternalism. Thus, the problem of medical paternalism is the due balance between the physician's beneficence and the patient's autonomy in the context of their relationship [9].

Final considerations

Autonomy and beneficence are common points in the physician-patient relationship occupying different concepts and historical moments in this context. The modification of such relationship emerged after the Second World War, with the social, cultural, and moral mutations that occurred in the western countries, which led to the so-called moral pluralism. Furthermore, the technical and scientific development led the physician to the separation in his interpersonal and family relationships, to a growing hospitalization and professional specialization, which produced in the population a feeling of growing distrust and contributed to increase the distance between the physician and the patient. Today, the physician's role – besides diagnosing and caring for human diseases – is to clarify, guide and respect patient's decision as an autonomous being. The replacement of the paternalist model by autonomy is the fundamental step of the physician-patient relationship in the plural society that contests authority in the name of autonomy.

Morality of the physician's paternalism started to be discussed from the valuation of the principle of the individual's autonomy and the model of medical decision based on the respect to autonomy seems to be ideal. It is up to the physician to understand that his capacity of showing to patients the indication, reasons, pros and cons and its respective consequences, provides a fundamental link for both assuming joint responsibilities.

The first great bioethical dilemma felt by physicians remains in the conflict generated between the respect to patients' freedom (autonomy). It seems that the solution for that problem is the balance between the physician's beneficence and the patient's autonomy in the physician-patient relationship context.

Today, the use of authority in the role of the physician to perpetuate the patient's dependence, instead of promoting his autonomy, is still tempting. It is part of the whole formation historically perpetuated until now.

The right to autonomy still bothers a little and there is an imperious need for policing health agents' actions. However, the obligation of respecting the patient's autonomy requires, above all, qualifying him to overcome his sense of dependence and to obtain, if not the desired control, at least the greatest control possible.

It may be considered that contemporary society lives a situation of paradigmatic transition, in which the current paradigm (beneficence) shows failures and is no more accepted in the contemporary plural society and its substitute (autonomy) is not yet fully established as a consequence of the medical formation in force, historically beneficent. Due to such gap, local discussion strategies should be adopted at forming organs and hospitals, to clarify, orient and foster adequate answers to the divergent points still existing. It is believed that only that way the merits of the subject studied will be more clarified from contribution, originality and feasibility of point of view.

Resumen

Autonomía *versus* beneficencia

El estudio discute los principios de autonomía y de beneficencia. Establece relación mediante un levantamiento bibliográfico, que puntualizó la evolución de la historia de la ética médica desde la era hipocrática hasta nuestros días. Frente a las nuevas perspectivas éticas, bioéticas y morales que surgieron en la contemporaneidad, la discusión apunta que el modelo de decisión médica basado en el respeto a la autonomía parece ser el ideal, a pesar de su difícil articulación con los parámetros clásicos que orientan la relación médico-paciente, como resalta la literatura nacional e internacional. Concluye considerando que se vive una situación de transición paradigmática en la cual el modelo vigente está dejando de ofrecer respuestas efectivas y su sustituto todavía no está totalmente establecido, sugiriendo la adopción de estrategias para fomentar la discusión dentro de los órganos de formación médica primando siempre la autonomía del paciente.

Palabras-claves: Bioética. Autonomía profesional. Autonomía personal. Paternalismo.

Resumo

Autonomia versus beneficência

O estudo discute os princípios da autonomia e da beneficência. Estabelece relação entre os dois conceitos mediante levantamento bibliográfico, cuja proposta é pontuar a evolução histórica da ética médica, da era hipocrática aos dias atuais. Diante das novas perspectivas éticas, bioéticas e morais surgidas na contemporaneidade, a discussão aponta que o modelo de decisão médica baseado no respeito à autonomia parece ser o ideal, apesar de sua difícil articulação com os parâmetros clássicos que orientam a relação médico-paciente, como ressalta a literatura nacional e internacional. Conclui considerando que se vive uma situação de transição paradigmática, na qual o modelo vigente vem deixando de fornecer respostas efetivas e seu substituto ainda não está totalmente estabelecido, sugerindo a adoção de estratégias para fomentar a discussão dentro dos órgãos de formação médica, primando pela autonomia do paciente.

Palavras-chave: Bioética. Autonomia profissional. Autonomia pessoal. Paternalismo

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