Medical attitude and autonomy of the vulnerable sick person

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Resumo Este artigo apresenta os resultados de pesquisa envolvendo amostra de 42 médicos de um serviço de oftalmologia de hospital terciário em Portugal. Foi aplicado um questionário com dez perguntas, destinado a avaliar as atitudes de três grupos de médicos com idades e formação pedagógica distintas, em face da autonomia do doente glaucomatoso. Os dados foram analisados indicando a correlação descritiva por meio do teste de Pearson χ^2. Resultam três atitudes diferentes com significado estatístico (valor de $p<0,05$) permitindo considerar a existência de três padrões de comportamento médico, adequados ao grupo etário. A formalização da prática médica à medida que a idade diminui (medicina defensiva) caracterizou o Grupo 1. O respeito pelo doente dominou o Grupo 2. No Grupo 3 prevaleceu a tendência para a medicina paternalista, onde o esclarecimento depende da educação e caráter do médico. Conclui que a conduta dos médicos remonta ao momento em que iniciaram a atividade profissional, à cultura médica predominante no período e à formação bioética.

Palavras-chave: Autonomia profissional. Autonomia pessoal. Bioética. Oftalmologia. Glaucoma.

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Discussion presented here derives from the need to reflect on medical profession, particularly in case of professionals whose working daily life involves in treatment of crippling pathologies, with stigmatizing feature in the social imaginary, as it is the case of glaucoma. Under these circumstances, physician faces the need to respond to issues such as values, priorities, and cultural needs of these patients, individually considered.

One may enumerate few guiding vectors for reflection, among issues presented. They are: a) physician's role in patient-physician relationship, which may or may not originate an asymmetric relational binomial; b) hospital structures impersonality that limit patient-physician relationship, influencing ethical decisions that question the sick's own dignity; c) conditions in which informed consent processes or practices or, as it is known in Brazil, a free and clarified consent as paradigm of the sick person's autonomy.

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Any profession, inclusively medical, has a *permanent altruistic commitment* toward society, which, in itself, is a moral value. A second value, acknowledge as basic and which exerts permanent surveillance about medical expertise, is *the scientific knowledge*, ethical and technical principle that guides the good exercise of any profession. Professional competences evaluation is a current requirement, expressed by the *quality certification of its member and by their compliance to behavioral codes*[1].

It is a feature of this certification that, regarding physician's ethical behavior, we propose to analyze in this article. To evaluate his predisposition toward classical paternalism, in which physician has absolute power over the sick person, or toward his autonomy, which materializes with suitable information and consent, through which patient may give his consent for procedures that may be undertaken upon him: *this capability to choose, prefer, exclude is what civic education should try to get in future citizens*[2]. Education is the foundation that allows anyone to constitute himself as a being of thought, word and communication. Thus, one of the basic rights of any individual attempting to be autonomous, along with freedom, is to have intellectual means need to benefit from this same freedom [3].

Underlining physician's behavior understanding in the institution where he works, hospital dynamics will be analyzed also, as public agency, with peculiarities and hindrances that are proper to it regarding respect for the autonomy of the sick and his well-being as ultimate goal. It will be considered, in that sense, the *Chart of Rights and Duties of the Sick* [4], approved by the Portuguese Ministry of Health in 1997, as part of hospital health services humanization efforts in the country. It should be emphasized that the right to health protection is consecrated in the Portuguese Republic Constitution and *it is based in a set of basic values* such as *human dignity, equity, ethics and*

solidariety [4]. These are the guiding principles that serves as basis for designing patients' rights and duties detailed in the mentioned Chart.

The research crosscut attempts to know how three groups of physicians in different age brackets will stand in face of the autonomy of a sick person with glaucoma, in as much as subject of rights and duties, whose vulnerability is a major factor to be considered. Such understanding seemed to us to constitute a challenge in itself. In view of a services rendering culture, eventually different, we tried to analyze professionals' attitudes taking several items in consideration, among which stand out the type of pedagogical and cognitive formation, clinical experience, and bioethics formation, pertinent to several problematic proposed for reflection.

Medical relationship in a patient-physician collaboration context, as the pillar of respect by autonomy while bioethics principle targeted to promote the sick's best interest, as well as free and clarified consent, taken as a legal paradigm of respect to this principle, are other ethical aspects of medical relation – seen in this study under the interpreters involvement perspective.

Principle of autonomy and its theoretical framing

The expression autonomy means self-determination, regulations of own interests and independence, excluding external factors influence, psychic or physical coercion, and, still, personal capability that reduces or even hinders decision power[5]. In etymological terms is word of Greek origin, composed by the adjective *autos*, which means *the self, himself* or *by himself*, and substantive *nomos*, which means *sharing, institution, law, norm, convention* or *use*. The general meaning of the word indicates capability of human being in giving himself to his own laws and share them with his peers or the individual's or collectivity condition, capable to determine by himself the law to which he complies [6].

Historically, such concept may had its origin in the rupture with pagan tradition, characterized by explanations from supra sensible sphere for phenomenological accidents in nature. The arousing of autonomous idea would relate, thus, to transition from a mythical universe toward rational knowledge, and constituting in it, an autonomization[7]. Autonomy acquires its true meaning when humankind tries to control the world through technique and science, and to submit it to human ends.

According to the idea of autonomy, all human being will be able to decide about himself, his behavior seemingly fair or not, safeguarding that to think and to act differently should not result in damage to other individuals, even if may bring losses for himself [6], as long as it shall not put the individual on eminent risk of death**.** Kant, in his *Groundwork of metaphysics of customs*, considers that *freedom is the basis of law and of ethics* [8]. Autonomy receives different denominations according to several authors, since respect to individual until consent.

However, it cannot be understood exclusively as self-determination of an individual, since mandatory inclusion of the other in autonomy issue bring new entity to the discussion that links individual action to social component. To be autonomous is tho have the right to selfdetermination, but to respect the right of others equally.

One of the reasons in order for the principle of autonomy win highlights which currently it is granted to it derives from the importance of the work *Principles of biomedical ethics* [9], in which Tom Beauchamp and James Childress outline four principles to guide ethical action in professional practice: *beneficence, non-maleficence, autonomy* and *justice.* Such principles find their roots in history of philosophy or in medical ethics tradition, from which they get their justification. According to the outlined by these authors, the four principles do not obey to any hierarchic disposition and they are equally valid in conflict situation, although autonomy seems to be preferred by the advocates of principlist theory.

Along the other guiding principles of wishfully good action, the principle of autonomy became during the last decades one of the main conceptual pillars of applied ethics, used in opposition to medical paternalism inherent to classical clinic practice, and it proposes a new patient-physician relationship, until then a paternalist feature. With principlism, Beauchamp and Childress elaborate a sort of *ethical paradigm* targeted to health sector professionals, aiming at providing a practic-conceptual benchmark which could guide them in real situation which would work as a methodology capable to deal with dilemmatic situations in the field of bioethics. This paradigm, constituted by the formulation of mentioned principles interpreted in light of the two theories – utilitarianism and *prima facie* deontology– admit exceptions in certain circumstances [10].

Since the *Nuremberg Code* that the concept of dignity and respect for humankind is linked to the autonomy idea of subject. Philosophic contributions that concurred the most for ethic reflection came out exactly from human rights protection movements and, thus, contemporary ethics basic principles began to take shape: beneficence, non-maleficence, autonomy, justice, and equity, which vulnerability added itself daily.

Consecration of human being dignity and his right to freedom inscribe the concept of autonomy and daily praxis of contemporary societies. Therefore, the principle of autonomy, designation by which principle of respect to individuals, requires acceptance that they self govern, that is, they are autonomous in their choices and acts, although integral respect to the autonomist idea, apprehended as concept of respect for the other [11].

Human dignity doctrine is underlying to the principal of autonomy of person, who is capable to deliberate on personal objectives and to act in such way that it will be as autonomous as capable to better self-determining in intellectual and effective

terms, in a voluntary fashion. In 1948, the *Universal Declaration of Human Rights* (United Nations Organization –UNO), in Sequence to the *Nuremberg Code* (1947), includes several rights that aim at autonomy and freedom of human persons, and its elaboration derives of knowledge from undertaken experiments with vulnerable human beings during the World War II. Several other codes succeeded it, aiming at greater practice suitability, due to the over strict legal dispositions of the *Nuremberg Code*, ill adapted to investigation reality. The *Declaration of Helsinki* (World Medical Association – WMA, 1964) contributed so trials with human beings would comply with specific ethics rules and criteria, which departed from the presumption of autonomy of investigated individuals.

The *Universal Declaration on Bioethics and Human Rights* [12] (UNESCO, 2005) came to reinforce the importance of respect to the principle of autonomy and individual responsibility. Protection of vulnerable or incapable individuals restated in Article V, acknowledgement in Article VI of free and clarified consent role as the expression of the principle of autonomy practice.

In Portugal, it was adopted legislation regarding biomedicine practice, in accordance to the Council of Europe Convention (CEC), establishing by means of specific norms suitable procedures for the general main biomedical areas, and specially on human rights, allowing that, people with different ideological motivations and with different directives from their government reach a common ethical opinion on actual situations. Law 12/2005 confers physicians a higher standing role, and it considers informed consent (or, in Brazil, free and clarified) as expression of individual's right to self-determination, letting in the right of *not to be*.

This set of ethics and legal normative presumptions requires that, in Portugal, physician to respect the will of the sick or his legal representative, his moral values and religious beliefs, acknowledging this domination on his own life, exemplified by Jehovah Witnesses, as well as respect for his privacy, limiting intromission of others in the world of the individual under treatment. As the Portuguese legislation conceives, physician's intervention on the sick can be admitted only if the later requests it, either medical or surgical intervention, even if such decision causes risks for his life. However, naturally, these presumptions exclude eminent risk of death and suicide authorization. This model, with large clinical application in countries where bioethics has developed most and positive results related to respect dignity of the individual seems to legitimate almost exclusively the practice wanted by the sick, which can yield to incoherent situations both from moral standpoint and medical practice.

Patrão-Neves states that (...) *a doctrine centered in the hegemony of the principle of autonomy does not safeguard space for emergence of other indispensable values for mankind personal realization* (...) as also are those of health professional and his patient relationship, mainly in the thematic scope that other moral theories will develop [13]. In parallel, the classical patient-physician relationship has set during long years in paternalist model whose roots are based in Hippocratic medicine, been represented by the principle of beneficence as the support and privilege of medical virtue.

Respect for the principle of autonomy started to grant the sick the right to share with his physician the responsibility in clinical decision-making, overcoming physician's paternalist view in his relationship with the sick. For Callahan, quoted by Cascais [14], the *movement of autonomy* will have corresponded to the need to protect the vulnerable, empowering the competent, establishing a greater balance between the physician and the sick.

The development of biomedical and technological research, as well as application of biotechnologies to humankind on medical science mastering, allowed for transforming of fatal diseases into chronic, which also changed physician's classical paternalist relationship with his patient. This relational binomial toward which equally contributed scientific disseminations and public opinion got new characteristics, acceptance of informed consent (or free and clarified) by physician as corollary of autonomy, structural pillar of the sick person's dignity and his right to individual self realization. Thus, the principle of autonomy began to be generally attributed to the sick and beneficence to the physician, and that of justice nominated by third parties beyond stakeholders directly (sick person, physician or other health professional) – as exemplified from societies established to advocate the sick person's rights, whose activities and complaints exert notable influence in public opinion [15].

Despite claim of the sick person's autonomy been present in countries where bioethics tradition is common practice, physician's paternalism seems to remain institutionalized in Portugal, mostly in consultations to hospital services more demanded specializations, in which demand/supply ratio is unbalanced. These services, much demanded by people, of whom ophthalmology is an example, are revealed in those that education aspects, which clinical information should be covered, it is not always present.

Additionally, considering the social injustice gap that gets deeper in our society, where cultural, economic, and even linguistic differences resulting from growing migration in Portugal are a reality, practice of respect for autonomy becomes antagonic to beneficence itself, at times. It is capable, by itself alone, to influence ethical decisions that questions the issue of the human person's dignity, which shall be preserved as essential bioethics value. The hospital environment itself restricts understanding of medical

indications in majority of situations. The hospital, impersonal and limiting, surpress family members presence, who have evidenced to be capable to contribute for a better reception, by patients, of clinical communication /information, who significantly are elders and uneducated.

Technological development may equally set apart physician from his patient, also leading to establishing problems of justice in distributing economic resources for health, and lower accessibility for the less resourced sick person or with greater debility. The emerging of multidisciplinary teams allow for physician's dissolution of responsibility, limiting confidentiality, which may, ultimately, lead to dehumanization of the medical act itself, been justified, then, in these circumstances, physician's paternalism as a means to benefit patient.

Autonomy cannot be looked as *absolute* principle of bioethics application, forcing the necessity for reflection. However, rather, it should be looked as relative principle that tries to develop, considering the specificity of each case. We understand that autonomy is a relative principle, exerted as to contemplate the context of the situation at time of decision-making. Respect is associated to sick person's freedom and his decisions must be considered, if truly autonomous and free. Additionally, autonomy has the influence of personality in decision-making capability, both generically and depending to existence of associated, chronic or acute diseases, physical/psychic traumas, cultural or economic situation, but seen according to a perspective capable to face human being as independent of third party opinion.

Thus, anyone of us may feel the importance to exert some kind of self-determination about our health. Despite religious, and cultural influences or, even, a crippling pathology constitute constraints to autonomy, the truth is that each one of us, in any situation, follows the most diverse influences about our own behavior. Therefore, taking individual reality in account, autonomy should be understood, as a principle to be developed – and, as such, should be taken as a relative principle.

Rejection of the importance of the principle of autonomy in absolute terms may seem negation of human rights culture. It cannot be forgotten, however, beneficence model and traditional paternalism in situation when the sick, as moral agent, feels incapable to decide which the best for his health is, while indispensable that medical decision reflects on his best interest.

In its turn, in view of classic principlism, European thought also is set in different position, been markedly more humanist, aiming at fundamentally contributing for the common good and not as much to the individual. According to Patrão-Neves, Anglo-*American concern will be targeted to micro problems that affect individuals more,*

while in Western Europe macro problems, preferably, which affect relationships between people and communities where they are inserted, are assisted[16].

K. Danner Clouser and Bernard Gert, in *A critique of principialism*[17], presented major critics on this theory classical formulation, considering the four principles profoundly instrumental. They set ten rules on not doing bad, so bioethics stop been a purely normative code, and it should be governed by more creative forms of action, capable to overcome a mere pure and blind principialism. Compliant to such rules without violating the principle of autonomy would contribute to formation of a new health professional.

Use of principialism adapted to new realities serves, however, as guidance for criterious decisions, been a deontologic model in which existence of four moral principles to apply in medicine and health care domain backlashes contributing to promote health professionals and patients relationship [16]. Other pertinent argument faces inclusion of autonomy in patient-physician relationship as technical level factor, stating that *recognition of patient's autonomy is corollary of the paternalism crises* (...) *it is a simple technical level issue* [18].

The principle of autonomy expresses the fact that to solve moral conflicts in a secular and pluralist society, there must be agreement among participants in the conflicts. In medicine, this conflict between physician and the sick, with the objective to get his consent or refusal of attitudes proposed by physician, can only derive from this agreement designated as autonomy, which includes patient's express permission, consubstantial on informed consent (or free and clarified). However, physician's intervention on the sick, or, taking from a broader perspective, of the health professional on the sick, generally, cannot legitimate every medical practice wanted by the patient, as in regards to eminent risk of death, in view of which it is mandatory physician's attempt to preserve life. What should exist always is the search for a contextual decision, trying to respect patient's convictions from a beneficent, utilitarian, and ethical logic.

Our hospital experience in Lisbon led us to consider this place as privileged to make dilemmatic questions in bioethics filed, since glaucoma, one of major causes for blindness in the *so-called* civilized world[19], is a crippling pathology that challenges professional practice. If detected at early stage, it can be controlled partially, through therapies to which the sick must adhere. It is indispensable, in that sense, an adequate clarification, and this communication depends on the characteristics of patient-physician relations, in addition to the way this information is supplied – equally the issue about the truth to be transmitted is made here.

Resorting to ever more sophisticated complementary exams allow early diagnosis, which, however, seem to reduce patient to a

condition of object, target of a battery of analytic results. In this context, patient-physician relationship personalization reveals as important with adequate information so the understanding of necessity of such exams and adherence to therapeutics (among which includes the surgical intervention) are internalized by the sick person. This later, once informed and clarified, may consent to a surgical intervention targeted to preserve just a very restricted view.

But it is not enough to assume these rights as granted in the Portuguese Republic Constitution and in the *Chart of Rights and Duties of the Sick*, with legal repercussion in case of non-compliance, as prescribed in Article VIII: *the right to accept or to refuse consent*; in Article V: *the right to information*; and in Article VI: *the right to knowing about his health*[4]. It is necessary to know them and to assume them in the clinic practice. The congenital or juvenile glaucoma cases in elders and children overlay the issue related to respect for autonomy the vulnerability problem, of those incapable to assume fully the right to autonomy, which adds another perspective for reflection in bioethics field.

Method

The survey results presented in this study was undertaken to prepare a Master's degree dissertation in Bioethics at Lisbon Medical School Bioethics Center, Portugal. Targeting this objective, a cross-section study of representative sample of physicians who work in a tertiary level hospital, a public health institution in that city. Those 42 physicians that accepted participating were chosen randomly among universe of 80 professionals that comprise the ophthalmologic service of the institution, whose ages varied from 25-70 years old. Medical degree, taking part in a glaucoma consultation, and availability constituted inclusion criteria in the research. Data collection period lasted three months in 2004.

A quantitative type of assessment was undertaken, through questionnaire with ten questions, applied during a presence interview. The instrument created by the first author of this article, under guidance of the second and validated by two bioethics experts, master's degree coordinators, Professor dr. João Ribeiro da Silva, at the time director of Lisbon Medical School Bioethics Center, and Professor dr. Heloisa Santos, geneticist and master's degree professor in Bioethics in the same institution.

According to stated in norms in force in Portugal, it was requested authorization of each of the interviewed to use his information, assuring data anonymity and privacy. Participants were clarified on the objectives of the study, and invitation to participate was then invited. Additionally, written authorization was requested – and granted - from hospital management where the study was undertaken, as well as from the ophthalmology sector, in a document stating objectives and criteria that sample selection was based.

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Selected sample in glaucoma consultation was distributed in three groups according to age bracket: Group 1, from 25 to 39; Group 2, from 40 to 54; and Group 3, from 55 to 70 years old. Such stratification aimed at detecting differences of conceptions among professionals, considered in the study hypothesis as deriving from professional formation and from medical practices changes during the period comprising the age brackets.

The responses constituted the material of analysis, undertaken by descriptive and comparative analysis of all variable in the three groups, presenting the absolute and relative frequency for categories variables, the average, the mean value, the standard deviation, as well as maximum and minimum values for the numerical variable related to age. Data statistical treatment was done by the *Statistical Package for the Social Sciences* (SPSS) program, using Pearson's χ^2 (chi-square), which works the percentages and not the averages. To check existence of statistical differences between categories variables, 95% confidence intervals were computed for numerical variables (age) and ordinal (gender), and a descriptive statistical analysis related to them was made. A non-parametric statistical study was undertaken, considering sample distribution by age bracket, which did not comply with a normal curve.

Results

It was noted, from undertaken inquiries, normal distribution, with a balanced population based in random choice of the elements of the groups. In representation of the demographic characteristics of the sample there is, in Group 3, a predominance of the male gender, while in the two other groups there is a gender balance. Average ratio of ages per group was 30.7 years for Group I; 49.1 years for Group 2, and 60.7 years for Group 3. When comparing these three groups among themselves (χ^2), a significant statistic difference is found ($p<0.05$) with the non-parametric test undertaken (frequency in %), relative to the following questioning: 1) How do you receive a sick person after he hears the opinion [of another professional]?; 2) Attitude in clarifying the sick person; 3) How do you react in view of a therapeutic refusal?; did you have medical deotonology classes?

In the first set of responses, regarding question III ($p=0.029$), physicians belonging to Group I stated that a good receptiveness will depend on physician being informed or not. Those of Group 2, in opposition, received well this attitude, and those in Group 3 accept badly resorting to a second opinion, stating that despite acceptance of the sick person, they considered that there was a breach in confidence by searching a second professional opinion about the health problem. The second set of responses relates to question VII ($p=0.030$), that is, attitude in clarifying the sick person. Such attitude, for Group 1, is part of a working method as any other; for Group 2 is essentially an issue of respect for the sick person; Group 3 faces this procedure is as matter of politeness.

Table 1. Group 1 – Attitude on clarifying sick person on patient-phydician relationship

Validity	Frequence	%	Percentage validity	Accrued Percentage
It is an issue of respect and care for the sick person	2	14.3	14.3	14.3
It is a working method as any medical act	11	78.6	78.6	92.9
All above	1	7.1	7.1	100.0
Total	**14**	**100.0**	**100.0**	

Table 2. Group 2 – Attitude on clarifying sick person on patient-phydician relationship

Validity	Frequence	%	Validade percentual	Percentual cumulativo
It is part of physician's character	1	6.7	6.7	6.7
It is an issue of respect and care for the sick person	4	26.7	26.7	33.3
It is a working method as any medical act	6	40.0	40.0	73.3
All above	3	20.0	20.0	93.3
First two hypothesis	1	6.7	6.7	100.0
Total	**15**	**100.0**	**100.0**	

Table 3. Group 3 – Attitude on clarifying sick person on patient-phydician relationship

Validity	Frequence	%	Percentage validity	Percentage acrued
It is part of physician's character	3	23.1	23.1	23.1
It is a politeness issue	2	15.4	15.4	38.5
It is an issue of respect and care for the sick person	1	7.7	7.7	46.2
It is a working method as any medical act	3	23.1	23.1	69.2
All above	1	7.7	7.7	76.9
First two hypothesis	3	23.1	23.1	100.0
Total	**13**	**100.0**	**100.0**	

Concerning question VIII (p=0.005), it deals on how physician reacts in face of patient's refusal to therapeutics, Group 1 clarifies on the risks of refusal; Group 2 reacts well, but clarifies on the risks of refusal; and Group reacts badly and tries to convince patient to comply with medical indications.

Table 4 Group 1– How do you react to patient's refusal to therapeutics?

Validity	Frequence	%	Percentage validity	Accrued percentage
Well	4	28.6	28.6	28.6
Try to convince him that it is wrong and that he should obbey the physician	3	21.4	21.4	50.0
Clarify him on the risks of refusal	7	50.0	50.0	100.0
	14	**100.0**	**100.0**	

Table 5 Group 2 – How do you react to patient's refuse to therapeutics?

Validity	Frequence	%	Percentage validity	Accrued percentage
Well	6	40.0	40.0	40.0
Badly, rejects seen him	2	13.3	13.3	53.3
Try to convince him that it is wrong and that he should obbey the physician	2	13.3	13.3	66.7
Clarify him on the risks of refusal	5	33.3	33.3	100.0
Total	**15**	**100.0**	**100.0**	

Tabela 6. Grupo 3 – How do you react to patient's refuse to therapeutics?

Validity	Frequence	%	Percentage validity	Accrued percentage
Well	1	7,7	7,7	7,7
Badly, rejects seen him	7	53,8	53,8	61,5
Try convincing him that he is wrong and should obbey the physician	4	30,8	30,8	92,3
Consider him as autonomous and owner of decision	1	7,7	7,7	100,0
Total	**13**	**100,0**	**100,0**	

Finally, a statistically significant difference is found in question IX (p=0.013): Group 1 states to have attended bioethics and medical deontology classes in their formation in medical school; Group 2 states not having attended or had contacts with mentioned classes, but rather in debates on topics related to patient-physician relationship; and Group 3 states not having deontology, although had contact with the topic at legal medicine classes. Comparison between groups provide statistically significant difference between groups 1 and 3, that is, respectively, with physician up to 39 years old and with those over 55 years old (p<0.05), related to the following questions: Va- How informed consent should be done?; Vb- Why to sign the document?; VII- Attitude in clarifying the sick person; VIII- How do you react to therapeutic refusal?; IX-Did you attend medical deontology classes?

Regarding question Va (p=0.034), physicians in Group 1 consider that document targeted to getting patient's consent should include a *complete information*, as most complete as possible, including all complications that may derive, while Group 3 chose *verbal agreement* as selected option. Concerning question Vb (p=0.025), referring to reason for signing the document, the response that in percentage terms got higher number of results took place in Group 1, the *defensive medicine*, immediately followed by *to safeguard both parties*, while in Group 3, *mere formality* and *for been more correct* dominated

Table 7. Group 1 –Why should the patient sign a document?

Validity	Frequence	%	Percentage validity	Accrued percentage
Mere formality	2	14.3	14.3	14.3
Defensive medicine and technician protection	5	35.7	35.7	50.0
To safeguard both parties	7	50.0	50.0	100.0
Total	**14**	**100.0**	**100.0**	

Tabela 8. Group 3 – Why should the patient sign a document?

Validity	Frequence	%	Percentage validity	Accrued percentage
Mere formality	5	38.5	38.5	38.5
It is more correct	4	30.8	30.8	69.2
Defensive medicine and technician protection	2	15.4	15.4	84.6
To safeguard both parties	2	15.4	15.4	100.0
Total	**13**	**100.0**	**100.0**	

Regarding question VII (p=0.024), there was Manifested adhesion in Group 1 to response that considers attitude to clarify patient as a praxis professional methodolgy, while Group 3 considered as manifestation of politeness or related to physician's character. In reply to question VIII (p=0.002), physicians clarify patient protocolarly on risks of therapeutics refusal. However, physicians in Group 3 accepted badly the same attitude by patients.

Medical deontology classes, related to question IX (p=0.012), were a constant among physicians in Group 1, contrarily to Group 3, who did not have it or just attended them in specific disciplines – such as legal medicine, for example. Group 2 seems, thus, to be between the other two. However, there is, beyond statistically significant results in comparing all three groups, some items, which we consider worth noting, and may be an indicative feature.

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The way physician informs patient on his clinical status (question IV) did not show any statistically significant results between Group 1 and the other two. In the analysis of graphic distribution of responses, it is possible to evidence an inversion in chosen options like *informal choice* type among younger physicians, non-existent in Group 3. There is, in Group 2, greater percentage of responses in which physician presents the proposal that he finds suitable, discussing it with the patient and looking for the best solution – who decides. Concerning this question, groups 1 and 2 presented inversion in responses 1 and 6; in Group 1, option '*informal choice* attitude' (response 6) increases percentile, but responses 1 and 2 are scarce in Group 2, which presents higher percentage with therapeutic proposal made by physician (response 5) and jointly discussed with patient, who ultimately decides. We believe that in broader hypothetical sample statistically significant results could be gotten related to this item.

Table 9. Group 1 – How do you inform patient in face of a clinical situation?

Validity	Frequence	%	Percentage validity	Accrued percentage
Briefly	1	7,1	7,1	7,1
Just the indispensable	2	14,3	14,3	21,4
Propose therapeutics, in-forms, discusses, and patient decides	7	50,0	50,0	71,4
Informal choice attitude	4	28,6	28,6	100,0
Total	**14**	**100,0**	**100,0**	

Table 10. Group 2 – How do you inform patient in face of a clinical situation?

Validity	Frequence	%	Percentage validity	Percentage accrued
Briefly	2	13.3	13.3	13.3
Just the indispensable	3	20.0	20.0	33.3
Propose therapeutics, in-forms, discusses, and patient decides	9	60.0	60.0	93.3
Informal choice attitude	1	6.7	6.7	100.0
Total	**15**	**100.0**	**100.0**	

Table 11. Group 3 – How do you inform patient in face of a clinical situation?

Validity	Frequence	%	Percentage validity	Accrued percentage
Briefly	4	30.8	30.8	30.8
Just the indispensable	2	15.4	15.4	46.2
Propose therapeutics, in-forms, discusses, and patient decides	7	53.8	53.8	100.0
Informal choice attitude	0	0	0	100.0
Total	**13**	**100.0**	**100.0**	

Discussion

Bioethics expansion is able to encompass modern societies most characteristic ethical dilemmas, among which include those of medical forum. Former Hippocratic ethics in which is the physician who knows was replaced by other conceptions, attitudes, or norms, with more and different principles, capable to provide a start to modern bioethics. Combination of media attention and public interest also turned bioethics into discipline for politics, which feels forced to set statutes to protect the sick and his rights. Contemporary bioethics follows medical profession evolution for generations – period in which physician always faced Issues related to *what is good* for the patient. Given questionings raised by new diagnostics technologies and modern therapeutic interventions, currently these questioning may threaten confidence in patient-physician relationship.

The results from this study reinforce the idea that physicians' attitudes followed equal evolution. Within the scope of ophthalmology, we choose a sector of medical activity of greater vulnerability, like glaucoma, a disease socially seen as stigma. We found that in all three groups of researched physicians evidences of different ways to face

glaucomatosis patient's autonomy, comprising three distinct socioprofessional sets.

Currently, with all economic pressures on institutions, physicians are aware of patients' expectations and the difficulties to practice medicine ethically. Large portion of contemporary bioethics derived from examples with legal implications and, thus, it is necessary to understand bioethics legal framing, since medical ignorance takes to courts some of the medical decisions. A new culture in the development of clinic relationship, requiring more respect toward people's rights to their autonomy, inscribes in medical class current behavior, consubstantiate in assuming informed consent (or free and clarified) as the guarantor symbol of patient's moral autonomy. However, even though, respect for the principle of autonomy is not exempt of difficulties.

A new field of bioethics reflection and action will try to answer these difficulties, while this document constitutes in appreciation of sensibilities. We see the results as an echography of attitudes and social personality of each of studied groups, as statistically evidenced. Ethics evolutions reflects in all three evaluated physicians age brackets, a variable that allows comparing three ages and groups of men and women, with differentiated formation and influences, translated into a profile in responses provided.

In Group 1, the acting model type of *independent choice* dominates where physician's role implies in explaining patient with all facts and alternative in exempt fashion, acting in accordance to his decisions: patient's clarification is a *working method*.

Enhanced autonomy [20] includes Group 2 physicians, where patient-physician dialogue is encouraged, as well as exchanging ideas and knowledge. There is not standard attitude, but case-to-case adequacy toward patient's expectations: *clarification* of patient act has the role of respect for the patient, fostering guidance and management of eventual disagreement. It favors the right to a second opinion.

Group 3 professionals, in view of the right to information, request another opinion, therapeutic refusal, and informed consent (or fee and clarified), reveal fragility, expressing a hierarchic predominance between physician and patient: *clarification to patient act* depends on technician's character, who clarifies the essential as a matter of courtesy. This *paternalist information* centered in physician, granting him the role of patient's health guardian, who can provide him with all information judged as necessary.

Final considerations

Some reflections remain from the exposed**:** the principle of autonomy, today, overlays traditional physician paternalism, whose virtualities are recognized anew, after been

considered almost as a moral anathema.
It means independence in relation to external control and acting according own choice. The respect for the principle of autonomy is a reality in current medical practice, deriving from respect for human dignity doctrine, which refuses use of humankind as simply a means.

To achieve the target of possible autonomy it is necessary communication between physicians from different pedagogical and cognitive background, as with the symbiosis of several conceptions and ways of understanding will result, fortunately, true ethics praxis. We suggest a broad debate for normative definition of medical professionalism, where all participate supported by their specific knowledge, so economic and political interests do not overlay ethical medical practice, improving, thus, ethical ambience in institutions. We remind in relation to inclusion that philosophic contributions to ethical reflection are based in the *Universal Declaration of Human Rights* principles, translated in every language in the world, and in dispersed columns in a street in Nuremberg, jointly to remind us that such principles resulting from human rights advocacy shall become integral part of human being basic culture.

Resumen

Actitud médica y autonomía del patiente vulnerable

Este artículo presenta los resultados de la búsqueda involucrando la muestra de 42 médicos del sector de oftalmología de un hospital terciario en Portugal. Se realizaron cuestionarios con 10 preguntas, destinado a evaluar las actitudes de tres grupos de médicos de edades y formaciones pedagógicas diferentes, en relación a la autonomía del patiente glaucomatoso. Los resultados fueron analizados indicando la correlación descriptiva a través del test de Pearson χ^2. Se aprecian tres actitudes diferentes con significado estadístico (valor de $p < 0,05$), considerando así la existencia de tres personalidades médicas, correspondientes al grupo etario. La formalización de la práctica médica a medida que la edad disminuye (medicina defensiva), caracterizando al grupo 1. El respeto por el enfermo dominó en el grupo 2. Ha prevalecido en el grupo tres la tendencia para la medicina paternalista, dónde las informaciones al patiente son resultado de la educación y el carácter del médico. Concluyendo, la conducta de los médicos evidencia el momento en que iniciaron y desarrollaron su profesión, la cultura médica y su formación en bioética.

Palabras-clave: Autonomía profesional. Autonomía personal. Bioética. Oftalmología. Glaucoma.

Abstract

Medicalattitude and vulnerable patient's autonomy

This article presents the results of a research done involving samples of 42 doctors from an ophthalmology´s service of a tertiary Hospital in Portugal. An inquiry with ten questions was applied, in order to evaluate three groups of doctors with different ages and pedagogical background, regarding the autonomy of the patient with glaucoma. The informatization was analyzed indicating the descriptive correlation, using the test of Pearson χ^2. The results show three different medical attitudes, with different statistical meaning (value of $p<0,05$), allowing to consider the existence of three doctor's patterns, regarding their age group. The formalization of medical practices at younger age (defensive medicine) characterized the first Group. The respect for the patient is a characteristic of the second Group. Paternalist medicine remains evident in the third Group, where the elucidation depends of the doctor's education and character. It conclude that the attitude of the doctors is influenced by the time they started and developed their medical activity, the predominant medical's culture and the bioethics' information.

Key words: Professional autonomy. Personal autonomy. Bioethics. Ophthalmology. Glaucoma.

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