The exercise of autonomy for the elderly in medical treatment

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Abstract

The research was carried out aiming at knowing the elders' opinion on the exercise of their autonomy when they are under medical treatment. It approached from the desire or lack of it in knowing the several diagnosis, prognosis and treatment stages, until those responsible for decision-making in the physician-patient relationship. The interview was held with 112 elders, representing 77% of the participants in a physical activity program for aging at the Federal University of Amazonas. The result showed that the elderly want to be informed about their diagnosis (96%), prognosis (95%) and treatment (98%). Most people (92%) think that decisions should be made jointly by physicians and patents. In case of transfer of autonomy, the son or daughter (70%) was considered the most suitable. The survey has shown that elders wish to exercise their autonomy in all phases of medical treatment.

Key words: Bioethics. Personal autonomy. Health of the elderly.

Resumo

O exercício da autonomia do idoso em tratamento médico

A pesquisa foi realizada com o objetivo de conhecer a opinião dos idosos sobre o exercício de sua autonomia quando em tratamento médico. Abordou desde o desejo ou não de conhecer as diversas etapas do diagnóstico, prognóstico e tratamento até os responsáveis pelas decisões na relação médico-paciente. A entrevista foi realizada com 112 idosos, o que representa 77% do total de participantes de um programa de atividades físicas para o envelhecimento desenvolvido pela Universidade Federal do Amazonas (Ufam). 0 resultado mostrou que os idosos desejam ser esclarecidos sobre seu diagnóstico (96%), prognóstico (95%) e tratamento (98%). A maioria (92%) acha que as decisões devem ser tomadas pelo médico e o paciente em comum acordo. No caso de repasse de autonomia, o filho ou a filha (70%) foram considerados os mais indicados. A pesquisa mostrou que os idosos desejam exercer sua autonomia em todas as fases do tratamento.

Palavras-chave: Bioética. Autonomia pessoal. Saúde do idoso.

Resumen

El ejercicio de la autonomía del anciano en el tratamiento medico

La investigación fue llevada a cabo con el objetivo de conocer la opinión de los ancianos sobre el ejercicio de su autonomía cuando sometidos a tratamiento médico. Abordé desde el deseo o no de conocer las diversas etapas del diagnostico, pronóstico y tratamiento hasta los responsables por las decisiones en la relación médico-paciente. La entrevista fue llevada a cabo con 112 ancianos, lo cual representa el 77% del total de participantes de un programa de actividades físicas para el envejecimiento desarrollado por la Universidad Federal del Amazonas (UFAM). El resultado demostré que los ancianos desean estar enterados acerca de su diagnóstico (el 96%), Pronóstico (el 95%) y tratamiento (el 98%). La mayoría (el 92%) piensan que las decisiones deben ser tomadas por el medico y el paciente en común acuerdo. En el caso de repase de la autonomía, el hijo o la hija (el 70%) fueron considerados los más indicados. La investigación demostré que los ancianos desean ejercer su autonomía en todas las etapas del tratamiento medico.

Palabras-clave: Bioética. Autonomía personal. Salud del anciano.

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This research intends to stimulate reflection about the exercise of autonomy for the elderly and dividing responsibility in the treatment, having as an objective the physician's performance in their job of preserving life not interfere or contradict the patient's values and beliefs. The line that delimits the exercise of the elder's autonomy and when does it become necessary to make interventions aiming to give quality of life to the years they have been living is very thin, and makes the process an anguish and full of dilemmas.

To bring the ill back to health one needs compromise from the involved parts. The physician needs to exercise judgment, to use scientific knowledge and technology in the means of diagnosis and therapy; the patient needs to exercise a receiving posture of willingness to recover, and also be willing to let go of a few comforts that may be necessary to reach the proposed goal.

In the case of elderly patients, it is difficult to establish this autonomy. Sometimes, they do not present apt mental faculties to make decisions. There are times when they want to participate, because they are sure their lives are at risk. There are situations that, feeling powerless and weakened by the disease, they prefer the family or a specific family member to make the decisions for them. Still, there are those who prefer the physician to decide, putting on the professional the weight of the responsibility of succeeding or not. The family, in its turn, most of the times does not know how to decide. Frequently, they approach the physician to know about the health problems of the elder and ask the professional not to tell them, claiming knowing about their health situation might cause damages to their emotional state.

Searching to outline patterns to guide physicians through these dilemmatic situations, the present research intended to know the elderly's opinion about their participation on the decisions, concerning their own medical treatment, considering a moment in life where their health was good. Such condition was attested by participating in a physical activity program, guided for the old age, having the objective of stimulating physical autonomy and social life of the elderly.

Involved Principles: principialism

The use of beneficence and benevolence as if they had the same meaning is frequent; however, that is not true. The principle of beneficence, in the philosophical and moral sense, means to do good. Benevolence promotes men's interest and seeks happiness for the society.

Benevolence is an emotional disposition, aiming to do good to others. It is a good quality of character, a virtue. A disposition to act the right way. It is considered that, in general, all human beings have it. Therefore, humans would have a natural principle of benevolence or the search for and achievement of good to others, the same way they are bound to care about their own lives, health and personal wealth.

To Beauchamp and Childress, beneficence is the obligation to avoid or remove damages and to promote what is good. Medicine, as a human activity, operates under the auspices of beneficence. The objective of all therapeutic acts, all decisions is to provide efficient assistance to

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an ill person. According to the Belmont report, beneficence has a double obligation, first, damages must not becaused, and second, maximizing the benefits, minimizing the losses. Thus, the concept of beneficence imposes the moral obligation of acting in benefit of the other, as relating to actions such as protecting and defending other people's rights, helping disabled people, collaborating to keep away dangers that threaten other people, etc.

The principle of the non-maleficence, according to Beauchamp and Childress, is the obligation of not causing damages. In the Hippocratic tradition, there is the principle of help, or, at least do no harm. Sometimes, the practice of medicine may cause damages due to a bigger benefit. The pain or damage caused to a human being could only be justified by the health professional in the cases where the first person to benefit is the patient. The family, other patients and society as a whole must take second place.

The principle of justice requires that benefits, risks and costs be equally provided among the parts involved in the process. This principle is related to the care and protection of people with weakened capacities, in a broader sense, the social layers excluded from education, from the unrestricted access to health, to housing and to political participation.

The principle of autonomy derives from the definition of the word itself, the term was derived from the Greek *auto* (own) and *nomos* (law, rule). This means auto-determination of the person to make decisions that affect their lives, health, physic-psychological integrity and social relations. It is referred to the capacity human beings to make choices over what is good or over what is their wellbeing. The person is autonomous when they are free from internal or external coercions, to choose from the options presented them.

To reach this situation, it is necessary for an alternative of action to exist, or that its creation to be possible: *There is no exercise of autonomy when there is only one path*. When there is no freedom of thought or choices, when there is only one alternative, or yet, when there is no freedom to act according to the alternative or option desired, the action taken cannot be considered autonomous. Autonomy is a principle of moral freedom, which attributes to all human beings the condition of moral agent, and as such, must be respected by all that keep distinct moral options.

Autonomy implies, therefore, that no moral may be imposed to human beings against their conscience. From this, one can realize that full autonomy is an ideal. Practically, the human being is always restricted by society rules, religious influences and other behavioral conditioners. In purely physical terms, the human beings are born dependent and become autonomous by the contribution of biological, psychological and sociocultural variables.

However, even having reached autonomy in many aspects of life, a person may act as non-autonomous in certain situations. Physical alterations, emotional and psychological disorders may compromise the appreciation and rationality of choices made. So, in some of those situations, the evaluation of free manifestation of decision is so hard and resonates with so many bioethical questions discussed in the area of health. When autonomy is reduced, it is up to third parties, family members or even health pro-

fessionals to decide for the non-autonomous person.

The concept of autonomy has intimate connection with the concept of competence. The judgment of competence-incompetence of a person must be evaluated and each decision guided in particular and not all decisions of their lives at once. It is not common to question the patient's competence to decide when their decision in accordance with the physician's. However, all patients must be judged competent until their incompetence is proven, a situation in which their autonomy is reduced. Legally, one can assume that an adult is competent until the Judiciary considers him incompetent and restricts his civil rights.

Due to lack of resources, the socio-economically vulnerable groups have fewer alternatives to choose from in their lives, which contribute for their lives not to fully develop their autonomy potential. Yet, they must be seen and respected as autonomous, considering the restricted context of choice possibilities. During treatment, physicians cannot decide for them under the allegation that they are not capable of understanding or giving options among which to choose.

So, prioritizing the exercise of autonomy does not mean to follow individualism, as humans live in a society and ethics is a way to rule the relations between people in order to ensure social cohesion and harmonize social and collective interests.

The physician-patient relationship

The physician-patient relationship is a determinant for the success of the medical treatment. In 1972, Veatch proposed four models of physician-patient relationship: the priest-like, the engineer, the collegiate, and the contractor, each of them may be associated to a specific level of patient's autonomy. The priest-like model is characterized by the fact that the physician may take a paternalist posture concerning the patient, in the name of beneficence. The decision made in the care does not take into consideration the patient's desires, beliefs or opinions. Physicians not only exert their authority, but also the power in the physician-patient relationship, taking away the patient's possibility to perform their autonomy.

The engineer model, on the contrary, is characterized by the power of decision to be centered in the patient's hands. The physician preserves his authority, but gives up part of his power, because they give clinical information to the patient and executes the actions that he proposes, granting them unrestricted autonomy in the possible therapy.

In the last two models of physician-patient relationship, the power of both is more balanced, entitling the patient to exercise his personal autonomy. The collegiate model is characterized by the decision power shared equally between physician and patient. The contracting model, by preserving medical authority, as the holder of specific skills, assumes the technical decisions. The patient participates actively of the decision making, exercising his power of choice, concerning the treatment according to his life style, moral and personal values.

The principle of the autonomy in the physician-patient relationship that characterizes three of the presented models, proposes that the physician should ponder that they should only manipulate, put on drugs, prescribe and conduct

his patients if they are apt, aware and accept such procedures and attitudes. This idea makes physician and patient develop a dialogue seeking understanding, makes them capable of promoting a respectful and acceptable professional relationship under technical, social, and ethical points of view. However, in current medical practice, what is observed is that ill people are still induced to lose the right over their own bodies, the right to live, to be sick, to heal and to die as they wish; that is, they lose the right to autonomy.

The belief in science tends to make physicians assume a position of omnipotence toward illness and the patient, who starts to be under his tutelage in an unconditional way. The patients start to be seen as a bunch of organs that must be fixed, according to the scientific precepts. This belief in the scientific truth makes the physician believe that they have the right to invade the autonomy of the subject to impose on them their truth. It serves as an alibi for the exercise of power over the patient. This power is performed as direct, necessary and inevitable; however, it is not right or necessary, quite the opposite: it is a factor that contributes to the lack of success of a treatment, at least in the psychological area, which may lead the patient to somatize.

Therefore, defending the autonomy in the physician-patient relationship is not to propose an inversion in the current relation, but to recognize that both subjects have voice and space in the process, with respect to the differences of values and expectations of each. It must be recognized that the subject of the therapeutic process is the sick person. Medicine, technology, physicians and other professionals must put themselves as means, instruments that may and should be used by the sick in the process of health-illness.

The information and the free and clarified consent are considered in many western countries as fundamental moral concepts for a medical practice with balanced power and respectful about the principle of patient's autonomy, because their satisfaction is related to the quantity of information received and their participation in the treatment. Often, there is no information about the diagnosis and the prognosis, justified as a way to protect the patient. Along with that, there are cultural differences in the way of facing illness and the expectation related to the physician's role.

Therefore, it is necessary to reflect about the principle of autonomy in the physician-patient relationship, especially in the assistance to the elderly patient, so the involved parts feel valued and respected in their dignities.

Method

A descriptive study, of transversal cut was carried out with the elderly enrolled in the "Happy Elders Always Participate" program, at the Third Age University, which was developed in the Physical Education and Physiotherapy school at the Federal University of Amazonas (UFAM) in Manaus, Brazil.

This physical activities program, oriented to the ageing, has existed for 18 years and integrates the university extension programs. It works from Monday through Thursday, during the afternoon, in their premises, the UFAM campus. Among the many physical activities performed by the elderly, the following may be mentioned: hydro-gymnastics, swimming, choreographed dancing and walking.

Data collection took place during November and December 2010. From the 145 subscribed for the

activities, 112 elders (77%) participated in the research. The research was performed through a patterned questionnaire (attached), previously tested in 10 elders, to make necessary adjustments.

Results and discussion

Sample characterization

One hundred and twelve elderly were interviewed: 96 (85.7%) women and 16 (14.3%) men. As for the age group, 72 (64.3%) were between 60 and 69 years old; 32 (28.6%) were between 70 and 79 years old, and 8 (7.1%) were over 80 years old on.

In general, women's participation in elderly projects is very common. This fact may occur due to higher female longevity or because they are used to taking care of themselves and their health during their whole lives. Since the end of adolescence, they are driven to regularly attend health services, in preventive actions and therapies conditioned by their reproductive history, to participate in family planning programs, pre-natal, as well as those related to baby caring, during their first year of life, vaccination and breast feeding.

Women also turn to health services by occasions of giving birth, abortion, miscarriages, menstrual problems or menopause, for preventive cervical and breast cancer exams, as well as for hormone reposition therapy or the use of birth-control methods, among other many services and programs destined at the integral care of the female part of the population.

The little participation of the male public may be justified by the lack of normality and acceptance that men face the ageing and its limitations. Ageing is getting closer to the characteristics only socially attributed to women, such as being fragile, recognizing the dependence and experiencing care. Old age redefines the individual and this redefinition of the social role is so much more intense if elder men have built their history distant from the female social roles or those of the impaired. Additionally, along their lives, men attend less the health care services, greatly restricting their trip to the doctor only in cases of accidents or circumstantial aggravations. As a consequence, it is usual that, when they use those services, they already present some kind of illness with some degree of seriousness.

In relation to schooling, the distribution showed that 60 elders (44.6%) had less than 10 years of study and 62 (55.3%) had 10 years or more.

The biggest percentage found was from 1 to 12 years of study, with 37 cases (33%), what indicates that elders have gone through fundamental school and stopped studying in high school (table 1). Two cases of illiteracy were found (1.8%), which currently is less frequent among this population that did not have easy access to schools during childhood or young age, but was after that, contemplated with popular projects of education for the young and adults.

Table 1. Schooling distribution

Years of study	Nº	%
0 (illiterate)	2	1.8
1-3 years	22	19.6
4-6 years	17	15.2
7-9 years	9	8.0
10-12 years	37	33.0
>13 years	25	22.3
Total	**112**	**100**

About marital status, the biggest percentage was of married, with 46 elders (41%), followed by widowed, 39 cases (34.8%). Eleven

single elders were found (9.8%) and 16 (14.3%) were divorced.

The exercise of autonomy in medical treatment

Most of them (96.4%) want to have information about their diagnosis (table 2). The manifestation of this willingness by the interviewed reveals itself comparable to the Medical Ethics Code (CEM), that in Article 34 foresees: *the physician must providing the patient the diagnosis, prognostics, risks and objectives of the treatment, unless when direct communication may cause damage, and in this case, the physician must report to the patient's legal representative*.

The bioethics literature also points to the need of respecting the patient's autonomy, indicating that the informed consent is a prerequisite for the realization of the medical treatment and that its obtaining must be preceded by accessible quality information: *any medical intervention (preventive, diagnostic or therapeutic) must only be carried out with previous, free and clarified consent of the person involved, based on the information given and adequate to their comprehension*. One can understand, therefore, that the interviewees agree with the idea that the respect to the autonomy and dignity are ethical imperatives and not favors that the professional may or may not grant. No one is subject to anybody's autonomy.

Table 2. Desire to have information about their diagnosis

Options	Nº	%
Yes	108	96.4
No	4	3.6
Does not know	0	0
Total	**112**	**100**

They must listen to their patient and family members with patience and self-restraining, knowing that those act thinking about the best for the patient.

Because of this, it is fundamental for the physician to be aware of the signals from the patient, aiming to capture how much autonomy or paternalism they wish to get in front of the diagnosis, not causing them more damage than the disease already has. Many patients wish to solve personal problems or have projects they would like to finish and no one may deny them this right. Others prefer not to know the seriousness of their condition, and it is a right to be granted as well.

Table 3. Desire to know about the diagnosis, even if serious or terminal condition

Aternatives	No	%
Yes	105	93,8
No	7	6,2
Don't know	0	0
Total	112	100

When questioned about the possibility of the diagnosis being a serious or terminal condition, most of them (93.8%) still preferred to know the opinion of the professional (table 3). Such answer is backed by CEM as well, in Article 32, that forbids the physician from not using all available means of diagnosis and treatment, scientifically recognized, and within reach, to favor the patient. Searching this objective, it is necessary to consider that the physician should not have closed opinions, such as lying or telling the truth.

Concerning the desire to obtain information about the treatment which they will undergo, 98.2% stated they would like to know (table 4). Note that it is forbidden for the physician *to disrespect the right of the patient and his legal representative over the execution of diagnostic or therapeutic practices, save in cases where there is imminent risk of death*. (article 31 of CEM).

Table 4. Desire to be informed about treatment

Alternatives	No	%
Yes	110	98,2
No	2	1,8
Don't know	0	0
Total	112	100

The elders informed that they wish to know about the prognosis of their health problems in 94.6% of the cases (table 5). The Bill of Rights and Duties of the Ill, effective in Portugal, states that the *ill have the right to be informed about their health situation. The communication must be clear, taking into account the personality, instruction degree and clinical and psychological conditions*. It adds as well that *the information must contain elements of the diagnosis prognostics and treatment, eventual risks and alternative treatments*.

The individual is sovereign over himself, his body and mind. Therefore, the physician's omission of any information to the elderly patient about the treatment is not justifiable, since the professional holds the scientific and technological knowledge related to his area, but the patient is a human being, whose dignity must always be preserved. The principle of autonomy or consent is the recognition that the secular moral authority derives from the consent of the involved in a common project.

Table 5. Desire to be informed about prognostics

Options	Nº	%
Yes	106	94.6
No	6	5.4
Don't know	0	0
Total	**112**	**100**

When questioned about which one should be responsible for the decisions of treatment, 92% said it should be the elder and physician, in common agreement. There were, still elders who preferred that the decisions be made by the family and the physician (3.5%). Some of them chose the decision power to be held only by the physician (2.7%) and, in 1.8% of the cases, they wished that decisions be made by common agreement with the physician, the elderly patient, and the family (table 6).

Each man judges well the things they know, and for those matters he a good judge. We choose what we know to be best, as far as we know. The choice requires a rational principle. Its own name seems to suggest that it is that of what is elected preferably over other things. The elderly clearly manifested their wish to exercise their autonomy in the treatment, sharing with the physician the responsibility for the decisions (92%). Only the least of them (2.7%) still accepts paternalism of the medical conducts of the past, when the physician decided alone.

Table 6. Responsible for the decisions about medical treatment

Options	Nº	%
Physician	3	2.7
Elder patient	0	0
Family and medic	4	3.5
Physician and elder patient	103	92.0
Physician, elder patient and family	2	1.8
Total	**112**	**100**

Results on the transfer of autonomy

In the case of the elders being unable to make the choices about the many steps of their treatment, preferences of to whom they would like to transfer their autonomy were their children (69.6%), spouse (14.3%), sibling (6.2%), physician and friend had the same percentage, (3.6%), family as a whole (1.8%), and nephew/niece (0.9%) (table 7).

The elder must have their autonomy preserved. Their convictions must be respected. Their participation, many times, is restricted by their own family. Even in situations of temporary or definitive impairment, they may preserve their wishes or treatment restrictions. The early decision making and the search for an attorney may be the way. This makes the medical team work easier, since it avoids the dispute and divergent decision making, made by different members of the family.

Table 7. Responsible for the decision making in case of transferred autonomy.

Responsible	Nº	%
Physician	4	3,6
Family	2	1,8
Spouse	16	14,3
Children	78	69,6
Friend	4	3,6
Nephew/niece	1	0,9
Sibling	7	6,2
Total	**112**	**100**

The attorney chosen by the elder acts as his interlocutor, and is considered the person who can best defend their interests.

General Considerations

The research showed that elders, who were part and always participated of the Happy Elders Always Participate program, are well aware of their rights. They wish to have their autonomy in the medical treatment and clearly express that, independently of being patients, they are humans, with values, beliefs, and life experiences that cannot be put aside. However, data does not show that they intend to override the physician figure in the physician-patient relationship, but to find a dignifying role in the conduction of actions that care about their own lives.

It is clear that they consider important family participation, but, as long as they are capable of deciding, they want to do it, in a partnership with the physician, who, they hope, can clarify the many conducts necessary to the case, as well as the decisions that must be taken in common agreement.

Elders seemed to fear being deceived about the information concerning their health, and said that, in case of a serious or terminal condition, the fact of knowing the truth would favor the preparation for the end in several ways: emotional (asking for or granting forgiveness and saying goodbye to their loved ones), material (dividing assets and documents), and spiritual (religion).

The interview was carried out with the alternatives from the data collection questionnaire, so the elder's speech would not suffer any influence or induction from previous knowledge. Only after the answer was normally commented by the elder, the alternative was marked. With that, it was possible to observe that the word family does not represent the favorite choice. It seems that if a decision was made by the family, a consensus would be dif-

ficult, there would be even more division than the existent, with absent, uninterested spouses and children, or in litigation with the elder. Thus, the decision might not be according to the preference of the elder himself. That being, previously declaring the responsible for making decisions in their place, brings the certainty that the choice will be over a family member with much affinity, and that will respect their preferences.

A curiosity arisen by the research is that the member chosen to make the decisions in the treatment when the elder is not able anymore usually is the son or daughter, including the married elders who live with their spouse. Only interviewees without any children chose the physician, nephew, niece, or friends for the decision making.

In the moment of the interview, it was possible to notice, by the evolving of the conversation, a few contributions that complemented the research. About the family, the elders were clear about the importance that it has in their lives, but they made sure to inform that there are special members within this group, with whom they have bigger trust for the help to follow the treatment. Usually, it is a member from the health area, communicative and dynamic to dislocate behind the health team, aiming to obtain information and clarify doubts, and that in a past situation, has already accompanied another family member. This choice seems to be motivated by affinity, falling, most of the times, over someone who knows the elder well and respects their preferences and thus, is capable to make the decision closer to theirs. Criteria based on gender, age or birth order (in case of children), have not been observed.

Many elders complemented the interviews with interesting testimonials. Some of them said they go alone to their appointments, so the physician will tell them everything directly.

Others said they take a companion, but just to help clarify their doubts. There were still those who complained about their companion and physician who excluded them and kept them from participating in the appointment. There were cases in which physician asked the elder to bring a family member to keep them company during the consultation, which was interpreted as an indicator of the seriousness of the case. An elder, before undergoing surgery, secretly gave her granddaughter a diary containing her recommendations, in case any complications might take place, which looked to the researchers as an idea of an inceptive vital will.

The things discovered during this work also confirm that the new CEM coincided with the demands, currently imposed by the society, that expects, based on the physician's conduct, a partner who dominates the scientific knowledge and the new technologies, but conducts them in a humanized way, respecting the patient's autonomy, that, even made fragile by the illness, still has values and beliefs that must be taken into account because of the dignity implicit to their human condition.

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References

1. Hume D. Enquiries: an enquiry concerning the principles of morals. Oxford: Clarendon Press; 1989.
2. Kipper DJ, Clotet J. Princípios da beneficência e não maleficência. In: Costa SIF, Oselka G, Garrafa V, coordenadores. Iniciação a bioética. Brasília: CFM; 1998. p. 37-51.
3. Butler J. Upon the social nature of man. In: Raphael DD, editor. British moralists 1680-1800. Indianapolis: Hacke Publish Company; 1991. v. 1.
4. Beauchamp TL, Childress JF. Principles of biomedical ethics. 4th ed. New York: Oxford University Press; 1994.
5. Pellegrino ED, Thomasma D. For the patent's good: the restoration of beneficence in health care. New York: Oxford University Press; 1988.
6. Bernard J. De la biologie a l'éthique. Paris: Buchet Chastel; 1990.
7. National Commission for the Protection of Human Subjects on Biomedical and Behavioral Research. The Belmont report. Washington: Government Printing Office; 1979. p. 4.
8. Stepke FL. Bioética. São Paulo: Loyola; 2001.
9. Gillon R. Primum non nocere and the principle of non-maleficence. BMJ. 1985;291:130-1.
10. Marino Jr R. Bioética global: princípios para uma moral mundial e universal e de uma medicina mais humana. São Paulo: Hagnos; 2009.
11. Pegoraro O. O lugar da bioética na história da ética e o conceito de justiça como cuidado. In: Pessini L, Barchifontaine CP, coordenadores. Bioética e longevidade humana. São Paulo: Centro Universi- tário São Camilo/Loyola; 2006.
12. Muñoz DR, Forte PAC. O princípio da autonomia e o consentimento livre e esclarecido. In: Costa SIF, Oselka G, Garrafa V, coordenadores. Op. cit. p. 53-70.
13. Pessini L, Barchifontaine CP. Problemas atuais de bioética. 4ª ed. São Paulo: Loyola; 1997.
14. Gracia D. La bioética medica. In: Organización Panamericana de Salud. Bioética temas y perspectivas. Washington: Opas; 1990. p. 3-7.
15. Culver CM. Competência do paciente. In: Segre M, Cohen C, coordenadores. Bioética. São Paulo: Edusp; 1995.
16. Harris J. The value of life: an introduction to medical ethics. London: Routledge and Kegan Paul; 1985. p. 197-8.
17. Veatch RM. Models for ethical medicine in a revolutionary age. Hastings Cent Rep. 1979;2(3):5-7.
18. Foucault M. O nascimento da medicina social In: ________. Microfísica do poder. Rio de Janeiro: Graal; 1979. p. 46-56.
19. Martins A. Biopolítica: o poder do médico e a autonomia do paciente em uma nova concepção de saúde. Interface (Botucatu). 2004;8(14):21-32.
20. Soares JCR, Camargo Júnior KR. A autonomia do paciente no processo terapêutico como valor para a saúde. Interface (Botucatu). 2007;11(21):65-78.
21. Hall JA, Roter DL, Katz, NR. Meta-analysis of correlates of provider behavior in medical encounters. Med Care. 1988;26:657-75.
22. Pellegrino ED. Is truth telling to the patent a cultural artfactƒ. Jama. 1992;268:1734-5.
23. Diniz D. Bioética e gênero. Rev Bioét (Impr). 2008:16(2):207-16.
24. Conselho Federal de Medicina. Código de Ética Médica: resolução CFM nº 1.931, de 17 de setembro de 2009. Brasília: Conselho Federal de Medicina; 2010. (versão de bolso).
25. Organização das Nações Unidas para a Educação, a Ciência e a Cultura. Declaração Universal sobre Bioética e Direitos Humanos. Brasília: Unesco/Sociedade Brasileira de Bioética/UnB; 2005.
26. Freire P. Pedagogia da autonomia: saberes necessários a prática educativa. São Paulo: Paz e Terra; 1996.
27. Oselka G, coordenador. Bioética Clínica: reflexões e discussões sobre casos selecionados. 2• ed. São Paulo: Cremesp/Centro de Bioética; 2009.
28. Portugal. Ministério da Saúde. Carta dos direitos e deveres dos doentes de Portugal [internet]. 30 jan. 2008 [acesso 24 fev. 2011]. Disponível: http://www.portaldasaude.pt/portal/conteudos/informacoes‡uteis/direitos‡deveres/direitosdeveresdoente.htm

29. Mill JS. On liberty. Boston: Collier; 1909.

30. Engelhardt HT. Fundamentos de bioética. São Paulo: Loyola; 1998.

31. Aristóteles. Ética a Nicômaco. 4ª • ed. São Paulo: Martin Claret; 2001.

32. Goldim JR. Autonomia, tomada de decisão e envelhecimento [internet]. 2000 [acesso 24 fev. 2011]. Disponível: http://www.bioetca.ufrgs.br/gerauto.htm

Authors' participation

Maria Zeneida Oliveira wrote the article, designed and carried out the survey. Rita Barbosa was the coordinator and Stela Barbas, was the advisor, and both worked in all stages of the paper.

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Annex 1
Questionnaire for Data Collection

Identification data:

Name:

Address:

Telephone

: 2. 65-69 years 3. 70-74____

Gender: 1.M__2.F ______ 5. 80 years or older______

Age: 1. 60-64 years

4. 75-79 years 3. 4-6 years____

Schooling years

1. Illiterate
2. 1-3 years

4. 7-9 years 5. 10-12 years_______6. 13 years old on _______

Marital Status:

1. single________
2. Married______
3. Widowed____
4. Divorced__________

Research data:

1. In the medical appointment, would you like the physician to inform you about:

1.1 What is your illness (diagnosis)?

1. Yes__ 2. No__ 3. Don't know_____

1.2 If it is a serious or terminal condition, would you like to know?

1. Yes__ 2. No__ 3. Don't know_____

1.3 How is the treatment going to be?

1. Yes__ 2. No__ 3. Don't know_____

1.4 What may be expected from the treatment (prognostic)?

1. Yes__ 2. No__ 3. Don't know_____

2. In a medical treatment, who should make the decisions?

2.1 The physician____

2. The elderly patient________

2. 3The family______

2. 4The elderly patient in common agreement with the physician_____

2. The elderly patient and family in common agreement with the physician___

3. In a case of illness in which you do not have the mental abilities to make decisions about your treatment,

what other person would you like to do it for you?

3.1 The physician' who is assisting you________

3.2 Family______

3.3 Spouse_______

3.4 Children____

3.5 Friend________

3.6 Another. Please specify:__