Patients sometimes make choices that may harm their health. Should practitioners be able to override these choices if they are acting in the patient’s benefit?

Should practitioners override patient choices?

This debate focuses on when patients’ autonomous choices differ from what health professionals consider to be in their “best interest”. Practitioners face such situations in a variety of settings and the question is “what is morally right?” This scenario is fictional but is based on the authors’ clinical experiences.

Ethical scenario
Bill Carter, aged 77, lives alone in a rural area. He has schizophrenia and Parkinson’s disease, both controlled with medication. He has failing eyesight and is frail and unkempt. He has no close neighbours and relies on a friend to deliver food. Since he does not like to cook, Mr Carter only eats cold meals, often bread and jam. He enjoys a glass of stout in the evening, which he believes helps him sleep.

Mr Carter, a confirmed bachelor, has always lived alone and has no close family. His home is in a poor state of repair and overcrowded, with boxes of magazines cluttering most rooms. He has an open fire with a back boiler to heat water, but it is often unlit and there is damp on the walls.

Mr Carter can move around his home with a walking stick, but spends much of his time sitting in his chair by the fireplace. There are numerous trip hazards and he frequently presents with bruises. On a routine visit to administer his two-weekly depo injection, the community nurse found Mr Carter on the floor, saturated in urine and complaining of a pain in his shoulder. He refuses to leave the house and believes he just needs to be cleaned up and given his injection and some pain relief. However, the nurse believes he needs medical attention and a mental capacity assessment.

Argument for the proposition
Mr Carter should be able to remain in his own home
One of the strongest arguments in favour of the resolution is Mr Carter’s autonomous choice to remain at home. This principle of respect for autonomy is widely viewed as each individual being free to make choices and decisions in line with their capacity to exercise their moral discretion [Hugman, 2014]. Autonomy refers to an individual’s general capacity, namely

5 points for discussion
1. Does Mr Carter have the capacity to make a treatment choice?
2. Is coercion an everyday part of nursing practice?
3. Is it right to be paternalistic?
4. Is it morally justified to take Mr Carter away from the familiar surroundings of his home?
5. In terms of informed consent, are patients always fully informed?
that of self-governance (Edwards, 2009).

In healthcare, competence judgements differentiate people whose decisions should be accepted from those whose decisions should not (Beauchamp and Childress, 2013). Competence concerns “the ability to perform a task” (Beauchamp and Childress, 2013). Competence to decide is related to the decision in question, and individuals should rarely be judged incompetent in every sphere of life (Beauchamp and Childress, 2013). Edwards (2009) said that until the parts of the nervous system required for rational thought are destroyed (such in persistent vegetative state) a person has not lost capacity to be autonomous.

Mr Carter arguably retains capacity to make this decision. His standard of living should not lead to him being deemed incompetent to make a decision about staying at home – he is autonomous. Giving or withholding consent is a significant way in which people can exercise their moral autonomy (Hugman, 2014), providing he has been fully informed about options, risks and other relevant factors, his informed choice should be respected.

**Code of ethics**

The Nursing and Midwifery Council (2008) code confirms nurses’ obligations in respect of autonomy. Clause 14 states “you must respect and support people’s rights to accept or decline treatment and care”, while clause 1 states “you must treat people as individuals and respect their dignity”. In the International Council of Nurses (2012) code, clause 1 states “in providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected”. Respecting Mr Carter’s choice to remain at home, therefore, means he is respected as an individual.

An additional consideration is that Mr Carter should have the autonomous choice to remain at home and lead the life he chooses. Krebs (2008) says any impedence of individual freedom is an infringement by the “nanny state”. Respect for autonomy means individuals have the right to choose their lifestyle, even if this choice conflicts with the views of practitioners.

Further arguments in support of this resolution relate to the principles of beneficence and non-maleficence. Beneficence refers to “a moral obligation to act for the benefit of others”, while non-maleficence affirms an obligation not to inflict harm on others (Beauchamp and Childress, 2013). Is it morally justified to undertake a course of action where the risks of harm may be greater than the potential benefits? Mr Carter would be at risk of psychological harm if he was taken away from familiar surroundings where he has lived all his life and his independence removed. This would almost certainly affect his state of mind and could be deemed morally unjustified.

**Argument against the proposition**

Mr Carter should be admitted to a hospital to assess his injuries, mental state and ability to live independently. The first question is “Does Mr Carter have the capacity to understand the reasons for hospital admission?” He has a mental illness, but this does not necessarily mean he lacks the capacity to make an autonomous choice. To confirm his competency, certain criteria from the Mental Capacity Act 2005 must be met (Mughal, 2014). If a patient is deemed to have capacity to make treatment choices, practitioners must be able to justify any decisions they make to overlook these choices. The argument below is based on the assumption that Mr Carter has the capacity to make this choice.

The first argument regards the nurse’s duty of care; Griffith and Tengnah (2014) say nurses owe patients a duty of care and are accountable to the patient if they cause harm by breaching that duty. Mr Carter was found on the floor and the nurse’s duty is to ensure he experiences no more harm.

**Role of paternalism**

To prevent more harm, the nurse has a moral obligation as well as a duty to intervene. Its paternalistic nature makes this decision difficult but Beauchamp and Childress (2013) point out that overriding another person’s preferences is justified when the goal is to benefit or prevent harm to that person. Many philosophers believe paternalism can sometimes be justified and restricting individual freedom is warranted when this maximises benefits and minimises harm to the person concerned (Gillon et al, 1985). Whether respect for autonomy should have precedence over professional beneficence is a central problem in biomedical ethics. Although dated, Benjamin and Curtis’ (1992) suggestion that paternalism is justified in certain circumstances is relevant. They believe it can be justified if:

- « The patient’s rationality is impaired (autonomy condition); »
- « The patient is likely to be significantly harmed without intervention (harm condition); »
- « It is anticipated that the patient will agree with the intervention retrospectively (ratification condition). »

While Mr Carter has capacity, his injuries mean he is temporarily disorientated.

If this is the case, he would meet Benjamin and Curtis’s (1992) criteria for paternalistic intervention as the harm condition would be met; he may agree with the decision to admit him to hospital once he had received treatment, thus also meeting the ratification condition.

In psychiatry, caregivers aim to obtain informed consent from patients, but often feel required to restrict freedom when treatment is deemed to be in the patient’s best interest. Despite paternalistic actions being justified, the notion of coercion may be relevant. This term is often used almost synonymously with pressures exerted by one person on another with the intention of making the latter act in accordance with the former’s wishes (Liegelos and Eneman, 2008; Szmukler and Appelbaum, 2008). However, coercive intervention is sometimes required to avert danger (Widderhoven and Berghmans, 2006). Mr Carter’s situation requires both paternalistic and coercive intervention – both can be justified if the aim is to prevent him from further harm.

**Conclusion**

Key arguments around this case have been presented but more could be addressed. To continue this debate, go to nursingtimes.net/patiencechoice.

**References**


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