Free research paper on medical decision making patient rights

Business, Decision Making

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Decision-making is a vital process to any patient. Typically, there are competent and incompetent patients who make and take ready-made medical decisions respectively. However, is it necessary to make decisions for the incompetent, and if so, why? What are the rights given to competent patients in making medical decisions and why is it important for patients to make decisions for themselves? The complexity of the problem of decision making for incompetent patients is best evident, for example in patients who are under age and their parents need to make an informed decision concerning their health.. Certainly, it is pertinent to focus on medical decision making to both competent and incompetent patients and the philosophical background on patient rights on decision-making in order to improve patient quality outcomes.

Relevant Information

Incompetence also covers elderly people who might or might not be facing Alzheimer Dementia, who totals of two million in the United States (Rothman 23). In addition, there are those incompetent due to mental retardation, brain damage from trauma, stroke and alcoholism. The recent bioethics have

justified and implemented the rights of patients in making medical decisions. All major and competent health care professional organizations recognize that the competent individual has the right to accept and refuse medical care or treatment as well as experimentation

The concept of competency is a moral issue central and vital for consideration when a patient is deciding on a medical treatment. Notably, the statement of whether or not an individual is competent is often incomplete and misleading to many people (Buchanan 19). Precisely, competence in the context of medical decision-making refers to the ability to make sober and reasonable decision concerning medical treatment. Decision-making varies substantially with the capacity that they require of the decision maker for performance at an appropriate level of adequacy. For example during decision-making, the patient should access all relevant information for performance on the medical treatment (Buchanan 28). The level and specific forms of abilities to reason, understand and decide in the context of medical choices vary among different classes of patients as well. Noticeably, many patients may have diminishing competence over time depending on their present healthy or mental condition. For example, the effects of dementia, in other area, the environment may affect the relative level of decision-making. Moreover, side effects of medication often impair competency as well (Siegler 60). It is important to make decisions for patients because the person's interest in making an important decision, especially concerning health care issues provides strong support to the care providers to achieve quality patient care. In addition, the adult health care decisions are in most cases reasonable, however, many patients under

different circumstances are competent to make their medical decisions. In practice, if a patient is incompetent after undergoing thorough assessment, care providers disregard all rights of making decisions about their medical treatment.

The second moral issue-underlying patient right on medical decision-making borders on capacities needed for competency-why to include understanding and communication and the capacity for reasoning and deliberation (Buchanan 30). A significant deficiency in the reasoning capacity affects the decision-making competence. Understanding and communicating involves the various capacities involved in the process of being informed and expressing a choice of treatment. This requires the patient to have conceptual, linguistic, and cognitive ability that is necessary for receiving medical information and comprehending the information. The nature of the proposed treatment will involve diagnosis of a medical issue, different alternative treatments, and the proposed treatment. The second capacity is reasoning and deliberation this involves retention of the information assimilated and allowing the process of decision making to take place. It requires the patient to draw inference of the consequence of making a certain decision compared to the alternative (Siegler 80).

Competence as a threshold concept is the third factor of consideration. In essence, this involves the informed set of doctrine that has free and informed consent of a competent patient to a medical procedure that healthcare providers may need to perform. The decision making process occurs between the patient and the physician in the sense that if the patient is manipulated into the decision, it will serve another end of the patient

perspective. On the contrary, and if the patient is competent and the decision-making process is voluntary, it will serve the patient's aims and goals. Besides, If a patient is not competent its either he/she is unable to make a decision or the decision will be seriously flawed (Siegler 100).

The forth factor of consideration regarding a patient’s right in making medical decisions anchors on the standards of competences underlying values. The standards include promotion of individual wellbeing- this is based on the assumption that patients are usually better judges of their own better than others in the context of medical decision-making. Pertinently, however, patients only make correct judgments of themselves having received information and advice from a physician. Modern treatment offers different mixes on the benefit and risk of treatment, a situation that supports demands that health care decision making should be on a joint undertaking between the physician and the patient. Notably, this follows the fact that both the care provider and the patient bring on board the knowledge that another one lacks to choose the best alternative for the patient. The same value of patient wellbeing that requires patient participation, also seeks to protect them from harmful health care decisions. The second standard includes respect for individual self-determination. In other words, this involves understanding a person's interest in making significant decisions about his/her life (Rothman 48). A patient’s interest in choosing what is right need to balance, for example, against their interest in alternative that suits their underlying goals and aims. In essence, there are many theories that have discussed why individuals find it important to make medical decisions (Rothman 50). According to preference theory, the aims and goals

underlying a person, fully determine their best in the context of medical decision-making. In addition, hedonist theory explains that it is true that the choices made in accordance to an individual aims and values usually, but not always, brings a sense of happiness. According to Feinberg, a person's self-determination is sovereign only when they have made a voluntary choice based on their underlying aim and values (Fulford et al. 53). Furthermore, Feinberg theorizes that the self-determination is not sovereign. Accordingly, self-determination is an individual interest to make decisions because to do so would require accepting the person’s choice, however much it failed to be voluntary. It is not consistent with Feinberg position that operates under a precondition that only if the individual values something besides for oneself well-being, but puts into consideration their family and physicians. Nevertheless, Feinberg’s view is a balanced because its single valued foundation shows the balance between self-determination and well-being (Rothman 67).

The fifty moral issue involves the decision on standards of competency. The proper standards of competency are central in order to value choices. Seemingly, focus on the well-being and self-determination of a patient maybe misleading because there are other significant factors. One of those factors is the maintenance of public confidence in the integrity of the medical profession to protect the trust between the physician and patients (Fulford et al. 127). People may disagree where the threshold should be set for medical decisions. Essentially, the disagreement may occur because of personal interests of both the patient and healthcare providers. Moreover, conflicts regarding patients’ competency and rights often occur when the

care providers assign different weight to different values of self-determination and well-being. Mostly, because incompetency may precipitate conflicts, it is critical to strike a unanimous agreement (Buchanan 38).

In addition, the sixth moral concern borders on the differences among medical decision-making threshold standards. Admittedly, a number of different standards of competency exist and have considerable literature supporting them. The decision made by the patient will be clarified and be defended when it is examined and analyzed against the standard of competency (Buchanan 38). Similarly, a problem occurs when a patient refuses treatment, a situation, which reflects incompetence. Usually, a patient is entitled to make a decision regarding his or her treatment when in a mentally stable condition often described as a sound mind status. With little doubts, a patient’s refusal to undergo medical treatment is a common criticism of the well-being of the patient’s competency.

In two-step model of patient decision-making authority, Charles Culver and Bernard Gert reveals that the level of competency conflicts two distinct issues -rationally of the choice and the competence of the decision maker (Buchanan 40). Charles and Bernard argued that it was the rational decision of a patient that should retain their decisional authority. Agreeably, competence is a patient’s property, and competence should be assessed prior to the decision made by the patient. Competence involves the ability to carry out the mental task; to understand the relevant information before making a decision, to realize that one is being asked to choose medical treatment that are being suggested. In the model, Charles and Bernard

suggest that it is necessary to distinguish competence and rationality of a patient who is refusing treatment and is subjected to depression. When a patient faces mood swings, however, and refuses to eat or agree to the consented treatment, this does not count as incompetence. Specifically, refusal to eat, take medication and fluids does not justify the physician to conclude that the patient is incompetent (Buchanan 52). The philosophers, Bernard and Charles, are right in their arguments. First, that competence is a property of the individual, not a decision and is a minimal threshold requirement. Second, it is true that the criticism of a patient's action is often similar to irrational patient treatment. Essentially, the patients' rights are key to attain quality healthcare outcomes.

Conclusion

Decision-making is a vital process to any patient. Typically, there are competent and incompetent patients who make and take ready-made medical decisions respectively. The concept of competency is a moral issue central and vital for consideration when a patient is deciding on a medical treatment. Many patients may have diminishing competence over time depending on their present healthy or mental condition. Moreover, side effects of medication often impair competency as well. The patient needs to have conceptual, linguistic, and cognitive ability necessary for receiving medical information and comprehending the information. The recent bioethics have justified and implemented the rights of patients in making medical decisions. Therefore, it is pertinent to focus on medical decision making to both competent and incompetent patients and the philosophical

background on patient rights on decision-making in order to improve patient quality outcomes.

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