Applicability of the principle of respect for autonomy: the perspective of Turkey

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Turkey has a complex character, which has differences from the Western world or Eastern Asia as well as common points. Even after more than a century of efforts to modernise and integrate with the West, Turkish society has values that are different from those of the West, as well as having Western values. It is worth questioning whether ordinary Turkish people show an individualistic character. The principle of respect for individual autonomy arises from a perception of oneself as an individual, and the person's situation may affect the applicability of the principle. Patients who perceive themselves to be members of a community rather than free persons and who prefer to participate in the common decisions of the community and to consider the common interest and the common value system of the community concerning problems of their life (except healthcare or biomedical research) rather than to decide as independent, rational individuals may not be competent to make an autonomous choice. Expectations that such patients will behave as autonomous individuals may be unjustified. The family, rather than the patient, may take a primary role in decisions. A flexible system considering cultural differences in the concept of autonomy may be more feasible than a system following strict universal norms.

the moral norms of any given culture following anthropological analysis, but it may be possible to establish a transcultural medical ethics depending upon ethical pluralism and dialogue.³

The concept of autonomy is a manifestation of Western culture, which emphasises individualism, personal happiness and self-actualisation. In this context, "personhood" is viewed from the perspective of autonomy and individual rights.⁴

The liberal concept of autonomy defends individuals from oppression by others. Being a person gives one the capability of free and rational choice based on individual preferences and values. Autonomy is based on identity and the particular nature and character of the self. Actions are free to the degree that they are consistent with one's self-identity. But because of the social nature of humankind, dependence is an essential human feature. Individuals live in social situations, and their choices are contextual. Dependence may not diminish one's freedom if one is dependent on something that he or she identifies with. Persons are interconnected, and they acquire habits of action and thought within social circumstances.⁵

The term *autonomy* does not imply a concept with only one meaning. How people define and exercise autonomy differs from place to place. If autonomy is accepted as a universal principle, there are nevertheless various versions of it. It is not necessary for every country to follow one standard practice that is related to a certain culture.⁶

Perceptions of the self in relation to others differ from one culture to another. For many non-Western cultures, personal interconnectedness and the social and moral meaning of relationships has a vital role. It must be considered how each person sees himself or herself in relation to others, to understand autonomy in a cross-cultural context, rather than as a concept that is universally independent of cultural perspectives.⁷

Traditional societies emphasise "familial self", which is characterised by an intense emotional family togetherness and interdependence among members of a family. "Personhood" is defined in the context of one's community. Paternalism is the guiding principle in such circumstances.⁴

In some settings, the standard for individual informed consent may be inapplicable, since decisions are made in conjunction with others, within communities. It is important to know about how members of different communities see themselves as involved in decisions or how different communities think of themselves as inter-relating members.³

The concept of single, uniform, cross-culturally relevant global bioethics disregards intercultural variations when determining what is right or wrong. The moral meanings of illness, health and healing systems are culturally grounded. The empirical facts revealed by anthropological research yield the descriptive thesis known as cultural relativity. The facts of cultural relativity may compel the conclusion that what is right or wrong can be determined only by reference to the beliefs and practices within a particular culture or subculture. It may not be possible to apply general principles without detailed local knowledge. Acknowledging cultural variation and moral pluralism may be necessary for relevance and applicability of the international ethical principles.¹ There may be some viable forms of moral pluralism, such as "procedural pluralism"—the idea that moral goals and values are universal in some sense but that the methods for reaching them may differ between cultures—or "negotiated universalism"—the idea of negotiating values in a given context between cultures without the parties trying to persuade each other that their own values are better.² It is not necessary to accept uncritically

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Cultural groups are not monolithic entities: there are intracultural and intergenerational differences. An examination of concerns regarding informed consent must also focus on the patient's family dynamics and the circumstances surrounding the patient's desire to relinquish his or her decision-making authority. People have different views and attitudes towards inherited traditions. A patient's community and cultural heritage may supply his or her values, but whether a patient is acting autonomously when following them differs, depending on the patient. Individuals acquire a subjective sense of identity within their families, and the familial ties affect a person's concept of self.⁸ So it must be questioned for each patient how much room for individual autonomy there is in a particular case.

INDIVIDUALISTIC AND COLLECTIVISTIC CULTURES

Family, culture and experience influence people during their development. Acquiring personal values independently is not possible. Persons develop their moral structure as a result of identifications.⁹

According to a libertarian view, persons are moral strangers, they have different values, and nobody can know other persons' values unless they directly express them. But in many families, the family members share similar values, and they also affect each other. Even if they do not share same values, they know each other's values much better than other people's. It is difficult to say that family members are moral strangers.¹⁰

The people of collectivistic cultures are interdependent within their in-groups and are especially concerned with relationships. They give priority to the goals of their in-groups. The people of individualistic cultures are independent of their in-groups; they give priority to their personal goals. People in a society sample from both the individualistic and collectivistic structures. The terms *idiocentrism* and *allocentrism* correspond to *individualism* and *collectivism* at the level of personality. Allocentrics tend to define themselves with reference to social entities. They often internalise the in-group norms, and they enjoy acting according to in-group expectations. The largest distinction in collectivistic cultures is between in-group and out-groups. In individualistic cultures, the largest distinction is that between self and others. An allocentric motive structure is related to receptivity to others, adjustment to the needs of others and restraint of own needs and desires. An idiocentric motive structure is related to internal needs, rights, capacities and the ability to withstand social pressures.¹¹

In a collectivistic culture, prediction of behaviour depends on social contexts, norms, and roles more than on attitudes and internal processes of the self. People in collectivistic cultures behave less consistently across situations than people in individualistic cultures.¹²

This bipolar, unidimensional conceptualisation of individualistic and collectivistic cultures construes autonomy and embeddedness as conflicting and considers individuation as necessary for the development of autonomy. This view implies that closely interrelated selves cannot be autonomous. But according to another view, there are two independent dimensions: interpersonal distance, relating to separateness and connectedness, and agency, relating to autonomy and dependence. Because the two dimensions are independent of each other, a combination of autonomy and connectedness is possible. The "autonomous-related self" is shown to be prevalent particularly in urban, socioeconomically developed contexts with close-knit human ties.¹³

Three contextual family patterns have been described: interdependent, independent and emotionally interdependent. These are differentiated according to emotional and material dimensions. The classic model of the extended family of rural

traditional societies is characterised by material and emotional interdependence. The nuclear family of industrial urban/suburban middle-class cultures is characterised by independence. The emotionally interdependent family pattern, which can be found in the rather more developed areas of the world, is characterised by emotional interdependence and material independence.¹⁴

CULTURE AND RURAL SETTINGS

Turkey's characteristics reflect a change from a rural, agricultural society to an urbanised, industrialised one. Yet, it can be said that there is a tendency towards traditional Islamic culture, with a collectivistic orientation. Cross-national value surveys continue to show familism and collectivism as leading Turkish values. Although the basic structure tends to be the nuclear family, it performs the functions of an extended family by providing social, emotional and material support. The socio-cultural structure is characterised by close interpersonal relationships. Nuclear family, relatives and close neighbours surround the individual as a network of close ties. Turkish families are reported to transmit collectivistic rather than individualist values. Close emotional bonds are still prevalent in interpersonal relations. Children continue to respect their parents and are responsible for their care in old age. Providing for the needs of older adults is a duty of children or other relatives, although increasing urbanisation decreases intergenerational material interdependence. Parents also continue to support their children, even if they are adults.¹⁵⁻¹⁹

On the other hand, there is a heterogeneous culture with major value differences among various segments in Turkey, because of an attempt to transform the traditional society. Different living styles began to emerge with social change. There are differences between rural and urban Turkish culture. It has been found that Turkish culture has strong individualistic elements in addition to a collectivistic outlook. However, emotional interdependence remains important even as the material interdependence of family members decreases. Studies of Turkey¹⁸⁻²⁰ refer to an integration of collectivistic and individualistic values, described as "individualistic self-realisation together with collectivist group loyalty".¹⁸

Traditional Turkish culture contains paternalistic values. "Respect for the older, love for the younger" is expressed frequently. "Water belongs to the younger, word belongs to the older" is a proverb that summarises the relationships between people, *water* symbolising compassion and care and *word* symbolising decision-making. *Big* and *little* are used instead of *older* and *younger*. *Big* expresses high social status as well as being older. Another word, *koca*, which means "big" or "huge", also conveys an idea about social relationships: it also means "old man" and "husband." The old man is a community leader, and the husband is the chief of the family. A hierarchy of respect and obedience from the bottom upwards and of love and compassion from the top downwards is considered ideal. The hierarchy in the family is between parents and children and also between older and younger children. A proverb says, "Big brother is partly a father; big sister is partly a mother." Younger siblings do not address the elders by name, but use titles: "big brother", "big sister". It is also improper to address older people outside of the family without using a title of respect. Any older member of the society is an aunt or an uncle, and younger people must show respect. Any younger member of the society is a child, and the elders must show care and compassion for them. Elders also can discipline younger people. In the process of rapid urbanising, industrialising and modernising, this type of relationship has loosened, but it still exists, especially in rural and suburban areas.

In rural areas, the model of the extended family of three or more generations still exists. Several generations of a farming family use the same land and live together. Usually, the younger generation cultivates the land for the support of the whole family. If an old villager without any health insurance needs expensive treatment, this means a field must be sold. The decision may be critical both for the patient and for the rest of the family. Under some circumstances, the family, rather than the patient, takes the decision in practice. If the family could stop the sale of the field, the patient's decision would make no sense. Some old and illiterate persons are dependent on their children. If the son considers the situation "hopeless", the patient may never be taken to the hospital. Likewise, the decision about long-term care of the patient belongs in practice to the family in most circumstances. Taking an older person to a nursing home is rare; instead, the patient is cared for at home. It is meaningless to exclude the people who take the decisions in practice. The family could facilitate communication with the patient. Family involvement also creates a chance to know the family and gives health personnel an opportunity to understand whether there is oppression.

Some patients may have some affiliations relating to tribal culture, which may have a negative effect on the patient. If health personnel find out that the patient rejects these affiliations, openly or inwardly, they may support the patient against oppression. However, it can be difficult to choose a path regarding a patient who has internalised the situation. It is not a care giver's duty to try to make patients change their lifestyle, world view or values. Besides, acting as a centre of power and directing or forcing patients towards another centre of power can be paternalistic. It is difficult to say that a patient who has this sort of dependence has autonomy. The principle of beneficence may be preferred in such conditions.

Devotion must be mutual for a harmonious community. Close relationship does not necessarily mean harmony. Health personnel have to scrutinise every patient or research subject and conduct themselves in a manner that is appropriate for the situation. After all, it is possible for health personnel, rather than families, to oppress patients. A procedure that includes family involvement may also create a chance for the family to scrutinise whether health personnel oppress the patient.

CHOOSING THE WAY OF CHOICE

When constructing a normative theory of patient autonomy, the nature of personhood and the applicability of this theory must be taken into consideration. The descriptive literature indicates that there is no strong patient preference for autonomy in the liberal, individualist sense and that many patients may prefer a paternalistic model.^{21–24}

Integrity—that is, acting in accordance with one's own moral beliefs—should be considered when resolving cultural conflicts between healthcare providers and patients. Persons may be able to agree about particular cases without agreeing about underlying basic principles. Both parties should avoid imposing their own values as universally valid truths. Changing fundamental values may not be necessary for achieving agreement. Alternative ways of interacting may help healthcare provider and patient to scrutinise their intentions, so as to respect the integrity of both parties. There may be some occasions when values are extremely conflicting and accommodation is impossible, but even then an agreement about a fair procedure for resolving differences may help in achieving a "negotiated settlement".²⁵

Different interpretations of autonomy may be considered, such as "critical reflection" or "procedural independence", which express the idea that conscious submission to some form of external authority may be possible; "identification", which

expresses that dependence may not be problematic if one can identify with a source and one is dependent on this source; or "negotiated consent", which expresses that patients and physicians should have an intention to understand each other about the meaning of the situation in which they are involved.²¹

Beneficence-oriented rather than autonomy-oriented approaches may be preferred while "balancing and over-riding" the ethical principles to solve ethical dilemmas, because of sociocultural factors. The relationship between healthcare provider and patient exists in a particular historical context and is influenced by social conventions and cultural values. Responsibility to the group may suppress autonomy, and in a collectivistic society, people put the public interest before self-interest.²⁵

The family may not necessarily be a problem or a source of prevention for its members. Families are important for many people; many make decisions within the family, and many decisions have a direct impact on the family members. Some forms of decision-making in families may be ethically problematic because they constrain the liberty and interests of some family members. But if the incompatibility of first preferences is resolved by building consensus, the decision will not be problematic, even if the first preferences of some or all members cannot be satisfied. In the context of healthcare, the family is often in a position to be harmed. Healthcare decisions can impose a responsibility of care, emotional stress or high economic costs on family members. Enforcing benefit may be justified in the family context. Interfering with the liberty of one of the family members is different from interfering with the liberty of a stranger. The family is in a privileged position from which to assess the harm and to choose whether to accept its imposition. The healthcare provider is not the one who will be harmed by the patient's decision and cannot know the values of the patient as a family member. The justification about family and enforcing benefit does not include the healthcare provider. If it is accepted that the family's position is special, the default assumption may be that the family has a right to be informed unless the patient objects, rather than the assumption that information can be shared only if the patient explicitly consents.¹⁰

CONCLUSIONS

There are different types of self-perception in Turkey, and various segments of Turkish society may differ regarding preferences about autonomy. These differences should be considered when finding a way between paternalistic and non-paternalistic models of healthcare. It would be difficult to argue that there is no room for individual autonomy in Turkey, but the applicability of the principle of respect for autonomy probably depends on the interpretation of *autonomy*. It will be important to find a more flexible concept of autonomy that is compatible with the structure of the culture and with the various self-perceptions. The principle of respect for autonomy or the principle of beneficence may be more applicable, depending on the case. There is a rather strong family life in most segments of the culture, but in others there may not be, so in each particular case, the patient's situation of identification with the family or a social group must be questioned. Patients who are rather independent from their families may prefer more autonomy, whereas rather family-dependent patients may require more family involvement. Sometimes patients need support against the family. Patients who are dependent on their family or social group because they perceive themselves as a strongly tied part of a community rather than as separate individuals may find it difficult or impossible to decide and act autonomously.

There is no point in forcing autonomy on such patients. Communication between health personnel, patient, and family is crucial. Healthcare givers should be aware of the different types of self-perception and should choose the best course of action for the situation. Case-by-case evaluation and shared decision-making, with family involvement if necessary, would be more appropriate than one standard procedure.

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