VILNIUS UNIVERSITY

FACULTY OF MEDICINE

Medicine

Centre for Health Ethics, Law and History

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INTEGRATED STUDY MASTER'S THESIS

Principle of Respect for Autonomy in Bioethics: Its Justification and Critical Assessment

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Vilnius, 2025

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SUMMARY

The principle of respect for autonomy has taken a central role in guiding ethical decision-making in Western culture and contexts. It affirms the right of rational individuals to make independent and informed choices. However, despite its dominance, limitations regarding its prioritised nature, individualistic framework, and lack of cultural considerations need to be acknowledged. This thesis aims to critically examine the principle of respect for autonomy, exploring its limitations and reflecting on its prominence within Western bioethics. It advocates for a broader, more inclusive, and context-sensitive understanding of autonomy that incorporates relational and cultural perspectives. The thesis has four main objectives: (1) tracing the historical development of autonomy and its entrenchment in principlism, (2) assessing its limitations, particularly regarding informed consent, vulnerability, and paternalism, (3) exploring an alternative, contextual, and relational understanding of autonomy as put forward in the ethics of care, and (4) establishing the need for a reformulation on the understanding of autonomy based on alternative perspectives to better reflect ethical pluralism and human interdependence. The findings reveal that autonomy's dominant individualistic interpretation presents significant challenges. Prioritising autonomy above other ethical considerations can marginalise vulnerable populations, overlook relational decision-making, and rigidly reject paternalism, even when protective. Informed consent, a key mechanism for safeguarding autonomy, is deeply rooted in Western ideals of rational self-determination, often failing to accommodate cultural diversity, interdependence, and different forms of consent that may be valued in non-Western contexts. The thesis concludes that a more inclusive understanding of autonomy is needed. By incorporating insights from care ethics and non-Western traditions, it advocates for a relational understanding of autonomy that recognises human interdependence, vulnerability, and social responsibility. Practical recommendations include fostering interdisciplinary collaboration to explore the integration of principlism and care ethics, revising informed consent processes to incorporate relational and cultural dimensions, and developing flexible, context-sensitive ethical decision-making models that respect both individual autonomy and collective well-being. Ultimately, this thesis contributes to the ongoing discourse on balancing autonomy with ethical pluralism and social responsibility in bioethics and healthcare.

Keywords: Principlism, Informed Consent, Paternalism, Care Ethics, Relational Autonomy, Cultural Pluralism

1 INTRODUCTION

The principle of respect for autonomy has taken a central role in guiding ethical decision-making in contemporary bioethics. The principle of respect for autonomy emphasises the right of rational individuals to conduct their own choices and informed decisions, about their own lives, bodies, and health free from external influence or coercion. The importance of autonomy is most prominently evident in the fields of medical ethics, healthcare policy, and human rights. In medical decision-making, autonomy ensures that patients have the right to participate in decisions about their treatment and care, making it a crucial principle that safeguards dignity, freedom, and individual rights. The principle of respect for autonomy assumes particular significance in contemporary bioethics due to the growing emphasis on patient-centred care and the global discourse on human rights. However, while the principle of autonomy has become deeply embedded within bioethical frameworks, its application is not without controversy. While the principle of respect for autonomy holds a significant place in Western bioethics, its limitations – particularly in relation to informed consent, paternalism, cultural differences, and vulnerable populations – suggest the need for a more nuanced examination. Despite its prima facie standing, there is growing recognition that its dominance in ethical decision-making may not fully account for the global diverse cultural perspectives and alternative ethical frameworks. As such, it is important to critically assess the principle's application and its broader implications within bioethical practice, considering the pluralistic nature of contemporary societies. The novelty of this thesis lies in addressing a significant gap in the existing literature that critically evaluates the limitations of autonomy from different perspectives. While much of the existing literature on autonomy focuses on Western bioethics, such as Azétsop & Rennie (2010), Mavropoulos (2024), and Vearrier & Henderson (2021), this thesis offers a novel contribution by critically examining the limitations of autonomy through the lens of care ethics and non-Western traditions, including Koggel & Orme (2010), Noddings (1984), Cockburn (2005), and Maio (2025), which represent areas that remain underrepresented in the medical ethics discourse. This thesis fills a critical gap by demonstrating how these perspectives can complement and enrich dominant Western understandings of autonomy, offering a more relational and context-aware perspective in contrast to the predominance of traditional Western understanding of autonomy in bioethics. This integration of care ethics, relational autonomy, and cross-cultural perspectives makes the thesis a novel and important contribution to the field.

Aim

The thesis aims to critically examine the principle of respect for autonomy, exploring its limitations and reflecting on its prominence within Western bioethics, advocating for a more nuanced understanding of autonomy that integrates relational, contextual, and cultural considerations.

To achieve this aim, the following objectives are outlined:

1) To establish the historical evolution of the principle of respect for autonomy, outlining key events and developments that solidified its central role in contemporary bioethics and its integration into the framework of principlism.
2) To establish the pitfalls of the principle of respect for autonomy in Western bioethics and to outline the challenges it faces in bioethical decision-making, particularly in relation to informed consent, vulnerability, and the role of paternalism.
3) To outline a relational and contextual understanding of autonomy as presented in care ethics and to illustrate how it defines autonomy in the clinical context and in regard to vulnerability.
4) To establish a critical evaluation of the principle of respect for autonomy by integrating perspectives from care ethics as well as non-Western traditions and to outline the need for a more inclusive and culturally sensitive understanding of autonomy.

Methods

The research methodology for this thesis consists of a narrative review and comparative analysis.[1] The literature search was conducted using several academic databases, including Web of Science, PubMed, as well as academic search engines such as Google Scholar. Keywords used in the search included: “Autonomy and History”, “Principlism and Autonomy”, “Beauchamp and Childress”, “Deontology”, “Kant”, “Utilitarianism”, “Mill”, “Informed Consent and Autonomy”, “Informed Consent and Incompetence”, “ Euthanasia and Autonomy”, “Assisted Dying and Autonomy”, “Ethical Dilemmas and Autonomy”, “Paternalism”, “Care Ethics”, “ Relational Autonomy”, “Autonomy and Chinese Medical Ethics”. Following initial research, key authors in the fields of principlism, medical ethics, and care ethics were identified, prompting the inclusion of relevant books for a deeper understanding. Inclusion criteria focused on peer-reviewed articles, questionnaire studies, scientific contributions, editorials, books and ethical guidelines published in English and German language, starting from the 1970s, especially to outline long-standing ethical theories as well as recent literature from the years 2020-2025. To cover foundational ethical theories, key historical works on Kantian, deontological, utilitarian, principlism, and care ethics were reviewed for context, while contemporary

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[1] The thesis employs a combination of narrative literature review methodologies and comparative analysis methodologies. The narrative literature review is selected as it allows the synthesizing of the existing literature on the field of ethical theories, principlism and care ethics to establish a comprehensive overview. It enables to put forward the outline of the historical developments as well as the understanding of ethical frameworks. Furthermore, it allows to provide a descriptive exploration on the topic by reviewing classical foundational works and contemporary literature. The narrative literature review allows a thematical organisation and allows the thesis to follow its chronology. The comparative analysis method complements the narrative review by comparing and critically opposing theories and the literature. Ethical theories are analysed regarding their implication to autonomy. The comparative analysis allows to identify areas and points of view, where the compared theories diverge and differ from each other. It also reveals practical challenges and shows its differences in application and understanding.

literature was included to provide practical examples in medical decision-making and emphasize their relevance for professionals in medicine and ethics.

Structure

This thesis is structured into six main chapters, each building upon the previous to provide a comprehensive examination and critique of the principle of respect for autonomy. The first chapter serves to introduce and open the theme of the thesis. Chapter two focuses on the historical development and philosophical underpinnings of autonomy, including contributions from key thinkers such as Rousseau, Kant, Mill, and Beauchamp and Childress. It also highlights main historical events that led to the progression of the contemporary understanding of autonomy. Further, in chapter three, after showing how principlism came into place as a dominant ethical framework in Western bioethics, the principlist approach is examined, focusing on the principle of respect for autonomy as one of four prima facie principles, highlighting autonomy's dominant role in bioethics and medical decision-making. The anti-paternalistic approach, which seeks to protect autonomy, is examined, along with informed consent practices that serve as a safeguard for individual autonomy. As a contrasting approach to principlism, the ethics of care is presented in chapter four, emphasising a relational perspective on autonomy. Highlighting the role of care in clinical settings with the need for a culture of care to support patients' autonomy and addressing vulnerability as a key concept in healthcare. Chapter five is devoted to the critical assessment towards the principle of respect for autonomy from the point of care ethics and non-Western Traditions. The final chapter synthesizes findings and offers further practical recommendations.

2 THE EVOLUTION OF AUTONOMY: HISTORICAL AND PHILOSOPHICAL FOUNDATIONS

2.1 THE HIPPOCRATIC OATH

The concept of autonomy in antiquity was limited to the field of politics. Nómos translating into law or rule, referred merely to the political capacity of Greek cities to make and govern their own laws to be politically independent and free. During antiquity, the term autonomy referred primarily to political independence (Gracia, 2012). This illustrates the overall lack of autonomy in personal decision-making, particularly concerning medical decision-making. In fact, the Hippocratic tradition did not regard issues such as informed consent, privacy, access to health care, and communal and public health responsibilities. Instead, a paternalistic orientation was practised (Beauchamp & Childress, 2012). As D.M. Sullivan states "a notable omission from the Oath is the word autonomy (Sullivan, 2019, p. 13). On the other hand, beneficence and non-maleficence have played a central role in the paternalistic approach, which revolves around the physician's personal integrity and the pledge of physicians to benefit the sick and to abstain from causing harm as well as injustice (Sullivan, 2019). It was the Hippocratic maxim “do no harm” that has been a fundamental principle of medical ethics. Under the Hippocratic Oath, physicians are required to benefit patients according to their best evaluation (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Paternalistic approaches were both acknowledged and widely practised. Fan outlines that strong paternalistic elements have been present, which included the physician judging and seeking the patient’s best interest despite their own wishes (Fan, 2002). It can be said that contemporary perspectives in medicine draw upon the heritage of Hippocrates, while also complementing principles of autonomy, informed consent, and focusing on patient-centred care (Sullivan, 2019).

2.2 THE ENLIGHTENMENT ORIGINS

The period of Enlightenment has seen a shift in the ancient political meaning of autonomy. This period has marked a significant and complex influence on the development of contemporary moral thought and of the understanding of autonomy. With changes in the social and political context, morality had to be newly justified and reconstructed (Saad, 2018).

Jean Jacques Rousseau (1712-1778) defends the idea that autonomy is not merely political but also a personal concept. It is fundamental to Rousseau that individuals decide for themselves, guided by their own reason. Rousseau, in fact, sees autonomy as a form of self-mastery that elevates the human soul “only with moral freedom and not merely with negative freedom the human being becomes truly the master of himself” (Neuhouser, 2011, p. 482). But as Neuhouser states, “Rousseau thinks of autonomy as something individuals can achieve, but only by surrendering part of their status as individuals and associating themselves with other members of a larger social organisation who think of their social membership as essential to who they are” (Neuhouser, 2011, p. 480). This reflects the main idea of Rousseau’s collective contractualism which Rousseau sets out in his works (Saad, 2018). His conception of the general will rest on the account that “the ideal of complete individual sovereignty is replaced by that of equal, shared sovereignty” (Neuhouser, 2011, p. 490). The French Enlightenment fostered doctrines of individual and political rights and freedoms (Pellegrino & Thomasma, 1987), but in terms of medical practice, traditional paternalism still dominated. As Pellegrino and Thomasma state, “the notions of individual rights and autonomy have lagged behind in the medical relationship” (Pellegrino & Thomasma, 1987, p. 24).

In the second half of the 18th century, the word autonomy received a new direction and meaning (Gracia, 2012). Immanuel Kant (1724-1804) and his deontological theory can be held responsible for this main change. In Kant's works, autonomy has a metaphysical meaning and is viewed as the essence of human beings as rational entities, regardless of how individuals perform moral acts and navigate their moral lives. For Kant, autonomy is seen as a pure feature rather than a characteristic of acts performed (Gracia, 2012). The Kantian autonomy is determined by pure reason alone, where the individual acts on moral principles provided by reason. Kant argues that society should be rationally constructed on objective grounds by using practical reason (Saad, 2018). Kantian ethics, a universal deontological ethical theory, employs the Categorical Imperative to evaluate whether one should act on a particular maxim (Gordon, 2011). The Categorical Imperative provides a moral standard. Kant (as cited in Gauthier, 1993) emphasises the importance of treating humanity – both in oneself and in others – not merely as a means to an end but always also as an end in itself. By this, Kant refers to respecting another person's dignity and intrinsic value as a rational and autonomous agent, a being who is both free and rational (Gauthier, 1993). Indeed, for Kant, it is irrational to act in a manner that contradicts what one wishes to be a universal law. The theory of deontology is largely based on Kantian influences. Deontology builds on rationality, and as Hine outlines, "many deontological theories make use of concepts such as autonomy and respect" (Hine, 2011, p. 385). And individuals should be treated as an end and the worth of others should be acknowledged (Hine, 2011).

2.3 MILL AND LIBERALISM

Ethical approaches in utilitarianism originate from the writings of John Stuart Mill (1806-1873) and his liberal political theory. In the context of the precedence of autonomy in the moral vision, maximising choice and minimising external interference became priorities carrying new moral significance (Saad, 2018). John Stuart Mill weaves philosophical concepts of autonomy into his political theory. Although he does not directly reference autonomy, he advocates for the concept and its implications (Saad, 2018). Mill argues that the moral obligation to grant people respect for autonomy would lead to a maximisation of human welfare, autonomy should only be restricted if there is a harm to others (Breeze, 1998). Mill's arguments are based on consequentialist reasoning that freedom is necessary for the development of individuality. He argues that allowing everyone in society to act on their personal judgment of what is right is essential for human development and happiness. The individuality resulting from respecting liberty benefits both each member of society and society as a whole (Gauthier, 1993). Modern Western liberalism can be credited with providing a strong foundation for self-determination as well as individual liberty (Fan, 2002).

2.4 POST-SECOND WORLD WAR

After the atrocities of the Second World War and the dramatic misuse of medicine in Nazi Germany, the regulations of informed consent, closely associated with the principle of autonomy, were expected to help avoid similar misuse and suffering in the future, aiming to advance the liberty rights of patients and human subjects in research (Rehbock, 2011). Therefore, it can be said that the Second World War marked a significant change in medical ethics. Despite this, change and awareness were only implemented after the atrocities of the Holocaust were revealed (Saad, 2018).

2.5 THE NUREMBERG CODE AND TRIALS

The Nuremberg Code of 1947 addressed the abusive treatment of individuals by Nazi medical research, leading to the first formal statement of the consent requirement in biomedical ethics (Manson & O'Neill, 2007). Regarded as the foundational code in research ethics, it aimed to protect research subjects from potential harm through the mechanism of informed consent (Mackenzie, et al., 2014). The Code was drafted to ensure that voluntary consent is obtained in all human research. Informed consent is viewed as providing assurance and evidence that no coercive or manipulative influence is present (Manson & O'Neill, 2007). The Nuremberg Code forbade research that undermined or overwhelmed the will, and it prohibited research involving individuals who lacked sufficient knowledge and comprehension. However, it did not address information disclosure or reference to autonomy (Manson & O'Neill, 2007). It can be said that it aimed to control research ethics and was subsequently extended to clinical ethics and the concept of autonomy in the following years. Beauchamp and Childress conclude that even though the Nuremberg trials have emphasised consent, the term “informed consent” did only receive a detailed account in the early 1970s, grounded on the emphasis of autonomy (Beauchamp & Childress, 2012, pp. 120-121).

2.6 THE BELMONT REPORT: ETHICAL PRINCIPLES IN RESEARCH

The Belmont Report, published in 1979 by the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, identified three general principles as the underlying conduct for research: respect for persons, beneficence and justice (Beauchamp, 2010). In the aftermath of the Tuskegee Syphilis Study and within its historical context of unethical research, there arose a call for greater transparency regarding the conduct of biomedical research and the importance of individual rights, including the right to be informed about the terms of research participation along with the option to decline participation (Siddiqui & Sharp, 2021). The Belmont Report is recognised as the first public document that articulated the notion of respect as a principle, referred to as “respect for persons” (Lysaught, 2004). The Belmont Report identifies respect for persons as one of the main moral principles (Gracia, 2012). According to the Belmont Report, respect for persons includes the obligation to acknowledge autonomy and to protect those with diminished autonomy (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). To ensure compliance with the principle of respect for persons, informed consent is obtained. Respecting individuals means allowing subjects, as much as they are able, to decide what happens to them. This choice is ensured when proper standards for informed consent are established (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). The principle of justice emphasises the fair distribution of the burdens and benefits of research. It also involves selecting individuals who are willing to bear the burden of research, focusing on healthy individuals while sparing those who are already burdened by disabilities (Beauchamp, 2010). The Belmont Report refers to widely accepted formulations that mention relevant properties upon which burdens and benefits should be distributed. “To each person an equal share”, “to each person according to individual need”, “to each person according to individual effort”,“ to each person according to societal contribution“, and “ to each person according to merit” (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). The principle of beneficence in the research context focuses on maximising potential benefits while minimising possible harms. It requires refraining from intentionally causing injury and ensuring that risks are reasonable in relation to probable benefits. This principle is closely related to informed consent, where a systematic and non-arbitrary presentation of risks and benefits should be outlined (Beauchamp, 2010). Beneficence is essentially an obligation that requires determining when it is acceptable to pursue specific benefits, even with the associated risks, and when it is better to forgo those benefits due to those risks (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Despite the wide acceptance of the Belmont Report and the progress it has made in promoting autonomy and safeguarding research ethics, there are also several critiques. The principle of respect for persons, centres around the principle of respect for autonomy and the principle of protecting incompetent persons. Critiques argue that to meaningfully protect incompetent individuals; one must appeal to the principles of beneficence or justice. This attitude is supported by Veatch “the Belmont Report offers a three-principle theory using the Kantian term respect for persons, it also subsumes the welfare of the incompetent under respect for persons” (Veatch, 1995, p. 203). While autonomy could be considered a component of a broader respect for individuals, it appears that the responsibility to promote the welfare of those unable to make decisions is clearly an aspect of the obligation of beneficence. Veatch states “if respect for persons includes only respect for autonomy, then nonautonomous persons are left stranded” (Veatch, 1995, p. 204). As stated by Beauchamp “the Belmont Report includes not only these three abstract principles and their analysis but also a moral view that moves modestly in the direction of applied research ethics, and because of its practical and policy objectives, the explanation of the principles had a notably applied character” (Beauchamp, 2010, p. 23).

3 PRINCIPLISM AND AUTONOMY: BEAUCHAMP AND CHILDRESS’ FRAMEWORK

Principlism and the four-principle approach emerged in the 1970s as a way of dealing with ethical decisions. Principlism has gained recognition for its usefulness in addressing various ethical dilemmas and has proven especially appealing to physicians seeking guidance in navigating through ethical challenges (Callahan, 2003). To provide the necessary ethical foundation, principlism combines utilitarian and deontological approaches to their theories (Callahan, 2003). As Hine adds “the four principle approach to bioethics, an approach most associated with the work of Tom Beauchamp and James

Childress is supposed to provide a framework for reasoning through moral issues in medicine" (Hine, 2011, p. 375). She also adds that by applying principles, it is possible to make decisions and take actions in medicine with a reasonable degree of moral justification (Hine, 2011). Beauchamp, a contributor to the drafting of the Belmont Report, has argued that the principles are not universally applicable for resolving ethical issues. As Gordon states "the Belmont Report is not an ethical theory but a brief guideline for ethical decision-making in the area on research on human beings" (Gordon, 2011, p. 266). Furthermore, Gordon concludes that the three general principles of the Belmont Report are deeply embedded in Western culture, which may conflict with its universal application, particularly concerning individual informed consent (Gordon, 2011). Unlike in the principlism approach, no common or particular morality is outlined, which means that methods of specification and balancing are not included in the Belmont Report. With the influence of principlism, the term "respect" has shifted. Prior to 1979, it was primarily associated with the notion of "respect for persons". From 1979 onward, a reconstruction of the notion of respect and how it can be observed was proposed. In fact, the use of the term "respect for persons" shifted to "respect for autonomy" (Lysaught, 2004). Lysaught claims that the term respect can be reduced to "non-interference, where autonomous and non-autonomous persons are decoupled, and respect applies only to the former" (Lysaught, 2004, p. 678). There has been a significant change in the meaning of respect for autonomy under Beauchamp and Childress. The period of the 1970s and the consequent rise of the new field in bioethics marked the shift from a traditional beneficence-based model of medical ethics to the direction of an individual autonomy model (Rehbock, 2011).

3.1 OVERVIEW OF PRINCIPLISM

Having been put forward in several influential works, principlism is an approach that aims to resolve issues in medical ethics by being a fundamental framework (Strong, 2000). Beauchamp and Childress define a cluster of four universal prima facia principles: the respect for autonomy, nonmaleficence, beneficence and justice (Gordon, 2011). The principles serve as the framework for moral decision-making in bioethics. Additionally, the principles can be seen as standards of conduct, and more specific rules for healthcare ethics can be developed by referencing the four principles (Beauchamp, 2010). Lawrence supports this view "the four principles have withstood challenge for nearly 30 years and still form the basis for most decision-making in both the research setting and in clinical practice" (Lawrence, 2007, p. 34). All four principles are needed to provide a comprehensive framework for biomedical ethics, but it must be mentioned that unless specified, the moral framework is abstract and not adapted for specific circumstances (Beauchamp, 2010). Beauchamp and Childress characterise the four central principles drawn from common morality as what W.D. Ross identified as prima facie duties, suggesting that each principle may be overridden by stronger moral consideration

(Richardson, 2000). Beauchamp and Childress emphasise that principles, duties, and rights are not absolute; these principles possess only a prima facie character and can therefore be justifiably overridden by other conflicting moral norms. Beauchamp and Childress draw on the theory of W.D. Ross of prima facie obligations and state "W.D. Ross defended a distinction that we accept in principle between prima facie and actual obligation. A prima facie obligation must be fulfilled unless it conflicts with an equal or stronger obligation" (Beauchamp & Childress, 2012, p. 15). "Obligations and rights always constrain us unless a competing moral obligation or right can be shown to be overridden in a particular circumstance" (Beauchamp & Childress, 2012, p. 15). Beauchamp and Childress even advance beyond the model proposed by W.D. Ross by balancing conflicting prima facie duties and interpreting moral principles (Richardson, 2000). Bioethical theory is meant to be action-guiding, and the aim is to guide actions in the future, especially in a fast-changing context as the field of bioethics (Richardson, 2000). Overriding a conflicting principle draws on the metaphor of weighing and balancing (Richardson, 2000). The approaches are essential because the nature of the principles is general, and the interpretation of the principles aims to make them more specific so that they can be applicable in different biomedical contexts. The content-thin nature of the principles, which expresses only prima facie rather than actual obligation, makes them prone to being overridden. Therefore, it is essential to specify and balance the principles according to the situations and circumstances (Hine, 2011). The approach of specification involves "qualifying abstract principles by qualitatively tailoring norms so that they provide a more specific set of moral instructions in a particular domain of case problem" (Veatch, 1995, p. 216). Gordon states that Beauchamp and Childress appeal to Henry Richardson's specification method, to prove why further content is always needed for decision-making (Gordon, 2011). It is also important to recognize that all general principles have exceptions, and that each principle is subject to modification and reformulation (Beauchamp, 2010). The specification approach and model need to be supplemented by a balancing approach. Balancing can be defined as "the process of finding reasons to support beliefs about which moral norms should prevail and is concerned with the relative weights and strengths of different moral norms, whereas specification is concerned primarily with their scope" (Beauchamp & Childress, 2012, p. 20). Beauchamp and Childress embrace a common morality approach, emphasizing that the four principles are inherently embedded in public morality, which they define as a set of norms shared by all individuals committed to morality, "the common morality is applicable to all persons, in all places, and all human conduct can be judged by its standards" (Beauchamp & Childress, 2012, p. 3). On the other hand, particular moralities can be described as non-universal moral norms that are concrete, content-rich, and rooted in various cultural, religious, and institutional contexts (Gordon, 2011). As Gordon outlines, Beauchamp and Childress seem to believe that specific moralities attempt to reach common morality by employing the methods of specification and balancing, and they assert that "a particular morality enriches the abstract universal principles of the common morality by adding empirical data to the principles and rules through the methods of specification and balancing in such a way that they become less abstract and richer in substance" (Gordon, 2011, p. 258). Beauchamp and Childress also state that particular moralities can be regarded as "works continuously in progress, rather than finished products" (Beauchamp & Childress, 2012, p. 408). Furthermore, common morality tends to become more refined when applied to cases and continually tested through a process of evaluation and adjustment (Gordon, 2011).

3.2 REVIEW OF THE FOUR PRINCIPLES

Autonomy

Derived from the Greek word's autos ("self") and nomos ("rule" or "governance"), the term autonomy has been broadened to include individuals, referring to both self-rule and self-governance. Personal autonomy encompasses self-rule that is free from controlling interference by others and limitations that prevent the execution of meaningful choices, such as inadequate understanding (Beauchamp & Childress, 2012). Autonomy can also refer to cognitive, psychological, and emotional abilities to make rational decisions. When displaying these abilities, individuals should have the right or freedom to decide without impediment in their decision-making (Pollard, 1993). Miller argues that it is important to bear in mind that it is not sufficient to describe autonomy merely as self-determination with the right to make one's own choices and to respect the obligation of non-interference with the choices of others. Instead, he outlines "four senses of the concept of autonomy" used in medical ethics that are important (Miller, 1981, pp. 24-25). Autonomy as free action refers to voluntary actions free from coercion and intentional decisions to either submit to or refuse medical treatment. Autonomy as authenticity refers to actions that align with a person's character and reflect their common attitudes, values, dispositions, and life plans. Autonomy as effective deliberation means that actions are based on an awareness of alternatives and their consequences, and that decisions are made after careful evaluation (Miller, 1981). Furthermore, Miller describes autonomy as a form of moral reflection, which can be understood as quite complex since it involves the "reflection on one's complete set of values, attitudes and life plans and requires self-analysis, awareness of alternative sets of values, commitment to a method assessing them, and an ability to put them in place" (Miller, 1981, p. 25). Beauchamp and Childress propose their three-condition theory, which categorizes autonomous actions based on Intentionality, Understanding, and Noncontrol (Beauchamp & Childress, 2012, pp. 104-105). The principle of respect for autonomy aims to acknowledge the rights of autonomous persons to make choices and hold certain views, as well as to enable them to act autonomously (Beauchamp & Childress, 2012). However, the obligation to respect autonomy does not extend to persons who are not considered to be able to act in an autonomous manner and are, therefore, rendered nonautonomous (Beauchamp & Childress, 2012). Judging a person as incompetent is not a straightforward task. It is important to keep in mind that incompetence in performing tasks can be reversible and time related. Furthermore, it needs to be distinguished from chronic or quickly reversible changes, relying on evaluation to determine if incompetency only prevails in certain circumstances. Beauchamp and Childress present a proposed schema found in the literature to determine incompetence, which involves the ability to formulate a preference, understand information, and the capacity to reason (Beauchamp & Childress, 2012).

Non-maleficence

Already proclaimed in the Hippocratic Oath and tradition, primum non nocere refers, above all, to the principle of doing no harm, which presents the obligation to abstain from causing harm. The obligation of non-maleficence refers to obligations of both not inflicting harm and not imposing the risk of harm. Often, the principle of non-maleficence is combined with the principle of beneficence, with the obligations of non-maleficence being considered more stringent than the principle of beneficence (Beauchamp & Childress, 2012). Beauchamp and Childress refer to William Frankena, who combines the two principles into four general obligations. The first obligation refers to the principle of non-maleficence “one ought not to inflict evil or harm” (Beauchamp & Childress, 2012, p. 151). Each of the other three obligations requires action that prevents or removes harm and consequently promotes good, thereby complementing the principle of non-maleficence on the basis of beneficence (Beauchamp & Childress, 2012). Despite the fact that other principles also justify moral rules, the principle of non-maleficence serves to support more specific moral rules, such as “do not cause pain or suffering” and “do not deprive others of the goods of life” (Beauchamp & Childress, 2012, p. 154). The principle of non-maleficence also leads back to the principle of autonomy, as it reflects the right not to get harmed physically or emotionally by others (Callahan, 2003).

Beneficence

The term beneficence connotes acts of mercy, kindness, charity, love and humanity and includes all forms of actions that benefit other persons (Beauchamp, 2010). The principle of beneficence strives to create a positive balance of goods over inflicting harms and includes rules as the maximisation of possible benefits and the minimisation of possible harms. In the medical context it expressed in terms of a positive obligation to assist those in need of treatment or in danger of injury (Beauchamp, 2010). The principle of beneficence, which refers to a moral obligation to act for the benefit of others, is deeply embedded as a fundamental tenet in ancient medical ethics, as established by Hippocrates and various moral theories. Utilitarianism, for instance, can be regarded as based on the principle of beneficence, which refers to the principle of utility in utilitarianism (Beauchamp & Childress, 2012).

Contrary to the principle of non-maleficence, which we are obliged to uphold for everyone, the principle of beneficence can be applied more selectively to those with whom one has a special relationship, such as family members or friends, resting on the concept of "specific beneficence" (Beauchamp & Childress, 2012, p. 205). General beneficence, for instance, is directed toward all individuals, even beyond special relationships. Beauchamp and Childress argue that the obligation of beneficence underlies moral obligation, such as when a person identifies themselves as capable of rescuing a drowning individual, even if no special moral relationship exists with that person (Beauchamp & Childress, 2012). To act kindly or generously towards others also requires developing a sense for others and respecting them as autonomous agents (Callahan, 2003). The fact that beneficence remains a dominant concept for many physicians, despite the shift toward an autonomy-focused approach with shared decision-making and information disclosure, raises important questions about the limits of beneficence and where the line is drawn between beneficence and paternalism. Pellegrino and Thomasma highlight that the major criticism from proponents of autonomy is the equation of beneficence with medical paternalism (Pellegrino & Thomasma, 1987). Pellegrino and Thomasma propose a beneficence model after identifying shortcomings in both the medical paternalism and autonomy models. The beneficence model regards each case as individual for the patient's best interest and requires communication between physicians and patients (Pellegrino & Thomasma, 1987). The authors describe beneficence as a fundamental requirement for medicine, essential for caring for patients and preventing harm, as care cannot be provided otherwise. Ultimately, beneficence is seen as the foundation of both autonomy and paternalism, which should be oriented towards producing the greatest benefits for the patient (Pellegrino & Thomasma, 1987).

Justice

The principle of justice refers to a broad principle, that can be explained in essence of "fairness, equitable, and to appropriate treatment in light of what is due or owed to persons" (Beauchamp & Childress, 2012, p. 250). The principle of justice also possesses a social character and focuses primarily on the pattern of distribution (Veatch, 1995). Beauchamp connotates the term distributive justice with the "distribution of primary social goods, such as economic goods and fundamental political rights and burdens that are within scope" (Beauchamp, 2010, p. 41). In terms of healthcare resources, resources should be distributed fairly and should not be influenced by factors as "race, gender, or socio-economic status" (Mavropoulos, 2024, p. 146). To treat agents fairly means to allocate resources in a way that allows them to function as autonomous individuals, which implies respecting their autonomy (Callahan, 2003).

3.3 CONFLICTS AMONG THE PRINCIPLES IN PRINCIPLISM

Beauchamp and Childress emphasise that the principle of respect for autonomy holds no moral priority over other principles, and in fact, all principles should be weighed equally. Respect for autonomy has only prima facie standing and competing moral considerations can sometimes even override this principle. As Beauchamp and Childress state, "principles, rules, obligations, and rights are not rigid or absolute standards that allow no compromise, instead, principles must be balanced and specified so they can function in particular circumstances" (Beauchamp & Childress, 2012, p. 15). It is not objectionable to moral norms that they can be justifiably overridden by conflicting norms in certain circumstances (Beauchamp & Childress, 2012). Beauchamp highlights "controversial problems with the principle of respect for autonomy arise when we must interpret its significance for particular contexts, determine precise limits on its application, and decide how to handle situations in which it conflicts with other moral principles" (Beauchamp, 2010, p. 38). Even though the principles are often not incompatible, there are situations in health care when one principle may conflict with another (Breeze, 1998). It can be said that it is not avoidable that principles get into conflict when applied to clinical practice and decision-making, and the question arises based on which principle to subsequently direct the decision-making process. Gillion points out that using the four principles, moral concerns can be explained and justified by applying one or a combination of the principles. To quote him "the four moral nucleotides that constitute moral DNA-capable, alone or in combination, of explaining and justifying all the substantive and universalisable moral norms of health care ethics" (Gillon, 2003, p. 308). The prima facie nature of the four principles allows for their "prioritisation in particular circumstances" and the reflection on "their proper scope of application", which can positively encourage agents to engage in "deliberated thoughts for themselves" (Gillon, 2003, p. 309). This implies that there seems to be no right approach but instead a flexible one, where situations need to be analysed through balancing and specification. Gordon states that the concept of principlism involves specifying and balancing mid-level principles to refine moral judgments in the event of conflict (Gordon, 2011). Cultural or religious obligations, which vary among individuals and cultures, can affect how a conflict is resolved and which of the four principles is prioritised (Gillon, 2003). Veatch examines the principlist approach to resolving conflicts among the principles. He advocates for a resolution through specification in a mixed strategy that involves lexical ordering alongside balancing (Veatch, 1995). Engelhardt, in his two-principle theory, prioritises autonomy or freedom over beneficence (Veatch, 1995). However, even Engelhardt, whose theory mainly centres on autonomy, acknowledges the necessity of incorporating considerations of beneficence within moral communities (Veatch, 1995). Engelhardt himself describes autonomy as a cardinal notion presenting the root of morality and the ground for accountability (Engelhardt, 2001). Donchin remarks that Engelhardt encompasses the prevailing conception of autonomy within a more inclusive ethical framework.

Unlike the principle of autonomy, which upholds the moral world in his account, the second principle, beneficence, rests solely on autonomy (Donchin, 2001). Also, Gillon believes that autonomy should be seen as "primus inter pares – first among equals – among the four principles" (Gillon, 2003, p. 310). He supports this by arguing that autonomy requires deliberation and independent decision-making based on one's own reasoning, which embodies morality (Gillon, 2003). Furthermore, individuals are most aware of their own needs and can best assess their requirements and circumstances. He shares the same point of view as Engelhardt, who believes that other principles rest on the principle of autonomy. Also, Callahan states, "the individualism underlying principlism is best seen in the central place given to autonomy," and "other principles seem ineluctably to lead back to it" (Callahan, 2003, p. 288). Gillon also asserts that he believes respecting autonomy will yield greater benefits than compelling an autonomous agent to follow a specific direction against their choice (Gillon, 2003). It can be said that, based on those accounts, the principle of autonomy would prevail. Callahan, mentions that the conflicts between autonomy and other principles "are meant to be resolved in a way that does minimum damage to person's autonomy- since it is autonomy to which all other principles point back" (Callahan, 2003, p. 289). All those accounts demonstrate the prevailing view in decision-making. Despite Beauchamp and Childress's assertion that the principle of autonomy holds only prima facie status and shares equal priority with other principles, practical considerations suggest that the principle of autonomy in Western ethics and medical decision-making often tends to be prioritised. Beauchamp and Childress support the method of reflective equilibrium, which aspires to bring "principles, judgements and background theories into a state of equilibrium or harmony" (Beauchamp & Childress, 2012, p. 404). Hirne describes the method as one that justifies specific moral beliefs and broader moral principles, encouraging individuals to "start with considered moral judgements, typically from the common morality and to test those moral beliefs and moral principles against these judgements and to adjust one's beliefs and principles until a coherent set is created" (Hine, 2011, pp. 381-382). Although Beauchamp and Childress acknowledge that achieving a state of reflective equilibrium is merely an ideal and cannot be realised, the "reshaping of beliefs will occur again and again in response to new situations and conflicting norms" (Beauchamp & Childress, 2012, p. 406). The value, therefore, resides not in attaining a final state but in the ongoing effort to reconcile conflicts and enhance coherence. However, there are also alternatives to principlism that aim to navigate emerging ethical dilemmas. Some authors, such as Strong propose the method of casuistry, which was revived and developed by Jonsen and Toulmin as a way of addressing moral problems through case comparison and practical reasoning (Jonsen & Toulmin, 1988). Strong in fact, while criticising the approach of specified principlism, describes casuistry as a case-based approach where specific ethical values about the case are taken into consideration. Furthermore, cases are compared to paradigm cases to determine the course of action. Casuistry does not always aim at resolving a case but sometimes concludes with alternative courses of action (Strong, 2000).

3.4 THE ROLE OF AUTONOMY IN MEDICAL DECISION-MAKING

Modern medicine, particularly as practised in Western society, revolves around the concept of patient autonomy. Indeed, autonomy has become a mantra in medical decision-making, and in cases of controversial areas and questions regarding medical decisions, the conflicts consistently centre on patients' autonomy and the respect afforded to their autonomy choices. Braun examines the autonomy-based approach regarding assisted suicide. An increasing number of countries have legalised forms of assisted dying for specific groups of individuals, such as those with irreversible medical conditions or disabilities, allowing them to end their suffering if it is unbearable and no improvement is expected, as well as no acceptable treatment alternatives are available (Braun, 2022). Ethical justifications for assisted dying commonly refer to the principles of beneficence and autonomy. The beneficence notion refers to relieving irremediable suffering in the person's best interest, and the ethical justification of autonomy refers to making "autonomous decisions about the circumstances of one's own death" (Braun, 2022, p. 497). Braun reflects that based on an autonomy-based approach, it would indeed be legal to provide assisted suicide to "anyone who makes an autonomous request, even if there would have been options available to improve the person's medical condition or if the person is not suffering from a medical condition at all, which would include persons tired of living without an irremediable medical disease" (Braun, 2022, p. 499). The message is that autonomy-based legislations would not assume that some forms of suffering justify the ending of one's life while others do not and that on accounts of an autonomy-based approach, "assisted suicide should not be understood as a medical intervention but rather as an autonomous action that does not invoke traditional medical principles as beneficence" (Braun, 2022, p. 500). Braun's work, in fact, reflects that the approach to decision-making in the clinical setting is right-based and influenced by the appeal to autonomy. Rigby and Symons examine the extent to which principlism provides guidance for ethical debates surrounding abortion and euthanasia. They argue that principlism alone does not offer a definitive resolution to these bioethical issues; however, they reference authors who invoke principlism to, for example, to defend abortion rights (Rigby & Symons, 2023). Watson and Chor (as noted in Rigby & Symons, 2023) argue that by referencing the principles, especially the principle of autonomy, they can justify access to abortion, particularly in relation to the protection of bodily integrity, the freedom to make decisions and control over one's life path (Rigby & Symons, 2023). Callahan reflects the mantra of the prevailing notion of autonomy. He states that "most Western societies would grant the patient's right to make the life-or-death choice" (Callahan, 2003, p. 289). Mavropoulos outlines that the principle of autonomy is often idolised and celebrated as a moral absolute in Western countries, particularly concerning practices and topics of ethical debate such as abortion, euthanasia, and gender reassignment (Mavropoulos, 2024). The absolutisation of autonomy is compared to religious attitudes in Christianity, where, on the contrary, an absolutisation of autonomy is not encouraged; rather, the principles should be "integrated into the general moral duties, values, norms, and virtues of Christian morality" (Mavropoulos, 2024, p. 154).

3.5 PATERNALISM WITHIN THE PRINCIPLISM FRAMEWORK

Paternalism can be viewed as a theoretical concept with various interpretations; it may be seen as a practice rather than merely a principle and can be referred to as "the practice of applying or withholding medical treatments solely by reference to the perceived medical consequences" (Pollard, 1993, p. 798). Paternalism comes from the Latin term "pater" and implies acting like a father or treating someone as a child (Rodriguez-Osorio & Dominguez-Cherit, 2008). However, it primarily focuses on behaviour that involves some form of restraint and benevolence (Grill, 2012). Whereas the term paternalism was largely associated in the late nineteenth century with less strategic benevolence in hierarchical relationships, such as between a king and his subjects, in contemporary moral philosophy, it now refers to benevolent intention, irrespective of power structures (Grill, 2012). In most definitions of paternalism, benevolence is regarded as the primary psychological motive for interference (Grill, 2012). While this positive implication of paternalism is highlighted by Grill, Beauchamp and Childress define paternalism as "the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this by the goal of benefiting or preventing harm to the person whose preferences or actions are overridden" (Beauchamp & Childress, 2012, pp. 215-216).The term paternalism is part of a critique based on the inherent value of personal liberty and autonomy. Although the term paternalism conveys a benevolent and protective intent, it is often linked to attitudes of overprotection, which are generally perceived as infringements on personal freedom and autonomy (Fernández-Ballesteros, et al., 2019). Particularly liberal tradition tends to be anti-paternalistic in the sense that paternalism is regarded to be prima facie wrong. John Stuart Mill emphasises the limited right of the state to interfere with individuals. Mill defends the view that people should be free to do as they like as long as their behaviour does not harm others, claiming that every individual is most concerned with promoting their own interest and is best to evaluate what is in their own interest (Grill, 2012). He embraces the values of development and individuality, clearly setting an anti-paternalistic direction. In liberal thought, there has been some progress regarding the topic of paternalism. In contemporary works, such as those by Feinberg, the author acknowledges the overly optimistic belief that individuals are always the best judges of their own interests. He refers to obstacles of voluntary choice as manipulation or psychological compulsion, therefore calling for the resulting principle of soft paternalism. "The resulting soft paternalism allows benevolent restriction of insufficiently voluntary choice" (Grill, 2012, p. 360). Moreover, the principle of respect for autonomy is fundamental to liberal thought, establishing a robust opposition to paternalism while also aiming to restrict it (Christman, 2014). It becomes evident that contemporary understandings of autonomy aim to limit the extent of justified paternalistic intervention, particularly in a medical context where respect for patients' autonomy is considered a fundamental ethical principle. Another critique of paternalism is that it often implies a sense of superiority and thus can be taken as insulting. However, if an interference benefits an individual, it is because something is preventing that individual from securing this benefit independently. The paternalist is superior only in the sense that they are better able to produce the benefit (Grill, 2012). Breeze elaborates on the need for critical analysis regarding the justification of paternalistic interventions in mental health care. She outlines that the justification for paternalism in mental health care presents a moral dilemma between respect for autonomy and beneficence (Breeze, 1998). The author elaborates on Kant's and Mill's theories, noting that both deontologists and utilitarians argue for the moral importance of respecting agents' autonomy. On both accounts, autonomy can be regarded as a property and is granted only to rational beings who are found in the maturity of their faculties (Breeze, 1998). From different starting points, Kant and Mill both arrive at similar formulations that emphasise respect for autonomy and freedom (Pollard, 1993). As Breeze summarises, "an autonomous decision is therefore dependent upon the presence of rationality and competence to make decisions, which appears to suggest some justification for paternalism and therefore requires analysis" (Breeze, 1998, p. 262). An example is outlined of a patient with a serious mental health condition, which causes him to act irrationally, leading him to refuse lifesaving treatment despite a good prognosis. The treatment would be administered based on beneficence but conflicts with the principle of autonomy (Breeze, 1998). In the medical context, the common interpretation of autonomy refers to the policy of non-interference; however, this interpretation conflicts in the mentioned case with the professional obligation to act in the patient's best interests (Pollard, 1993). Beauchamp and Childress propose six conditions under which they consider paternalism justified in health care, pointing out that it is only justified if the conditions are satisfied accordingly (Beauchamp & Childress, 2012). They refer to hard paternalism, which involves interventions to prevent harm or to benefit a person, despite the individual's actions being based on autonomous, voluntary, and informed choices (Beauchamp & Childress, 2012). The proposed conditions involve: "a patient at risk of significant, preventable harm", "the paternalistic action will likely prevent this harm", "the prevention of harm to the patient outweighs the risks associated with the action taken", "there is no morally superior alternative to the restriction of autonomy involved", "the least autonomy-restrictive alternative that will secure the benefit is adopted". and "paternalistic action does not compromise substantial autonomy interests" (Beauchamp & Childress, 2012, p. 222). This demonstrates that, according to Beauchamp and Childress, paternalism is only justifiable under certain circumstances, and priority should still be given to respecting an agent's autonomous decision. This also demonstrates the contemporary tendency to avoid paternalism whenever possible and reflects the common anti-paternalistic stance, highlighting that the concept of the autonomous agent must play a central role in medical ethics. Paternalism can be viewed as the antithesis of autonomy; however, the effects of conditions, such as illnesses that can impair a person's capacity for decision-making, are often ignored (Pollard, 1993). A lack of autonomy can in fact range from common examples such as addiction and mental or physical disability to cases of brainwashing and manipulation (Christman, 2014). Particularly for patients who lack the capacity for autonomous decision-making and deliberation, paternalism based on beneficence can often be beneficial in restoring the patient to a point that aims to reassert the agent's autonomy (Pollard, 1993). Despite our current understanding of autonomy, which has fostered an anti-paternalistic viewpoint, there exists a contentious idea presented in some papers that encourages us to reassess paternalistic actions in specific circumstances for the patient's benefit. Donchin critiques the dominant conceptualisation of autonomy and states the need for alternative formulations (Donchin, 2001). MacIntyre (as cited in Donchin, 2001) critiques liberalism and reflects critically on the erosion of authority and the traditional role of physicians, leading to patients feeling pressured to act on their own behalf; he calls for reinstating the privileged position of physicians, which may reflect paternalism that supports patient autonomy and care (Donchin, 2001). Pollard concludes that particularly in circumstances that limit the individual, such as illness, pain, or fear, respecting autonomy may require a response more complex than simple non-interference (Pollard, 1993). VanDe Veer analyses whether paternalistic interference can be justified while referring to the significant contributors Gerald Dworkin and Joel Feinberg (VanDeVeer, 1980). Feinberg accepts the form of weak paternalism, which rejects interference with voluntary acts of generally competent individuals (VanDeVeer, 1980). Smiley examines the justification of state paternalism and elaborates on contemporary philosophers such as Feinberg and Dworkin (Smiley, 1989). For Feinberg, paternalism appears justifiable when it aligns with the principle of liberty and when individuals are unable to make free choices (VanDeVeer, 1980). Dworkin justifies state intervention and non-paternalistic intervention by assuming that rational individuals would consent to the promotion of primary goods, despite the implications of paternalistic actions being involved (Smiley, 1989). Pellegrino and Thomasma suggest that medicine does involve instances of necessary and beneficial paternalism when it aims to preserve autonomy and life, or to prevent harm in situations that impair a patient's ability to make autonomous judgements (Pellegrino & Thomasma, 1987). It should not be neglected that the principle of autonomy and the importance attributed to it can sometimes hinder beneficial paternalism. Under certain evaluated circumstances, paternalism is not something we should deter but rather something we should encourage. While it is vital to uphold the standpoint of respecting the wishes of patients and individuals, thus making autonomy a central concern in future determinations, there are numerous instances where paternalism proves advantageous and many situations in which autonomy imposes limits on paternalism intervention. Christman states that it is “respect for autonomy that grounds the restrictions on the part of the paternalist’s potential interfering actions and valuing autonomy, on the contrary, might justify taking actions that advance, promote or enable the autonomy of the person” (Christman, 2014, p. 373). Christman closes his paper with some remarkable objectives “autonomy must be valued as well as respected in clinical practice if adequate attention is to be paid to the ways interaction with vulnerable individuals can facilitate the development of their autonomy”, “it is important to see autonomy as something we value and promote, and not merely something we respect at a distance” (Christman, 2014, p. 381). Particularly in a medical context, treatment choices can be complex, and patients’ decision-making capacity is often impaired. In medical ethics, advocating for patient autonomy is of high priority. This implies that patients should always be informed about the available treatment options and encouraged to choose between them. It is also important to mention that patients’ autonomy is respected even if they choose not to be informed or to trust their caregivers or families to make treatment-related decisions for them. As Grill contends, it is essential to remember that medical paternalism is also a characteristic of the personal relationship between caregiver and patient. While some relationships may be openly paternalistic, with the caregiver assuming the role of benevolent authority and expecting compliance, others can be covertly paternalistic, where caregivers manipulate patients for what they perceive to be their own benefit. Alternatively, there can be an equal and honest relationship in which caregiver and patient collaborate in reasoning about decisions related to medical care (Grill, 2012). This reflects the varying power dynamics within the provider-patient relationship. The moral imperative to respect patients’ autonomy can help balance these relationships, particularly in clinical settings, by enabling patients to become the ultimate decision-makers regarding their own care treatment. However, paternalism can be interpreted positively in cases of natural vulnerability. In such situations, a physician acts with consideration, education, and experience while maintaining emotional distance and keeping the patient's best interests in mind (Gauthier, 1993). Nevertheless, Gauthier states, “the principle of respect for autonomy in medical care requires health care providers to allow and encourage fully competent patients to make decisions about their own lives and medical treatment without attempting to control those decisions” (Gauthier, 1993, p. 22).

3.6 THE PRINCIPLE OF AUTONOMY AND ITS CONNECTION TO INFORMED CONSENT

Various ethical codes and declarations established after the Second World War have highlighted the significance of informed consent. Whereas initially, informed consent served as protection against exploitation and misconduct it has become increasingly more integrated with the respect of patient’s autonomy over time (Grill, 2012). The doctrine of informed consent maintains the “right to autonomy as free action" (Miller, 1981, p. 24). In the medical context, it is essential for the patient to be informed about the treatment. Upon receiving this information, the patient can grant permission, making the treatment intentional and voluntary. The aim of informed consent in medical ethics is therefore to protect patients' autonomy by requiring consent for all medical interventions and to ensure that agents make decisions on autonomous grounds (Manson & O'Neill, 2007). Informed consent refers to an individual's voluntary agreement to a medical intervention or research participation, based on a clear understanding of the implications involved (Beauchamp & Childress, 2012). Beauchamp and Childress accept seven elements of informed consent. Ranging from preconditions such as competence and voluntariness to information elements that include disclosure, recommendation, and understanding, and finally consisting of consent elements like decision and authorisation of the chosen plan (Beauchamp & Childress, 2012). However, more generally, the following components of informed consent are recognised across various literatures: competence, disclosure, understanding, voluntariness, and consent (Beauchamp & Childress, 2012). Pollard acknowledges that although informed consent ideally implies an understanding of the complete set of information, there is a shift towards the agent's understanding of the "adequate relevant information"," needed by a reasonable person to reach a considered decision" (Pollard, 1993, p. 798). This can be explained by the fact that agents are often confronted with unfamiliar themes, such as medical details that are generally unknown to the average person. Therefore, the emphasis is on ensuring that the agent understands the adequate relevant information (Pollard, 1993). Beauchamp and Childress support the view that understanding does not need to be complete and understanding the facts is usually enough for making decisions about diagnosis, prognosis, the characteristics and objectives of an intervention, available alternatives, associated risks and benefits, as well as medical recommendations (Beauchamp & Childress, 2012). Watter reflects on the importance of informed consent in the practice of prescribing medication that impacts patients' sexual functioning (Watter, 2024). While the practice of informed consent should honour the principle of patient autonomy, the "truly valuable informed consent", as stated by Watter, must be customised to the needs of the individual patient, with the significance of context being a paramount priority (Watter, 2024, p. 197). Often, excessive information may overwhelm or adversely affect the patient, while in other cases, it can enhance patient adherence. Informed consent should, therefore, aim to be contextual to prevent informed consent from devolving into a meaningless practice that causes patient confusion or incomplete understanding (Watter, 2024). Pollard argues that voluntariness is always regarded as a matter of degree, though a completely voluntary and free choice reflects the ideal, but in fact people rarely decide in ways that are entirely free of external influence (Pollard, 1993). The decision-making process depends on various competing factors, including family dynamics, cultural commitments, legal obligations, and individual experiences (Pollard, 1993). But as Beauchamp and Childress outline it is important for consent to be given without the absence of influences that negatively impact an autonomous act, such as coercion, persuasion and manipulation (Beauchamp & Childress, 2012). The principle of respect for autonomy encompasses both negative and positive obligations. Whereas the negative obligation signifies that the autonomous agent should not be subjected to controlling constraints from external sources, the positive obligation entails not only respectful treatment but also the promotion of informational exchange that can enhance autonomous decision-making (Beauchamp, 2010). Beauchamp and Childress further support this point by claiming that many autonomous actions could not occur without others' cooperation in making options available. This obligation compels professionals in healthcare and research to disclose information, ensuring understanding and voluntariness while fostering adequate decision-making (Beauchamp & Childress, 2012). It is important to mention the parallel between informed consent and the ability to make autonomous decisions. Autonomous actions are not possible without information disclosure and proper understanding. As Beauchamp states, "respect for autonomy obliges professionals in health care and research to disclose information, ensure understanding and voluntariness, and foster adequate decision-making, as true respect for autonomy requires more than mere non-interference in others' personal affairs" (Beauchamp, 2010, p. 37). Savulescu and Momeyer argue that the revealing and the disclosure of information is important in the sense that it helps persons to hold relevant true beliefs, but to hold relevant true beliefs, rational deliberation must be present. "Just as physicians should aim to provide relevant information regarding the medical procedures prior to patients consenting to those procedures, they should also assist patients to think more clearly and rationally of their beliefs", "since holding true beliefs is necessary to be autonomous, we do not respect autonomy when we allow patients to act on irrational beliefs" (Savulescu & Momeyer, 1997, p. 287). Nevertheless, the authors argue that it is fundamental to care about the rationality of patients' own beliefs for the decision-making process (Savulescu & Momeyer, 1997). Literature in bioethics has increasingly suggested that any justifiable analysis of informed consent must be rooted in autonomous choice by patients and subjects (Beauchamp, 2010).

3.7 CHALLENGES AND ERRORS IN INFORMED CONSENT

Particularly, the field of medical practice involves patients who lack autonomy or have impaired competence to consent, as diminished cognitive capacities are a common side effect of medical conditions and complications. Numerous patient groups are unable to give informed consent or comprehend important information because of cognitive impairments, mental confusion, or young age (Manson & O'Neill, 2007). Incompetent individuals may include those who lack autonomy, such as young children, patients with advanced conditions like Alzheimer's disease, and people in a persistent vegetative state (Beauchamp, 2010). A person with diminished autonomy is considered incapable of deliberating and acting according to their desires and is consequently controlled by others (Beauchamp, 2010). The errors surrounding informed consent also pertain to specific populations, such as minors. If the individual is a minor and not of legal age, effective or valid consent under prevailing institutional rules is not possible (Beauchamp, 2010). The problem is that even if the minor gives consent autonomously and responsibly, the consent is regarded invalid. Due to the lack of legal competence among minors to give consent freely and autonomously, this authority is transferred to legal guardians, typically parents or relatives. Albuquerque and Garrafa argue that "the complexity of situations related to the participation of children and adolescents in decision-making processes that affects them directly shows one of the problems of principlism, as it shows the weakness arising from a heightened emphasis on the autonomy of the individual, which does not consider the specifics of each case and other factors related to each particular situation" (Albuquerque & Garrafa, 2016, p. 456). It is essential to foster progressive respect for the autonomy of minors through the establishment of mechanisms and protections for individuals who are unable to legally give consent (Albuquerque & Garrafa, 2016). The concept of individual informed consent does not serve as a universal standard to which all individuals, including those from different cultural backgrounds, can adhere. This results in the rejection of non-Westerners to the universal norm of individual informed consent, as it can be regarded as a form of Western ethical imperialism (Gordon, 2011). The concept of informed consent can be viewed as rooted in the Western individualistic perspective, but it is also essential to consider other cultural viewpoints, as obtaining family or community consent is significant in clinical settings. As Gordon asserts, "family-informed consent is equally valid and should be applied in a particular cultural setting, meaning that different communities can specify and balance moral norms according to their community-specific morality" (Gordon, 2011, p. 263). Grill suggests that informed consent might be seen as a routine process that not only fails to safeguard patients' autonomy but also leads caregivers to avoid their professional duties (Grill, 2012). Manson and O'Neill propose a new way of thinking about informed consent, as they regard accepted accounts of informed consent as problematic. They particularly critique the notion that informed consent is regarded as important solely because it upholds individual autonomy. "Informed consent is not, and certainly not primarily, a way of exercising autonomy" (Manson & O'Neill, 2007, p. 188). The principle of autonomy is not the only important ethical requirement in bioethical practice, as autonomy always goes hand in hand with other prima facie principles; they, therefore, outline other justifications of why informed consent matters should be proposed (Manson & O'Neill, 2007). One of the reasons informed consent is essential instead includes its role in providing standard and manageable methods for securing obligations and preventing breaches of significant responsibilities, particularly in relation to ethical, legal, and professional duties. In fact, overemphasising individual choice on practical grounds does not guarantee that attention is directed towards the full range of ethical, legal, and professional obligations (Manson & O'Neill, 2007). Regarding consent and non-competence, they identify another major error, "when individual autonomy is seen as the sole justification for informed consent practices, there seems to be nothing left when individual capacities fail or falter, either because patients are generally incompetent to consent or because they cannot genuinely consent to a specific proposal" (Manson & O'Neill, 2007, p. 193).

4 ETHICS OF CARE: A RELATIONAL PERSPECTIVE ON AUTONOMY

Care ethics is a branch of ethics that is particularly emphasised and prominent within the context of medical ethics, health care ethics, and nursing care. The ethics of care can be regarded as fundamental to relationships, practices, and all actions in healthcare and human interaction. Beauchamp and Childress contend that the essence of moral life lies not in following moral rules, but in having a dependable character, a strong moral sense, and suitable emotional responses (Beauchamp & Childress, 2012). Beauchamp and Childress also recognise that even specific principles and rules do not convey emotional engagement in the same way as when physicians and nurses demonstrate compassion, patience, and responsiveness in their interactions with families and patients. Morality would be a "cold and uninspiring practice, without appropriate sympathy, emotional responsiveness, excellence of character, and heartfelt ideas that reach beyond principles and rules" (Beauchamp & Childress, 2012, p. 30). The care ethics represents an opposing pole to the principlism-based approach, which focuses on decision-making based on universal rules and principles, rationality, autonomy, objectivity and impartiality (Botes, 2000). On the contrary, attributes related to the ethics of care can be classified as providing contextual and need-centred care, involvement and empathy in the maintaining of relations as well as extended communicative rationality (Botes, 2000). The ethics of care also challenges liberal, principlist-based accounts and proposes the core idea of an ethics of care that assumes that "individuals are not the isolated and abstract entities as described in traditional liberal theory but are fundamentally relational and interdependent" (Koggel & Orme, 2010, pp. 109-110). Furthermore, care ethics identifies the limitations of liberal perspectives on autonomy and other concepts such as justice, aiming to reconceptualise these ideas in relational context (Koggel & Orme, 2010). Koggel et al. support this perspective through the lens of feminist relational theory "over the last four decades, feminist relational theory has developed from projects of identifying and fine-tuning critiques of mainstream liberal theory to delineating and expanding relational approaches that extend the insights, approaches, implications and applications of feminist relational theory" (Koggel, et al., 2022, p. 2). Koggel et al. reflect on feminist relational theory by referencing the works of various authors. They identify eight distinct features that are characteristic considerations for relational theories (Koggel, et al., 2022). They classify the second outlined feature as interpersonal relationships and care ethics. They emphasise that the networks and structures of relationships are crucial in establishing the context for the dynamics of interpersonal relationships "interpersonal relationships are nested in broader social, economic, and political relationships, ones that shape personhood and possibilities for autonomy" (Koggel, et al., 2022, p. 4). Furthermore, as another mentioned feature, which they classify as non-ideal theory, they highlight that relational theories do not focus on implementing ideal relationships. Instead, they insist on "current conditions, context, and circumstances of relationships as a starting point for moral and political theory" (Koggel, et al., 2022, p. 6). Regarding the ontological status of humans, the ethics of care provides relational perspectives that understand individuals as being born into and shaped by their relationships (Koggel, et al., 2022).

4.1 INTRODUCTION TO CARE ETHICS

The ethics of care originated primarily in feminist writings, with the earliest articulation linked to the work of Carol Gilligan, who challenged the negative assumptions about women's moral development. Gilligan refers to the subordinate status of women and the differences between the sexes. She elaborates that women inherently possess the ability to care, are sensitive to the needs of others, and have the capacity to incorporate judgement into other points of view. Men, on the contrary, focus on individuation and personal autonomy; they tend to devalue women as carers, and consequently, women's concerns about relationships are often regarded as a weakness rather than a fundamental strength (Cockburn, 2005). Gilligan emphasises that understanding social context and addressing others' needs is fundamental to the moral reasoning that underpins the ethic of care (Koggel & Orme, 2010). Transitioning from Gilligan's critique of an ethics of rights to an ethics of care, care ethics highlights the significance of context, interdependence, relationships, and responsibilities within a social framework. It has broadened from social psychology into various other disciplines. In fact, care ethics is applicable to all aspects of human relations and organisation and provides responses to not only theoretical challenges but also to changing social circumstances (Koggel & Orme, 2010). Kuhse and Singer illustrate care ethics themes through two key representatives of the ethics of care: Nel Noddings and Virginia Held (Kuhse & Singer, 2009). Both authors agree on the importance of caring interactions between intimates and the necessity of tailoring one's response to the relationship in which one is involved. In relation to the significant role of relationships, care is embedded within various connections. Moreover, care engages emotions, with empathy being the cornerstone of care ethics. Furthermore, both agree that care ethics is not based on principles, where obligations are determined through reflection on moral principles, but rather, "the morally praiseworthy person acts directly on the motive of care and concern for others, and not on the motive of respect for moral principle" (Kuhse & Singer, 2009, p. 108). The fundamental point for the ethics of care centres on relationships involving two parties (Tong, 1998). Noddings talks extensively about the relationship between the "one caring" and the one "cared for" (Noddings, 1984). Caine et al. reflect on Noddings contribution, who asserts that those labels are not permanent but rather pertain to "labels for the parties in an encounter or in a series of encounters in a continuing relationship" (Caine, et al., 2020, p. 267). Also, Noddings asserts that it can be regarded as an absolute obligation to care for someone if there is a relationship with that person (Noddings, 1984). Instead of embodying a set of universal moral judgments, morality in care ethics is conveyed through the conscious act of caring (Caine, et al., 2020). Edwards outlines the existence of different interpretations of care ethics and connects these interpretations to practical applications in the field of nursing care. Care ethics, in its early form, emphasised gendered traits often linked to females rather than males. This focus resonated with the nursing profession, which is predominantly female and revolves around the principles of care as a practice (Edwards, 2009). Edwards reflects on Tronto's contribution to care ethics. She distinguishes between responsibility-based ethics, referring to care ethics where the starting point refers to relational involvement and the moral presupposition of responsibility for others. Edwards expresses Tronto's explanation as "responsibility-based ethics that is claimed to be a pre-existing moral relationship between people, and responding to their plight is automatic and not in need of justification" (Edwards, 2009, p. 234). In contrast to obligation-based ethics, which is included in the four principles approach, where a response occurs only after recognising an obligation to act, as the starting point refers to independence and separation (Edwards, 2009). Edwards expands on Tronto's perspective, claiming that the ethics of care is a hands-on pursuit directed toward a goal (Edwards, 2009). Women, influenced by their gender identity and historical social subordination, often cultivate skills in situational awareness and responding to unvoiced needs, which can improve caregiving by promoting agency (Donchin, 2001). Caring involves a cognitive aspect and requires various moral skills, as it encompasses not just insight but also an understanding of another person's circumstances, needs, and feelings. Van Hooft assures that "caring is seen as an overarching quality that gives action its moral character" (Van Hooft, 1999, p. 189). This demonstrates that care is essential to elicit an appropriate moral response. The ethics of care emphasises virtues that are fundamental not only for health care professionals but also for personal relationships that require intimacy. Van Hooft defines "the virtue of caring as the comportment of the self towards others, which has the inherent goal of enhancing the existence of those others, whether they are others in intimate relationship or simply fellow members of the human race" (Van Hooft, 1999, p. 190). Essential virtues for nurturing and expressing compassion encompass empathy, insight, reliability, and a strong moral compass. The quality of care and the attentiveness in addressing patients' challenges, requirements, and sensitivities form a crucial aspect of professional ethical conduct (Beauchamp & Childress, 2012).

4.2 PRESENTATION OF RELATIONAL AUTONOMY

Mackenzie et al. assert that relational autonomy serves as an umbrella term, which is articulated and justified in various ways by different theorists. Mackanzie et al. state that in their view, "relational autonomy is committed to a form of normative individualism, where autonomy along with the welfare, rights and dignity of individuals matter but relational autonomy is also committed to a social ontology of persons, where persons are embodied in social practices" (Mackenzie, et al., 2014, p. 42). Friedman further emphasises the social context in which individuals are situated "persons are fundamental social beings who develop the competency for autonomy through social interaction with other persons" (Friedman, 2003, p. 104). Relational theorists argue that to enable conditions for autonomy the context of significant social relationships is needed. Moreover, our choices and self-determination are influenced and constrained by social relationships and environments in which we are embedded (Mackenzie, et al., 2014). However, perceiving autonomy as relational involves considering individuality in relation to the contexts of social interaction and the network of relationships, along with shared aims and objectives that connect – for instance, in a medical context – the patient to family members (Donchin, 2001). Relational views of autonomy expand on moral agency. In contrast to Kant, who bases moral agency exclusively on rationality and duty, relational perspectives emphasise the individual's biological nature and emotional capacities (Donchin, 2001). This also involves adopting others' points of view and acknowledging the moral differences that influence decisions one might not otherwise consider (Donchin, 2001). Autonomy in fact, should not be understood based on individual choices of decision-making but instead through addressing the wider social constraints for decision-making. Relational approaches to autonomy hold the account that autonomy is a socially constituted capacity. Autonomy in fact should not be understood based on individual choices of decision-making but instead through addressing the wider social constraints for decision-making. Contrary to liberal traditions that regard autonomy as an individualistic state independent of interpersonal interactions, accounts of relational autonomy challenge this conception, viewing autonomy as inherently relational. Christman states "whether a person is autonomous is very much tied to the character of the social and interpersonal relations which she finds herself" (Christman, 2014, p. 369). This supports the idea that autonomy should not be viewed as simply existing through rationality, but instead as something that develops over time through relationships. Christman also refers to defenders of relational conceptions of autonomy that outline that in order to obtain the agency for self-governance, aspects central to the person must be taken into consideration as cultural, religious and social factors (Christman, 2014).

4.3 THE ROLE OF CARE IN CLINICAL SETTINGS

The clinical setting can be regarded as the most natural setting for care ethics. Ethics of care prevents to lose sight of patients that need care and aims to respond to their needs. Approaches such as the Kantian or the utilitarian centre healthcare around patients' autonomy and patients' rights as autonomous agents who are regarded as rational moral agents that should be treated as ends in themselves.

Treiger-Bar-Am states “Kantian autonomy is the capacity of a rational being to make universal laws” (Treiger-Bar-Am, 2008, p. 550). The ethics of care, on the contrary, recognises that in cases of illness or situations that render us unable to exercise our autonomy, the value of being cared for is fundamental. As Kuhse and Singer state “we should not assume that everyone is always capable of asserting and defending their rights in an autonomous way. Rather, we should recognize that sometimes people might need care while temporarily (and in some case permanently) being unable to assert and defend their rights. In this case, we care for them and see returning them to full autonomy as part of our obligation rather than as an assumption about their present status” (Kuhse & Singer, 2009, p. 112). Botes highlights the distinctions between the theories of care ethics and principlism, which she describes as opposite poles (Botes, 2000). She also outlines the strengths of care ethics in the application of the field of health care. Botes states that “care implies that ethical decisions are taken in a bid to fulfil the needs of others and to maintain harmonious relations” (Botes, 2000, p. 1072). The culture of care, often missing in healthcare, promotes understanding through empathy, viewed as the key element in the ethics of care (Botes, 2000). In addition, ethical situations are regarded as unique circumstances that allow for the accommodation of the needs of others as distinct and individually tailored. Maio reflects on the importance of a care ethics approach in the medical field of oncology. The field of oncology must not only make rational decisions to prolong life but also focus on supporting patients’ contextual needs and fostering their own resource development (Maio, 2025). Rather than relying solely on rationality, the field of oncology necessitates a contextual understanding and empathy to foster the mental growth and resilience of patients, preventing their diagnosis from defining and limiting them (Maio, 2025). Alternative relational models can also be applied more broadly to healthcare settings. Donchin reflects on the alternative models of “mothering”, “friendship”, and “sisterhood”. The goal is not to apply these models to patient care but rather to illuminate the dimensions of the physician-patient relationship, enabling relational capacities that can enhance the autonomy of patients (Donchin, 2001). For example, “mothering” primarily focuses on the agency of women to transform a dependent human being into an independent, autonomous adult. Although the model of mothering is also open to critique and rejection, the metaphor can illustrate the dynamics of the patient-physician relationship to enhance the alignment of practice and goals (Donchin, 2001). The field of medicine can utilise aspects of each of the relational models proposed, as all models involve caring relationships. The caring element embedded in these relationships entails shared activities and interdependence, distinguishing it from the more general notion of beneficence. An optimal relationship, as proposed by relational models, aims to cultivate the development of capacities for self-care that enhance one’s own abilities (Donchin, 2001).

4.4 THE INTERPLAY OF AUTONOMY AND VULNERABILITY

Vulnerability is a fundamental concept in clinical bioethics. In clinical ethics, vulnerability relates to the loss of health and the concerns regarding inequities faced by vulnerable populations. Vulnerability is a state that all embodied beings resist when faced with health threats, reduced capacities, and changing circumstances (Mackenzie, et al., 2014). "Vulnerable are those who are at increased risk of harms, either because they are in hazardous situations or because they have a decreased capacity, for whatever reason to safeguard their own interest" (Mackenzie, et al., 2014, p. 62). Engster advocates for the reconceptualisation of care ethics in terms of vulnerability and defines vulnerability as "susceptibility to harm, need, loss, coercion, domination and other ills or blights" (Engster, 2019, p. 106). Additionally, vulnerability can be conveyed through two fundamental ideas "the finitude and fragility of life which, in those capable of autonomy, grounds the possibility and necessity for all morality", and the second idea that "vulnerability is the object of a moral principle requiring care for the vulnerable" (Mackenzie, et al., 2014, p. 75). Vulnerability is unavoidable as an embodied being and a crucial concept within clinical ethics. The connection between vulnerability and respect for autonomy requires further exploration. In the clinical setting, patient's autonomy should be respected with the aim of making individuals less vulnerable to healthcare-related decisions by ensuring that informed consent conditions are met. The provision of information and participation in the decision-making process fosters patient autonomy. Mackenzie et al. state "respecting autonomy, by seeking informed consent, decreases one kind of vulnerability" (Mackenzie, et al., 2014, p. 73). The decision-making approach appears to impose a threshold for autonomy, leading to the exclusion of those who fail to meet the criteria, such as cognitively impaired, irrational, manipulated, or coerced individuals. These individuals often find that their voices are not respected, and they tend to suffer discrimination or other disadvantages. As a result, the criteria designed to safeguard autonomy and prevent coercion lead to the erosion of the right to be treated as autonomous, potentially increasing overall vulnerability instead (Mackenzie, et al., 2014). Concerning vulnerability from a relational perspective, the considerations of autonomy as social factors may influence decision-making and the options available, aiming to cultivate a more nuanced understanding of the barriers to autonomy. The goal should be to "identify and explain the fragility of autonomy to the diverse sources of vulnerability" (Mackenzie, et al., 2014, p. 74). Relational accounts of autonomy focus on the connection between vulnerability and the development and exercise of autonomy. Additionally, alongside vulnerability, there exist negative duties related to non-interference and positive obligations aimed at ensuring conditions that will alleviate vulnerability and facilitate the full development of humanity's capacity (Mackenzie, et al., 2014). The positive obligations should clearly be fostered. Engster refers to the concept of vulnerability as a feature affecting "even the most independent and autonomous human beings" (Engster, 2019, p. 101). This reflects the inherent and unavoidable aspect of vulnerability. By calling for the ultimate reformulation of an ethics of care concerning vulnerability, a broad focus could be placed on both protecting and enabling the vulnerable body (Engster, 2019).

5 RETHINKING AUTONOMY: CRITICAL PERSPECTIVES

5.1 CRITICAL ASSESSMENT OF AUTONOMY FROM CARE ETHICS

Significant critiques of applying a principlist approach to resolve ethical problems derive from the perspective of the ethics of care and feminist writings. Particularly, relational accounts in the field of care ethics challenge the dominant conception of autonomy as presented in principlism. Historically, autonomy has been closely linked to men, and the dominance of male figures in autonomy narratives creates a masculine influence on the concept (Friedman, 2003). Noddings dedicates a chapter to critiquing liberalism. She mentions the issues of relations between the liberal state and illiberal subgroups. She refers to the roots of liberal philosophy, where “white males” were the ones meeting the criterion of “mature, rational individuals” (Noddings, 2002, p. 83). Even as time progressed and women, people of colour, and unpropertied individuals came to be recognised as rational, the legacy of separation continued. This legacy endured despite increasing efforts to extend rights to all, which were once restricted to selected groups (Noddings, 2002). In another work, Noddings opens with the words, “ethics has been discussed largely in the language of the father: in principles and propositions, in terms of justification, fairness and justice, the mother’s voice has been silent and human caring and the memory of caring and being cared for, have not received attention except as outcomes of ethical behaviour” (Noddings, 1984, p. 1). In general, Western culture has primarily associated autonomy with traits defined as masculine, while, conversely, traits typically regarded as feminine have lacked any significant or meaningful connection to autonomy. Indeed, the problem lies in the fact that philosophical thinking about autonomy has been significantly shaped by this gender stereotype thinking (Friedman, 2003). Additionally, historical practices illustrate a pattern of dominance and subordination that is based not only on gender but also on race, ethnicity, and other marginalised groups (Donchin, 2001). The ethics of care appears to critique that the displayed universalism is incompatible with the plurality of humanity, creating an image that is not open to debate or disagreement (Cockburn, 2005). Instead, caring and trust should be prioritised, and the emphasis should be based on including relational characteristics; as Cockburn says, “different groups have diverse levels of dependence, vulnerability and special needs”, which are important to be taken into consideration (Cockburn, 2005, p. 83). There has also been a debate about the dominant conception of autonomy. The dominant conception of autonomy “requires a high degree of independence in thought and action” (Ells, 2001, p. 421). This led critics to point out that principlism neglects the extent to which communal life and relationships affect independence (Ells, 2001). Ells acknowledges that individuals are not entirely independent nor completely guided by reason and sometimes even tend to act contrary to their best interests (Ells, 2001). The ethics of care outlines the consistent and natural nature of human dependency. Cockburn discusses the impact of care ethics on the understanding and caring for children, emphasising its contextual nature. It can also be argued that children, much like adults, exist within networks of relationships and dependencies (Cockburn, 2005). It can be concluded that independence, due to the inherent nature of human beings, is neither achievable nor desirable. Furthermore, the overemphasis on autonomy in addressing moral issues, risks to overshadow other considerations as interdependency and interconnectedness. The narrow perspective risks overlooking the moral experiences and challenges of vulnerable individuals whose needs cannot be addressed within a framework centred on rationality and individualism (Ells, 2001). Beauchamp and Childress's understanding of morality, which relies on narrow paradigms to ground moral principles, can be regarded as a risk of perpetuating ideologies that promote concepts of rationality and individuality without integrating a broader and more inclusive understanding of morality (Ells, 2001). Donchin supports this view by emphasising that the abstract, non-interference-based conception of autonomy can cultivate moral indifference, which tends to impact vulnerable groups that are already dependent and in a subordinate social position (Donchin, 2001). The universally held perspective encompasses individuals within a universal and uniform model of personhood. The critique refers to the fact that vulnerable populations that do not align with this viewpoint, tend to be treated as inferior. Unlike an ethics of care, which views differences and vulnerabilities not as obstacles but rather embraces them within concrete situations. Engster promotes a re-evaluation of care ethics by focusing on vulnerability. He highlights that the prevalent notion of autonomy and independence can only be realised briefly in life, during times when one isn't reliant on others due to illness or various other circumstances (Engster, 2019). Liberal accounts neglect significant aspects of human existence wherein individuals are often vulnerable and dependent throughout many periods of their lives. Liberal accounts place no emphasis on preventing vulnerability, unlike care ethics, which aims to respond to individual needs and aims to anticipate individuals' vulnerability (Engster, 2019). At this point, one could even question the true existence of autonomy, given the natural nature of vulnerability and dependency. Gracia, states that the concept of autonomy has been criticised because "there are only few decisions of human beings that can be called autonomous, and because even these actions are not completely autonomous due to the influence of many uncontrolled factors, it is a purely "ideal" criterion" (Gracia, 2012, p. 63). Another critique is that the philosophical formulation of autonomy is abstract. Noddings contends that moral decisions arise from real situations rather than from universal principles, she states "moral decisions are, after all, made in real situations; they are qualitatively different from the solution of geometry problems" (Noddings, 1984, p. 3). Noddings states that women on the other hand, justify their actions, and their reasoning pointing towards "feelings, needs, impressions, and a sense of personal idea" (Noddings, 1984, p. 3). It can, therefore, be argued that understanding what autonomy entails is fundamental and that practice must be reoriented to respect it adequately (Donchin, 2001). Instead of referring to rules and rights, the focus should be grounded in responsibilities and relationships. Sevenhuijsen elaborates on the meaning and importance of care as an integral part of human existence. She also critiques the concept of autonomy for failing to recognise that care is a fundamental aspect of the human condition, present across all facets of life context (Sevenhuijsen, 1998). In the medical field, another challenge of autonomy is that the context of care often recedes to the background due to the standard physician-patient interaction model. The example cited by Donchin outlines the idea of the "model patient", depicted as a man who sees the physician as his "intellectual and moral equal". Their relationship is based entirely on rational reasoning to decide the treatment path, and once health is regained, they go their separate ways (Donchin, 2001). This suggests that the context of care is clearly not prioritised, while the substantial impacts of the patient's illness and the responsibilities of family members who are meant to provide care fade into the background. As discussed in an earlier chapter of the thesis, incorporating a care ethics-centred approach in medical care provides noteworthy advantages outlined. In the fourth chapter of her work, Noddings defends her argument regarding the inadequacies of liberalism (Noddings, 2002). Among the critical points identified is the overemphasis placed on autonomy. Liberalism and its ethical systems, such as Kantianism and utilitarianism, depend on and regard individuals as rational agents. Noddings critiques that this approach does not accurately reflect real persons and circumstances, and it overlooks aspects of personhood that influence decisions. In fact, the liberal roots overlook the importance of community and tradition, fostering instead the belief that "autonomous rational agents can detach themselves from their cultural heritage, personal loves, and individual projects and decide matters of fairness and justice" (Noddings, 2002, p. 73). Noddings contends that liberalism demonstrates a misguided starting point by concentrating exclusively on rational human beings. In liberalism, rationality is viewed as the core and defining characteristic of individuals, providing them with the right to respect and the autonomy for independent decision-making. Noddings notes that rational individuals making independent choices to fulfil their desires often overlook the essence and the reality of human existence (Noddings, 2002). She explains that, from an ethics of care viewpoint, people are motivated by factors beyond just their desires. Noddings states "often decisions are made on the basis of loving concern for a particular other or for the relation in which they find themselves" (Noddings, 2002, p. 78). Rationality appears to have an excessively narrow focus on life, neglecting its complexities, while the conception of reason often disregards vital traits such as emotion and emotional responses (Noddings, 2002). In opposition, Noddings proposes a different starting point, focusing on relation and encounter. She states, "a better start for developing a social theory is with relation and encounter" (Noddings, 2002, p. 79). By emphasising rationality, principlist accounts often justify ethical decisions based on rules and principles. However, as Botes outlines, this can lead to problems “on application to the social and moral phenomena”, which are interconnected to the dynamic nature of relations, contexts and values (Botes, 2000, p. 1073). The reigning framework of principlism is regarded as a mantra that ritualistically invokes a standardised list of principles. Critique charges the approach with “neglecting serious theoretical issues” and “bypassing troubling practical problems” (Donchin, 2001, p. 366).

5.2 CRITICAL ASSESSMENT OF AUTONOMY FROM NON-WESTERN TRADITIONS

Particularly when exploring medical practices and traditions in other cultures, it becomes evident that the emphasis on individual rights and autonomy solely reflects a Western ideal. Aside from the criticism that the four-principles approach tends to treat the principle of autonomy as a primus inter pares among the four principles, it faces significant criticism due to the concept of informed consent, which is perceived to possess a strong Western bias and thus may not be applicable to non-Western countries, where, contrary, family or community informed consent prevails (Gordon, 2011). Fan compares the ancient Chinese medical ethics and traditions, inspired by Confucianism, to Western medical ethics and highlights how the Western approach to medical decision-making might be viewed as “individualistic” and the Chinese pattern on the contrary be regarded as “familistic” (Fan, 2002). Fan illustrates that Western and Chinese traditions “represent two different overall moral perspectives on human life and relations” (Fan, 2002, p. 347). The appointment of surrogate decision-making signifies a triumph in Western society regarding patients’ autonomous choices, self-determination, and moral progress. By empowering individuals to maintain control when they can no longer exercise autonomy, surrogate decision-making appears to be an inherently integrated aspect of medical decision-making. Fan states that, in the Confucian tradition, even if the patient is competent, medical decision-making is a family and collective affair. In cases of incompetence, it is self-evident that the family assumes responsibility (Fan, 2002). Confucian values and tradition demonstrate that, in the past, when physicians treated patients at home, diagnosis, prognosis, and other relevant issues were discussed with the patient’s family rather than with the patient alone. Fan states “in the Confucian view, it is the family, rather than a separate individual, that is the human entity ultimately autonomous from the rest of society” (Fan, 2002, p. 351). It can be argued that the autonomy of the family in Confucian Chinese ethics is comparable to the autonomy of the individual patient in Western contexts. Krishna also emphasises how family decision-making is central, rather than individual choices, particularly concerning end-of-life decisions in Confucian traditions (Krishna, 2011). He outlines that, in contrast to Western models, a decision free from external influences cannot be made, stating, “Confucianism requires engaging and interactions in a network of relations with others” (Krishna, 2011, p. 187). Xu and Yuan, investigate young doctors’ attitudes towards the “doctor-family-patient” model in China (Xu & Yuan, 2024). The results obtained reflect the acceptance of incorporating family members into the medical decision process. Many young doctors tend to hold the view that medical conditions affect the whole family, thereby facilitating a better decision-making process. Even though some doctors also act and inform for self-protection considerations and to avoid medical disputes with the family. However overall, most doctors tend to regard "the family right to know as equally important to the patient's right to know when informed of a severe medical condition" (Xu & Yuan, 2024, p. 6). The autonomist framework is said to not only ignore patient's duties toward their family members, but it also tends to dismiss the fact that self-determining patients fundamentally exist in relation to others and that their interests involve and require a dynamic balance (Rodriguez-Osorio & Dominguez-Cherit, 2008). Gordon argues that Beauchamp and Childress overlook alternative concepts of family and community informed consent as valid means to clarify the principle of autonomy. In contrast, Gordon suggests that Beauchamp and Childress seem to hold that their interpretation of individual consent should dominate, implying that other interpretations are neither robust nor well-founded understandings of autonomy (Gordon, 2011). Fan outlines that many non-Western traditions practice different methods of obtaining informed consent, in contrast to the standard practice followed in Western medical settings. This can lead to conflict, as Western individuals often do not recognise other ethical medical traditions (Fan, 2000). The fact that different cultures, as seen in those inspired by Confucianism, approach medical ethics and practices on different foundations and on more relational terms should encourage greater openness and acceptance of other cultures. It also raises the question of whether the autonomy-dominated principlist approach is the best guide for medical decision-making; it should not be seen as the only valid approach. Bowman assesses the capability of Western biomedical perspectives to accommodate the growing prevalence of culturally diverse and pluralistic societies. He remarks that Western perspectives, focused on autonomy and independence and employing principlism as the fundamental framework to address bioethical issues, tend to "neglect the context of specific situations" (Bowman, 2004, p. 664). Identifying and clarifying ethical issues, according to Western traditions, tends to as Bowman describes, "minimize the complexity, ambiguity and emotional essences that often give an ethical dilemma its social and cultural meaning" (Bowman, 2004, p. 668). In the face of increasing culturally pluralistic environments, it is fundamental to take cultural contexts, subjective experiences and a re-evaluation of the principle of autonomy into consideration.

5.3 BRIDGING RELATIONAL AND PRINCIPLISM APPROACHES TO AUTONOMY

From the literature analysed, many authors note that the understanding of autonomy needs to change Friedman (2003), Ells (2001), Donchin, (2001). Relational accounts of autonomy provide a more realistic conception by recognising that autonomy is grounded in relational concepts and interdependency, as well as considering the social circumstances that facilitate self-direction (Ells, 2001). Ells also asserts that alternative conceptions of autonomy highlight what the dominant conception of autonomy lacks (Ells, 2001). Donchin argues that reformulating autonomy is “a positive conception of human agency that recognises relational experiences as an integral dimension of individuality” (Donchin, 2001, p. 367). At the end of her work, Donchin makes an important observation “we need a generalised conception of autonomy that recognises both that individual identity cannot be abstracted from its entwinement and that caring can easily become over intrusive unless the other’s autonomy is adequately respected” (Donchin, 2001, p. 382). Donchin acknowledges that care can become overly controlling or paternalistic if it fails to respect the other person’s autonomy. This underscores the need to recognise relational influences on autonomy while ensuring that care does not compromise an individual’s ability to make their own choices. Botes proposes to incorporate both elements of an ethics of care and an ethics of justice “a possible solution would be for members of the health care team to strike for balance between these poles when making ethical decisions and the solution would lie in the integrated application” (Botes, 2000, p. 1074). She refers to Gilligan, who has already argued that both ethical perspectives can be regarded to be “linked and in constant interaction” (Botes, 2000, p. 1073). It could be argued that the principle of respect for autonomy can be enriched and supported by insights from both frameworks.

6 CONCLUSION AND PRACTICAL RECOMMENDATIONS

Firstly, the historical evolution of the principle of respect for autonomy demonstrates a complex progression marked by philosophical, ethical, and historical milestones that have gradually shaped its contemporary understanding and significance. It also demonstrates how autonomy evolved from an absent concept to a personal concept before being incorporated into a rights-based framework that integrates informed consent and individual dignity into the ethical foundations of contemporary bioethics. These developments culminated in the establishment of principlism as the dominant moral framework, embedding respect for autonomy as a main moral principle, upon which bioethical decisions rest.

Secondly, while the principle of respect for autonomy remains a central and prevailing concept in Western bioethics, particularly in medical decision-making, its dominance reveals significant challenges. Despite its prima facie standing, autonomy is often prioritised above other ethical principles, with conflicting principles ultimately reconciled by reverting to autonomy. Informed consent practices, while essential for protecting autonomy, are rooted in Western ideals of individualism, frequently neglecting alternative forms of consent and the needs of those who are incompetent or vulnerable. Furthermore, the anti-paternalistic stance outlined reflects the notion that autonomy is often regarded as superior, overshadowing the potential for paternalism to function as a protective and supportive mechanism for those who are unable to exercise their autonomy fully. This highlights the limitations of autonomy as the sole framework for ethical decision-making, and it underscores the need to view autonomy through another perspective that protects vulnerable individuals.

Thirdly, care ethics provides a different perspective on autonomy by highlighting its relational and contextual aspects. It challenges the liberal, individualistic assumptions of principlism's understanding of autonomy and highlights that individuals are inherently interconnected and interdependent. In clinical settings, care ethics emphasises the importance of addressing the needs of patients, particularly when they are unable to exercise autonomy due to illness or vulnerability. Rather than prioritising autonomy as an isolated, independent right, care ethics advocates a more holistic approach, recognising vulnerability as a fundamental aspect of the human experience. This shift calls for a re-evaluation of how autonomy is exercised and understood, particularly in contexts where informed consent may inadvertently increase vulnerability, emphasising the need for care that acknowledges both autonomy and the inherent vulnerability.

Finally, critiques of principlism highlight the limitations of its autonomy-centred framework, which often reflects a narrow Western liberal ideal that prioritises independence and rationality while neglecting the complexities of human relationships, interdependencies, and the inherent concept of vulnerability. Relational perspectives from care ethics and feminist thought challenge this individualistic view, emphasising the need to consider vulnerability, emotions, and relationships as important elements in bioethical decision-making. Moreover, the universality of principlism is questioned in culturally diverse contexts, where collective and relational values frequently take precedence over individual autonomy. These critiques underscore the necessity for a broader, more inclusive bioethical framework that embraces cultural pluralism, situational contexts, and subjective experiences, ensuring ethical practices that resonate across diverse traditions while advocating for a re-evaluation of the principle of autonomy.

In conclusion, the principle of respect for autonomy has developed into a leading framework in bioethics, guiding decision-making through its focus on the individual rights of rational individuals and informed consent. While it remains the central and dominant framework in Western bioethics, it is essential to acknowledge that it is not absolute, particularly in its neglect of vulnerability, relational dynamics, and cultural diversity. Acknowledging these limitations enables us to integrate more contextual and sensitive elements, as highlighted by care ethics and other cultural perspectives, thereby enriching our understanding of autonomy and prompting us to reconsider and refine this dominant and significant concept in bioethics. Nevertheless, it is also important to mention that the ethics of care is subject to critique in the literature and does not serve as an alternative framework. Its challenges and limitations must be addressed to achieve a balanced and nuanced understanding of autonomy and to combine elements in a sensitive manner.

Practical Recommendations

Given the limited literature that combines principlism and care ethics in discussions of autonomy, further research and interdisciplinary dialogue are essential to enrich understanding and promote a more inclusive perspective on the concept of autonomy. Research should investigate healthcare and bioethics case studies that integrate principlism and care ethics, identifying how both frameworks can complement one another in addressing complex ethical dilemmas, particularly in diverse cultural contexts. The goal is to merge models of ethical decision-making that combine the strengths of both principlism and care ethics, addressing the limitations of each and offering more flexible, context-sensitive approaches to autonomy. Furthermore, informed consent processes should be reimagined to incorporate both individual rights and the relational and contextual aspects of autonomy. Informed consent ought to be viewed not merely as a formal process of individual choice but as a dynamic interaction that reflects and respects the relational, cultural, and vulnerable states of individuals and patients.

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