**Contextual Discussion of Parental Authority: An Ethical Dilemma from the Turkish Healthcare System**

**Abstract**

A seventeen-year-old female presented at the Emergency Department with left hip pain and the left leg in external rotation after having felt dizzy and collapsing at home. The orthopaedic surgeon wanted to see a hip x-ray immediately with the suspicion of femoral neck fracture and stressed the importance of early treatment for that possible orthopaedic emergency. When the patient was alone with the orthopaedic surgeon, she told him that she was pregnant. According to the current legal regulations, minors need to have parental approval for x-rays and other [medical procedures](http://en.wikipedia.org/wiki/Surgery) in such situations, so doctors need informed consent from the parents. However, the patient stated “if my parents learn of my situation they will kill me in the name of honour.” So, she asked the orthopaedic surgeon not to inform her family of her pregnancy, otherwise she would refuse treatment.

**Introduction**

In Turkey, according to article 16 of Turkish Civil Code 2001, the legal system has placed minors in the care and custody of parents. According to article 24 of the Patient Rights Byelaw 1998, parents also control also the medical care of their children. This parental authority and legal right together with religious and social codes have created many difficult situations and ethical dilemmas in healthcare practice. In patriarchal societies, extramarital sexual relations are unacceptable for women. Patriarchal social structures generally result in women’s limited ownership of their bodies with the underlying notion that women’s bodies belonged to the family and society (1). In an ideal state of law, one would like to report the threat of violence to the police. However, these organizations do not have the capacity to protect the child in most developing countries or they sometimes share similar values with the society (2). According to the Survey Report of the Human Rights Commission of the Turkish Grand National Assembly on Violence Against Women and Family Members in Turkey, 12,768 women of various ages were killed between 2005 and 2011 (3). This high number indicates the inability of public agencies to protect women and children against violence. Therefore, because of the discrepancies between protection laws and practice, the clinician’s choice in the present case becomes more challenging.

The main aim of this paper was to discuss the inefficiency of abstract ethical principles in solving concrete situations in different cultures. It will also attempt to show how a decontextualized ethical approach can deepen injustices against already disadvantaged groups. With these aims, this article will firstly discuss parental authority and informed consent in medical decision-making. Secondly, it will cover possible moral actions that the clinician can take according to deontological and utilitarian approaches and the principles derived from them. Lastly, it will discuss the role of social power relationships and cultural codes in routine medical practice.

**Parental authority in medical decision making**

Medical confidentiality, as non-disclosure of information given to the doctor by the patient that the patient does not wish to be disclosed to third parties without consent or permission, is an important feature of the doctor-patient relationship (4, 5, 6, 7). The debate on a minor’s rights to medical treatment is a sensitive area between parental responsibilities toward the child, and the immaturity and vulnerability of children (8).

What makes the present case problematic is that doctors are legally constrained from providing benefit to the minor confidentially according to current regulations. In the Turkish legal system, parental permission is obligatory in the medical care of minors until the age of 18 years. Therefore, minors do not enjoy confidentiality or the right to treatment according to their wishes.

The discussion of the mature minor doctrine can provide solutions to ethical dilemmas related to the minor’s autonomy. It allows minors to give consent to medical procedures when they can prove that they are mature enough to make a decision on their own. The reasoning behind this is that it is more important for a young person to have access to confidential medical services than it is for the parents to be informed of their child’s condition. Minors who are sexually active, pregnant, or infected with a sexually transmitted disease and those who abuse drugs or alcohol or suffer from emotional or psychological problems may avoid seeking care if they have to involve their parents (8, 9).

Cherry (8) argues that parents of traditional families must routinely think in terms of the best interests of the family as a whole and, as a result, families accept a wide range of choices that are in the best interests of the family, but not necessarily in the best interests of any particular child. Furthermore, cultural and religious beliefs play an important role in most traditional family decision-making. Therefore, in such a case, parents are not situated to define and defend the best interests of the child patient, which should lead us to discuss parental authority to make medical decisions for minors. Sometimes the traditional, moral and social roles of parental authority may cause significantly more harm than benefit.

In conclusion, parental authority must be questioned in medical practice otherwise it may count against the best interests of the child from the very beginning. The laws that regulate healthcare need to be discussed; otherwise they may implicitly support the persistence of patriarchal structures. The relationship between medicine, law and religion must be reconsidered to provide common ethical values and applicable laws which respect the right of confidentiality for mature minors.

**Ethical Theories, Truth-telling and Informed Consent in Medicine**

Medicine, law and religion are three traditional professions all of which expect their practitioners to be truthful (10). However, two important moral principles can come into conflict in the context of medical practice, namely beneficence and truthfulness. Potential conflicts of divided loyalty between patient and society seem to be embedded in the role of the doctor (11). When it comes to such concrete situations, should the doctor’s willingness to deceive depend on the severity of the patient’s condition or should they tell the truth in every case?

The utilitarian viewpoint is pragmatic about the incidence of harm in medicine. Some harm is inevitable in any system, and it is justified by the greater good of a larger number of others. Accepting some vaccine-damaged children as ‘a price worth paying’ for society’s freedom from epidemics of serious infections is an example of utilitarian view (12). If the doctor takes a utilitarian approach, they should inform the family, as it protects the public trust and is in accordance with the law which reflects the moral standards of society or at least the majority of the society. Therefore, a pure utilitarian approach is not efficient in solving ethical dilemmas such as the case of the current article. Minors may avoid seeking care because of such medical practices. Consequently, in practice, a utilitarian approach will increase injustices in society and put minors in a more disadvantaged position.

From a deontological point of view, truth is always a supreme value and telling the truth is the duty of clinicians even though innocent persons will be severely harmed. In Kant's categorical, imperative doctrine, truth telling is a duty (imperative) which is unconditionally binding (categorical). For Kant, ethics is primarily concerned with doing the right thing because it is the right thing to do, not because it is in the agent’s self-interest, or because it will produce good consequences, or for any other ‘instrumental’ reason (11). It is possible to say that for Kantian deontological approach, deception cannot be justified in terms of its positive effects on patients’ well-being (5).

In practice, the doctor could refuse to assent to the patient request to lie to her parents for specific reasons such as truthfulness and truth-telling could be a central value in his value-system and he could think the quality of the patient-doctor relationship would be unnecessarily burdened and impaired by deception and the crucial elements in healthcare of trust and confidence would be seriously undermined if not destroyed (7).

However, truthfulness is not the only duty in healthcare practice. Health professionals also have a duty not to inflict harm on patients (Premum non nocere) and to act in the best interests of the patient. In the case presented here, treatment of the femoral neck fracture serves the adolescent’s interests but if treatment is given with parental consent to protect the health of the minor, the clinician will leave the patient in a very difficult situation. So, any decontextualized approach is not just unhelpful for the decision-making process of real situations, but may also be dangerous. If clinicians neglect the context in which people make moral decisions it may lead to the reinforcement of further injustices.

Furthermore, the duty to respect the law and protect the patient from harm is contradicted in this case. Thus, it can be questioned as to whether ethics and the law is the same thing. Quite often, ethics prescribe higher standards of behaviour than does the law, and occasionally ethics require that physicians disobey laws. Ringheim (14) developed a similar point of view by stating that the enhancement of the survival of adolescents promotes a greater social good and some degree of dishonesty may be excusable to prevent serious patient harm. Likewise, Helgesson et al. (5) argued that it can be justifiable for physicians to fake diagnoses or present false or misleading certificates in order to help their patients when not doing so would be expected to have dire consequences in terms, for instance, of wellbeing, autonomy, or personal integrity.

In this case the harm from making exceptions to honest medicine and deceiving the family may be less. Nevertheless, one can question whether a fake diagnosis is the proper way to deal with the problem. Deception for the benefit of the patient may be regarded as a form of benevolent action. However, it is just a palliative solution and with regard to the discipline of bioethics, the problem is not actually solved and still exists.

More importantly, doctors have responsibilities and are accountable both to their patients and to third parties such as managers of healthcare organizations, to reimbursement institutions, to regulatory authorities, and to courts and when these responsibilities and accountabilities are incompatible; they find themselves in a situation of “dual loyalty” (17). Therefore, these deceptive actions will have personal consequences for the doctor. Lying may require cheating and stealing from the health insurance system which is illegal and certainly not acceptable from a utilitarian point of view (18). As a result of lying, they will take professional risks.

So, what is the scope of health care professionals’ or their organizations’ moral duty to help minors when laws or protection policies are not adequately established. More importantly how medical professionals should deal with the risk of eliciting an honor killing. As an example, in Turkey **"**Emergency action teams," formed by the Association for Preventing Honor Crimes and Validating Female Potential, or TÖDER, will be working in 20 villages around Mardin province where number of honor killing is high. The team includes the village’s teacher, medical professional and reverend.[[1]](#footnote-1) Any such civil initiative can raise awareness among medical staff and they can take part in prevention of honor killings. However this is not a widespread and well known practice in Turkey. One can argue that protecting a patient from an honor killing falls outside the goals of medicinesince it is unrelated to preventing, treating, or curing maladies. However a doctor who knows the lack of established protection policy nevertheless does nothing more than giving treatment can be a proximate cause of death in an honor killing and this will violate a doctor’s primary duty to act in his patient’s best interest obviously (19).

In this case, acting according to universal ethical principles or producing misleading diagnoses does not solve the dilemma. There is no best option that can be developed solely by the doctor. Solving this dilemma requires institutional and legal perspective changes to create the infrastructure that will facilitate personal choices and protect the patient’s autonomy and privacy. However, until these changes will actualised the medical professionals should publicise such ethical issues through discussions and writings not to be a part of oppressive and unjust social norms that are forcing minors and women to request lying or deception.

Thus, it is necessary to develop a gender and minor mainstreaming bioethics and to strengthen it with contextualised approaches (20). In the context of this case, it is obvious that the autonomy of the patient is greatly impaired not only because of the legal regulations related to minors but also because of the power relationships within society. Therefore, arguing the autonomy of the patient, which is very problematic in this case, might be helpful in deepening the ethical analysis.

One of the problems with the general principles of traditional bioethics is that they describe ethics as occurring in a content-free secular society and this limits the ethical analysis (21). One should take into account the contextual details and cultural and religious differences of actual situations.

Medical ethics and the law assume that adults are competent to make decisions about their medical treatment. This assumption is based on the principles of self-determination and autonomy (22). However, the theories generally do not argue whether or not genuine autonomy is possible, as in the real life of societies, people are autonomous to different degrees.

Mcleod and Sherwin, argue that health care institutions need to recognize social oppression and injustice in personal relationships. Certainly, health care by itself cannot, be a remedy for all forms of oppression. It cannot even cure all of the health related effects of oppression. If healthcare providers are to respond effectively to these problems, they must consider the impact of oppression on autonomy when making decisions and make what efforts they can to increase the autonomy of their patients (23). It is necessary at least to accept that healthcare which turns its back on oppression does not respect autonomy and cannot serve the best interest of the patient as this case shows (24). This may be criticized as a proposal of a new type of paternalism for patients whose autonomy is restricted by social structures. However, we believe that in order to prevent a deepening of the existing oppressive relations by the healthcare systems, a contextual discussion of ethical dilemmas from different countries and cultures will be beneficial.

**Conclusion**

In the present article, the concept of parental authority and informed consent has been discussed in the context of a case from the Turkish healthcare system. This article has attempted to give a critique of absolute parental authority in medical law and to present the pitfalls of decontextualized ethical analysis for concrete situations. Presentation and discussion of such cases during daily medical practice may improve the awareness of clinicians and reduce the associated medico-legal burdens. The introduction of relational autonomy and mature minor into bioethics could be helpful to solve ethical dilemmas in different cultures where some specific groups are oppressed by the social codes.

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