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FREEDOM, AUTONOMY, AND THE LIMITS OF MEDICAL PATERNALISM*

It is an old tradition in medicine and health care to suppose that "doctors always know best", and it is not therefore the patient's business to interfere with the practitioner's professional decisions. It has, indeed, been customary that in the doctor-patient relationship patients have been seen as quasi-children seeking help from their medical quasi-parents - a situation which has quite understandably been coined "paternalistic", or to substitute a nonsexist metaphor which some authors prefer, "parentalistic".

On reflection it is not very surprising that medicine and health care have managed to preserve the patriarchal spirit of earlier social arrangements to a large extent even in our own days. It is a fact that medical professionals can, by and large, claim self-evident *epistemic authority* over their patients in medical matters: they really "do know best" in the sense that they do possess more knowledge concerning injuries and diseases and their elimination and alleviation than most patients. It is both intelligible and advisable that those who require medical help should succumb to

this epistemic authority.

But the problem here is that epistemic authority does not necessarily justify all the patriarchal practices that doctors and nurses carry out in its name. There are moral and social dimensions in the issue which must also be taken into account. How are doctors and nurses to know what the patient's values and expectations are? And even granted that they can somehow discover what these are, is the mere knowledge sufficient to justify restrictions on the patient's liberty or violations of the patient's autonomy?

Medical paternalism in practice takes many forms, some of which usually go unnoticed, while others tend to raise vivid controversies. Two examples from the extreme ends of the continuum elucidate the point.

Consider, first, the following *Case of the Man with Lung Cancer*:

When a man aged 75 was examined for respiratory infection a shadowed area was detected in the chest x-ray. This was thought to indicate cancer of the lung. The patient recovered from the infection, and the only complaint he afterwards suffered from was intermittent claudication due to

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atherosclerosis. The patient was not informed about the suspected lung cancer - the doctor, however, followed up the progress of the shadow through chest x-ray examinations every few months, and noticed that it was growing very slowly. The patient was content and died suddenly two and half years later owing to occlusion of the cerebral artery. (Achté et al., 1982: 153)

Although the physician clearly acted paternalistically in not letting the patient know about the suspected cancer, not many people would hold that what the doctor did was seriously wrong. And even though I myself am willing to argue that the patient had a right to be informed, and that the physician had a duty to disclose the information, I admit that the issue of medical paternalism would be rather pallid if all its instances were similar to this one.

But this is by no means the case. Consider, secondly, the following *Case of the Refused Sterilization*:

Dr Elizabeth Stanley, a sexually active 26-year-old intern in the field of Internal Medicine, requests a tubal ligation. She insists that she has been thinking about this decision for months, she does not want children, she does not like available contraceptives, and she understands that tubal ligation is irreversible. When the staff gynaecologist on service suggests that Dr Stanley might marry sometime and that her future husband might want children, she indicates that she would either find another husband or adopt children. Although she concedes that she might possibly change her mind in the future, she thinks that this is unlikely and views the tubal ligation as making it impossible for her to reconsider her current decision. She speaks quietly but sincerely. She has scheduled a vacation in two weeks and wants the surgery performed then. The gynaecologist, however, refuses to carry out the operation, and suggests that the matter could be discussed again in a year. (Basson, 1981: 135-136; Childress, 1982: 233)

For a good many reasons, it seems that the second case invites more controversy than the first one. These reasons probably include the fact that sex and reproduction are involved, as well as the fact that the request is not what people usually expect from a 26-year-old educated person.

But whatever the sources of controversy, the case of the refused sterilization is interesting for my present purposes because it seems to evoke, almost automatically, all the main lines of argument which are normally employed in defence of paternalistic behaviour. There are, in fact, four responses which one may expect doctors to use in a situation like this. These four defences of the refusal are:

- (1) "But it's for *your own good!*"
- (2) "It would be *irrational* to do otherwise."
- (3) "It would be *immoral* to do otherwise."
- (4) "It would *hurt other people* if you were allowed to choose so selfishly."

Strictly speaking, the fourth alternative is not paternalistic at all, since it is a different matter to hurt others than to risk harming oneself. It is one of the core points of paternalism that it justifies restrictions or coercion in the best interest of the one whose behaviour is restricted, not in the name of doing good to others. The other responses, however, which appeal to the person's own good, rationality and morality, are essentially paternalistic in nature.

But what exactly is the moral status of these defences? Is it ultimately justifiable to act paternalistically in an attempt to protect another person's welfare, or rationality, or morals? To answer this question, let me present a few remarks on the definition of paternalism, on its division into different subcategories, and on the justification of its various forms.

As for defining paternalism, I prefer a broad approach. Any kind of caring control, or action in the name of protecting people's own best interest against themselves, can be coined paternalistic, whether or not the action in question is actually coercive, constraining or otherwise *prima facie* immoral. According

to this definition, it is quite possible that certain types of paternalism are justifiable, and indeed that some types are harmless enough not to warrant justification at all.

As for dividing paternalistic interventions into legitimate and illegitimate, my suggestion is that the decisive factor should be *respect for autonomy*, or respect for the competent individual's personal self-determination. My reason for employing this criterion is that autonomy is a necessary condition of the kind of happiness that is intrinsically valuable to human beings. Violations of a person's autonomy deprive her or him of something valuable, and therefore require justification.

Using respect for autonomy as the criterion, paternalistic interventions can be divided into three categories:

- (a) Into interventions which do not even *prima facie* violate the recipient's autonomy and are generally not in need of justification. This category can be coined *soft paternalism*.
- (b) Into interventions which involve *prima facie* violations of autonomy, but which can be justified by an appeal to the recipient's own best interest. The justification requires two conditions to be fulfilled. First, that the recipient of the interventions is not at the time capable of reasonably voluntary decision-making. Secondly, that the recipient would without the intervention inflict relatively grave harm on her or himself. Given that the justification is satisfactory, this category can be coined *weak paternalism*.
- (c) Into interventions which involve unjustifiable violations of the recipient's autonomy. This category can be coined *strong paternalism*.

"Weak" and "strong" interventions can be generically dubbed "hard paternalism", as opposed to "soft" forms of caring control.

Given that "hard" paternalistic interventions are legitimate only when the recipient is not capable of autonomous and voluntary decision-making, then a number of medical practices and public health policies in Finland are totally illegitimate from the ethical viewpoint.

It would not, for instance, be justifiable to hold back information from a patient who, without knowing it himself, may have lung cancer, as the doctor did in my first example. Nor would it be justifiable to refuse the sterilization requested by a competent adult, as the doctor did in my second example. Yet cases like these are part of daily routine in all Finnish hospitals and medical centres.

What is the explanation for such a policy? On what grounds do doctors think that they are entitled to "protect" their patients against the patients' wishes?

At this point it is useful to take another look at the responses which are usually given to demands for patient autonomy. (1) First, there are those doctors who insist that an intervention is "for the patient's own good" even though the patient himself disagrees. The physician's behaviour in such cases could be justified by classical utilitarian arguments, if it could first be shown that the classical utilitarian arguments are valid. (2) Second, there are those authorities in health care who contend that paternalistic restrictions are necessary, because without them "people would behave irrationally" and thereby harm themselves. If the kind of irrationality that can be generally attributed to people indeed justifies violations of autonomy, these authorities might have a point. (3) And third, doctors, health care authorities and ordinary citizens alike sometimes think that health laws and regulations should be used to "prevent immorality as such". The legitimacy of this argument depends on the legitimacy of the doctrine of legal moralism in general.

The common denominator in these three attempts to defend strong paternalism is, I think, the belief that individuals can be forced into being happy against their own expressed wishes and desires. I have no doubt in my mind that this is indeed partly true: the 75-year-old man who in my first example died happily without knowing about his disease was no doubt better off because of the physician's strong paternalism. But individual cases should be kept apart from more extensive *policy decisions* here. Even if there are cases in which people would gain by being kept in

ignorance or by being forced to wear seat belts or whatever, this does not prove that there should be laws, regulations, and general policies which require medical professionals to violate their patients' autonomy.

The problem with all ideologies and general policies which contradict the liberal view that I have sketched above is the following. Ultimately, the morality that should be compared with liberalism and anti-paternalism is not strong medical paternalism or legal moralism or any other particular ethical or ethico-legal doctrine. Rather, it is the general morality of totalitarianism, which requires the absolute submission of individual interests and liberties to the authority of the church, the state, or - in this case - the medical profession. I do not suppose that anybody voluntarily prefers totalitarian to liberal solutions, if the totalitarian policy in question is different from one's own preferred ideology. But the problem is that with regard to their own ideologies people tend to think differently.

The strength of the liberal solution is apparent here. Although there may be few persons who would consider the creed of autonomy to be the *best* policy, it is more than probable that the vast majority would agree that it is the *second best* alternative, preferable to the supremacy of any other ideology except one's own. Unless one particular ideology reigns in the minds of a people, then the people would be wise to choose liberalism. And this is the situation at least in most Western countries.

It seems, then, that strong paternalistic interventions cannot be justified by appeals to utility, rationality or morality, after all. And this implies, as already noted, that many prevailing practices within medicine and health care in Finland at least are wrongly paternalistic. Let me conclude by giving a few examples of these practices.

In the clinical setting, strong paternalism includes lying to patients allegedly in their own best interest, withholding information, refusals to treat patients, compulsory treat-

ment, and as the most controversial case which is now being discussed, refusals to accept voluntary euthanasia. Some of these practices are sanctioned by the law, and their elimination would therefore be a matter of revising the legislation. Others, however, are based only on the attitudes and values of medical professionals.

Other cases of strong paternalism within modern Western health care systems include, for example, prescription drug laws and the total prohibition of certain "hard drugs". In addition, many other instances of strong paternalism can be found in preventive medicine, by which public health authorities try to control people's life-styles. All in all, the whole organization of health care provision in many Western countries, and especially in Finland, would change dramatically if respect for individual autonomy were taken into proper account.

NOTE

- * *Lectio praecursoria*, 14 November 1990, University of Helsinki. The lecture is based on my doctoral dissertation, entitled *Freedom, Autonomy, and the Limits of Medical Paternalism*. A small academic preprint of the dissertation has been published by the Department of Philosophy, University of Helsinki in 1990. The book is forthcoming, under the title *The Limits of Medical Paternalism*, from Routledge, London.

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