

Ethical Conflicts between Patient Autonomy and Physician Centered Paternalism: An Account of Justified Paternalism

Abhijit Tarafdar

Philosophy, Presidency University, Kolkata, India

Corresponding Author: Abhijit Tarafdar, abhijittarafdar686@gmail.com

ARTICLE INFO

Keywords : Paternalism,
Patient autonomy, Liberty,
Patients' right, Doctor-
patient relationship

Received : 15, March

Revised : 26, March

Accepted: 18, April

©2025 Tarafdar : This is an open-
access article distributed under the
terms of the [Creative Commons
Attribusi 4.0 Internasional](https://creativecommons.org/licenses/by/4.0/).



ABSTRACT

This paper critically analyzes the ethical tension between patient autonomy and physician based paternalism within the doctor-patient relationship. The core problem lies in the asymmetry of medical knowledge, which has long been used as a tool to justify paternalistic interventions by physicians. Paternalistic interference breeds many moral questions from the perspective of patient autonomy and liberty and it inevitably creates ethical issues in doctor-patient relationship in the past few decades. With the advent of medical technology and awareness of patient autonomy, liberty, patients' right, many critics have started to inveigh against the domination of physicians and give emphasize on patient autonomy bestowing all the responsibilities upon the patients in medical setting. There is also another view regarding the authority of medical decision making which tries to combine the part of liberty or patient autonomy with a soft or lesser degree of physician centered paternalism. This paper explores this ethical conflict and defends a model of limited medical paternalism that supports rather than undermines patient autonomy, demonstrating their potential compatibility in modern healthcare.

INTRODUCTION

Achieving patient benefit is the most important task of healthcare providers for centuries. According to Mark Siegler, there are mainly two models of doctor- patient relationship; firstly, physician based paternalistic model and patient based consumerist libertarian model. According to him, the traditional paternalistic model in healthcare was founded on trustworthiness, medical competence and moral values or sensitivity of the physicians. In Siegler's words, "The physician-patient accommodation is a bilateral one in which the moral and technical arrangements of a medical encounter are determined mutually, voluntarily, and autonomously by both patient and physician" (Siegler, 1981, p. 85). Paternalism in medical setting is one of the most important issues which make the doctor- patient relationship separated from a mere contractual relationship between the coequals. At the same time it breeds many moral questions by the critics with the advancement of consumerism healthcare profession and awareness of patients' rights. Generally, the fiduciary relationship between physician and patient is established in such a way that patient is always considered as sick and physicians are considered as the healer. In this context, Talcott Parsons opines that patients are made to play the role of sick to be accepted of their social environment and to gain the attention of the physicians. So, here, the authority on decision making depends on the physicians which can be termed as paternalism (Parsons, 1951, p. 50). Thus giving emphasize on patient dignity and respect for autonomy many ethical thinkers put the charge of presumptuousness and condescension upon the concept of medical paternalism as it violates the patient's autonomy and they are claiming for extirpation of paternalistic intervention in medical care. This kind of claim is coming out because some critics are falsely confusing the ethical knowledge of the physicians with their medical knowledge. Now, indeed it is time to look for an appropriate and ethically justified account of physician centered paternalism restoring the patient rights and autonomy as far as possible for the benefit of the patients. In this paper, we will try to provide an account of diminution patient autonomy which seems inflicted intrinsically by illness of the patient and a defense of justified medical paternalism maximizing the respect to patient autonomy.

LITERATURE REVIEW

Paternalism

Firstly, we will tease out some general aspects of the concept of paternalism and autonomy and secondly, we will examine the application of these two notions in the context of doctor- patient relationship in medical practice. John Feinberg stated in his article "Legal Paternalism" with a classical liberal spirit that "the liberty- limiting principle called legal paternalism justifies state coercion to protect individuals from self inflicted harm" (Feinberg, 1986, p. 47). There are several definitions and opinions on the concept of paternalism and we will try to examine them in the context of doctor- patient relationship. Gerald Dworkin in his article "Paternalism" in 1972 writes, "By paternalism I understand roughly the interference with a person's liberty of action justified

by reasons referring to the welfare, good, happiness, needs, interests or values of the person being coerced" (Dworkin, 1972, p. 64). Jeffry Murphy also gave a definition of paternalism, according to him, "paternalism is coercing of people primarily for what is believed to be their own good" (Parsons, 1951, p.50). In this context, Richard Arneson extended the concept of paternalism by identifying paternalistic policies with some limitations on person's autonomy and freedom which can be justified by consideration for that person's welfare and which are brought about either going against his present wish or against his own prior commitments (Arneson, 1980, p. 471). They both argued on same point that paternalism involved coercion and constraint though have some differences. In contrast, Bernard Gert and Charles Culver opposed the above said view on paternalism in their article "Paternalistic Behavior", in this article they talked about the non-coercive and non-constraining character of paternalism. For them, coercion and constraint are the characters of law but not of paternalistic behavior. In this context they provided an example of a case; let's follow: A case where a physician is compelled to tell a lie to her patient's mother who is dying in bed in reply to her query about her son. Although, the physician had already known that her son was killed by police during his escape from prison. Here, the physician acted paternalistically but not using coercion or constraint to the liberty of action of the patient (Gert and Culver, 1976, p. 45). Here, the physician's intention to deceive the patient does not involve any kind of coercion or constraint to liberty of action. But it has the issue of violation of moral rules and in such case we need moral justification. In general, we can say that paternalistic violation of moral rules can be defended by claiming that physicians would prevent more evil to the patient by the violation than they are causing.

Principle of beneficence

In Alison Lurie's *The War Between the Tates*, a character utters, "I was less morally ambitious than you; I didn't aspire to do good. I only wanted not to do harm" (Lurie, 1975, p. 271). This view shows a common moral distinction between beneficence and nonmaleficence, with the latter often considered as the minimum moral obligation in human relationships. Ethicists generally use the term beneficence to indicate actions intended to enhance good, while nonmaleficence is used to indicate the duty to avoid harming others. However, these terms are not entirely adequate rather they seem to serve as useful shorthand in ethical framework.

Given that paternalism in healthcare is considered as welfare paternalism that is acting to benefit others without patient's consent or contrary to their expressed wishes or actions it becomes significant to clarify the concept of beneficence which underpins the ethical justification for paternalistic interventions. Principle of benefit works both as a guiding ethical maxim and as the moral basis for such actions.

Perhaps the terms beneficence and welfare or benevolence are sometimes used interchangeably, this discussion will make distinction between them. Benevolence will be used to recognize a general disposition or intention to

promote the well-being of others. On the other hand, beneficence denotes specifically to the act of benefiting others.

Principle of benefit can be understood in both wide and narrow meanings. The broader definition incorporates the concept of nonmaleficence that is doing good intrinsically involves escaping harm to others. This broader interpretation perhaps seems justified because one cannot truly be said to have fulfilled the duty of beneficence if one has simultaneously caused harm. Besides its moral significance, the duty of beneficence remains ambiguous particularly in debates surrounding so-called "beneficent euthanasia." Central to this debate is the question of whether death invariably produces harm and, if so, whether such harm is morally justifiable when outweighed by benefits such as the alleviation of pain and suffering. An important distinction between nonmaleficence and beneficence rests in this very tension; the maxim to promote welfare can at times seem to conflict with the moral duty to avoid causing harm. This ethical conflict may arise either in relation to the same individual person or between different human beings as in clinical research. In such circumstances, the duty of nonmaleficence is generally seemed to take precedence.

William Frankena provides us a broad conception of beneficence, identifying four moral elements:

1. One should not to inflict harm.
2. One should prevent harm.
3. One should remove evil.
4. One should promote good (Frankena, 1973, p. 47).

Frankena puts these ethical maxims hierarchically, with the first being the most significant and each subsequent principle carrying progressively less moral weight. Interestingly, he realizes that the fourth maxim that is promoting welfare might represent an ideal rather than an ethical obligation or duty. This nuanced conception is vital for distinguishing actions that fulfill ethical expectations from those that surpass them. This act of prioritizing is also reflected in the Hippocratic maxim "first, do no harm" which possess a moral ordering that favors the avoidance of harm over promoting good. This maxim implicitly underscores the ethical conflict between escaping from harm and promoting the welfare of others.

A more modified approach involves accepting the moral and practical distinctions between the duties of nonmaleficence and beneficence from the outset. Such clarification enables a more accurate evaluation of their respective, moral weights and the potential for conflict between them. Basically, the duty of nonmaleficence is characterized by inaction i.e. refraining from harmful behavior whereas beneficence entails active, positive steps aimed at improving the condition of others.

Individual autonomy

Perhaps the most frequently cited authors in the context of discussing autonomy are John Feinberg, Immanuel Kant and John Stuart Mill. Kant's autonomy of will and Mill's autonomy of action are complementary to each

other. Kant's deontological account of autonomy emphasized on the free will which inherently exists in human thought considered as the province of autonomy and it is prior to the human action. Human autonomous will is characterized by self legislation and self governance and it is "not merely subject to the law, but . . . must be considered as also making the law for itself" (Kant, 1958, p.108). And the law it makes out is also considered as a universal law, according to Kant. For Kant, individual autonomy is the ground for all our moral action or behavior. He contends, "Categorical imperative not only to follow universal law but to follow a universal law which we ourselves make as moral agents" (Kant, 1958, p. 108).

John Feinberg in his writing "Harm to self" introduced so many aspects of autonomy to understand the meaning of autonomy when it is applied to individuals (Feinberg, 1986, p.47). Those are as follows:

1. The ability to rule oneself.
2. The condition of self governance and the virtues associated with it.
3. A perfection of character derived from the concept of self governance.
4. The right of self- governance is fundamental within a person's own moral sphere.

For Feinberg, one might hold both ability and condition but not have the right. On the other hand, one might possess the right and ability still lacks the condition. In summary, if we are not capable of self governance then one cannot impose autonomy on us from outside. According to Feinberg, there are so many virtues that can be attached to the concept of autonomy and based on those virtues one be called autonomous, those are as self possession, individuality, authenticity, moral independence, responsibility and so on.

METHODOLOGY

In this article I have used qualitative method. I have tried to critically analyze every aspect of the debate between paternalism and autonomy in medical ethics and tried to explore at what extent medical paternalism can be ethically justified.

RESEARCH RESULT AND DISCUSSION

The application of paternalism and autonomy in doctor- patient relationship

From the above discussion we may assume that a principle stating that the action or inaction of physician towards patients can be paternalistic even if the interference of the physicians towards the patient is not coercive and liberty restricting. Since violation of autonomy seems to be most basics criteria, for this reason, we can make this criterion as a foundation for distinction between various modes of protective control. In this context, we can draw a distinction between two kinds of medical paternalism; those are hard paternalism and soft paternalism. Thus, we can stipulate the protective behavior which does not violate the recipient's autonomy can be considered as soft paternalism, whereas caring or protective behavior which violates the recipient's autonomy falls under the domain of hard paternalism. In this context, one might say that the only morally relevant factor is whether the physicians do respect the patient's

autonomy or not. Thus, it follows that soft paternalism is generally does not need justification whereas hard paternalism because of its *prima facie* autonomy- violating nature, is always in need of moral justification.

We can further assume that every individual being expects to preserve their autonomy and it is recognized by the principle of autonomy in health care. But the main question is how ethical value enriched doctors and patients can set their therapeutic relationship in the scope of paternalism or patient centered autonomy. However, paternalism and patient autonomy seems contrapositive still the intention of both of them are the patient's good. Early codes of conduct in medical ethics were used to assume the hard paternalism as the morally acceptable etiquette in medical practice ignoring the respect for patient autonomy and the patients also were used to be acquiesced with this manner. Patients were quite responsive to this paternalistic attitude rather than being dogmatic. But now the patients are campaigning for the respect for autonomy under the shade of human rights all over the world. Many ethical reformers are trying to establish medical practice accompanied by the apotheosis of autonomy and paternalistic profanation and some reformers are in favour of eschewing minimal paternalistic intervention in medical practice. In this regard, the dilemma occurs when a doctor tries to abolish paternalistic attitude pushed by the society or law but some patients expect such physician centered paternalistic intervention because lack of health care related knowledge. The doctors are used to fall in a dilemma in such cases where they have to either indulge themselves into the expectations of the patients to receive accolades from them or the social or moral condemnation.

Consider a case for example, a doctor discovers a breast cancer of a woman but she has no swollen axillary lymph nodes and the doctor thinks of performing a mastectomy instead of radiation therapy (Komrad, 1983, p.4). Now the question is whether the doctor should insist autonomy in the patient by providing her information about all the advantages and disadvantages of mastectomy where the patient rests the decision unconditionally on the physician. Even if the patient is told to scrutiny her decision still it may seem like flipping of a coin between two therapeutic options because she has no knowledge about treatment. Though nobody can restrict a person's autonomy in choosing a particular action based on non- rational technique still the question comes that when autonomy seems like capriciousness still it ethically acceptable? A patient may encourage the doctor for showing non- paternalistic attitude in earlier stage but may differ in later stage if the result comes out bad for non- paternalistic attitude. For example, a patient with angina told his doctor about his taking up of jogging and the doctor allows him with some cautions. Initial few months of jogging he has no incident but one day he found severe angina bout resulted out as myocardial infarction. After recovery the patient blames his doctor for not forbidding him from jogging and not showing paternalistic attitude that he would not prescribe him unless he gave up jogging (Komrad, 1983, p.5). Thus it shows that the condition for moral justification of paternalism cannot be always depend dogmatically on the issue of autonomy as

autonomy varies person to person based on the mental capacity and demand of the patients.

Conditions for ethical justification of paternalism

Having analyzed and established that it is irrational to dispose all kinds of paternalism, it remains to define limited or justified paternalism. However, there are certainly some conditions where humans inevitably invite paternalism in health care. These conditions are stated by some philosophers; say for example, Kant talked about inability to culture reason, Mill considered immaturity of people, Beauchamp and Childress considered non-autonomous character of people as the conditions for paternalistic interference. Where the patients are not able to express their autonomous will in decision making then paternalistic interference can restore their well-being. We can assume that a person's ability to exercise is power of autonomy can be the criterion for determining paternalism or non-paternalism in doctor-patient relationship. Paternalism is for the patients who are suffering from diminished rights of autonomy because of their impaired capacities; paternalism is not to negate the patient's individual rights. We have already provided an account of paternalism in this paper. Now, we need a moral justification for paternalistic behavior in medical setting as it violates moral rules by refusing patient autonomy in some circumstances. If we say that physician's paternalistic behavior produces benefit to accrue people other than the patient then it is not a justification of paternalism but that doesn't mean that paternalism cannot benefit others. If paternalistic behavior of the physicians needs to be justified then it needs justification with solely reference by the patient's welfare. However, producing the patient's good doesn't provide us a sufficient condition for physician's paternalistic interference rather it can only give us a necessary condition for justifying paternalism. The reason of justification is producing lesser evil than the evil would be provided by the violation of moral rules by the physician to the patient and for a patient, it seems rational not to interfere with the physician's violation of moral principles or rules to his regard. On the other hand, to make such paternalistic violation of moral rules for the best interest of the patient as a sufficiently justifiable we need to make it universally acceptable or publicly advocated. Let's consider a case; Mr. A is walking forth and back on roof top of a building, perhaps, with an intention of jumping off from the roof of a five storey building. When he was caught and interviewed by police and doctor he disclosed that being afraid he might jump off and he was suffering from depression for past few months. In this situation, the doctor decided to commit him hospitalization for two days under his supervision for the protection and safety of Mr. A though he was not wanted to be hospitalized. It is clearly an instance of paternalistic action and the doctor believes that he is qualified to do so for the best interest of that mentally sick person. In support of moral justification the doctor might claim that it is to prevent the patient from greater evil like serious injury or death. However, the doctor might not argue that death is an evil of such a magnitude that paternalistic interference is always justified. Rather, the doctor might claim that

there are several reason of preventing the patient from self inflicted harm or death; say for example, there is no reason of killing himself, hence it seems irrational and preventing him to execute his freedom by killing himself is lesser evil than the death. Besides this necessary condition, the doctor might give a sufficient condition to justify his paternalistic behavior by claiming that all rational persons will agree that in such circumstances a physically or mentally sick person should be deprived of his freedom for a short period of time for his own good. Thus we can provide a strong justification for paternalistic behavior of the physician. In this regard, Talcott Parsons opined, "by definition of the sick role, the sick person is helpless and therefore in need of help. ... He is not only generally not in position to do what needs to be done but he does not 'know' what needs to be done or how to do it"(Parsons, 1951, p.51). On the other hand, Pellegrino considers diseases or illness as "an ontological assault aggravated by the loss of freedom we identify as peculiarly human"(Pellegrino, 1979, p.32). In this way, we can say that illness mitigates and diminishes the human liberty or autonomy. One may say that disease works as an attenuation for autonomy and does interfere with the capacity to take rational decision. In such contexts, the patients inevitably invite the paternalistic intervention of the physician for their own good and to overcome diminish of autonomy. Thus, in some serious situations paternalistic interference is very much required for the patient's good. So, we can assume that paternalism in some situations does not go with the principle of autonomy, at the same time, in some situations it goes for restoring or preserving patient autonomy. In other words, we can say that the doctors should respect the patient's capacity or potentiality of autonomy instead of respect for autonomy. Hence, the most important therapeutic goal should be restoring or preserving patient autonomy within the bounds of patient's capacity to exercise autonomy. In this context, Gert and Culver bring in a new condition to paternalism, as follows: "a person's well-being is only to accelerate his capacity of become autonomous"(Gert and Culver, 1976, p. 50). So, we can consider this definition as an appropriate feature of limited or justified paternalism as it talks about promoting physicians' continuous effort to titrate the patient's freedom in the doctor- patient relationship. From this definition we need to understand that paternalism needs moral justification as it talks about violating moral principles.

CONCLUSIONS AND RECOMMENDATIONS

Having examined Kant's universal law depending on pure reason and Mill's liberty of action which is discerned by harm principle that other people's liberty or freedom cannot be violated, we can say that patient autonomy and paternalism, they both act for the best interest of the same moral agent and the principle of autonomy talks about protecting individual interest whereas paternalistic interference for the patient's good protects the interest of fiduciary relationship. Both Kant and Mill focused on autonomy not merely as a right rather as a duty to pursue on the basis of potentiality of individuals. On the other hand, paternalism though acts in the absence of patient's consent but there is a chance of eventual consent and it supports autonomy if it falters; so these are reciprocal. Autonomy varies person to person as we have seen

autonomy can be varied and diminished due to illness and for this reason it is not universal; it depends on the ability to act autonomously. Our legitimate aim in this research paper is to establish that the patients who are suffering from serious diseases need paternalistic treatment with maximization or restoration of their autonomy as far as possible which is called justified or limited paternalism. Keeping this goal in mind, we can say that paternalism is not to negate or ignore the patient's right and autonomy rather it is for the patient's good wherever the situation permits for such paternalistic interference. Paternalistic behavior not always violate the moral rules even if where the patient gives up his autonomy to the physician for his own good still the physician have the moral duty to respect the sentiment of faith shown by the patient. We can consider paternalistic treatment even if without any consent for the patient as morally justified if it is for the patient's best interest and if there is a reasonable hope for eventual consent. It is a kind of dynamic relationship where the actual aim is to set the doctor- patient relationship on a spectrum of maximization patient autonomy and limited paternalism. Physicians need to consider the effect of their attitude towards patient on fostering her ability to participate in therapeutic decision making. They are also required to be aware of the patient's life narrative to understand the importance of the decision against this background. They have to consult with their patients with caring attitude and empathy so that they can build mutual trust. In difficult circumstances the physicians need to anticipate and discuss the treatment procedure with the patients. Patients need to be accompanied in the decision making process. To conclude, we can say that restoring autonomy is not a challenge for the paternalism rather we can accept limited paternalism with maximization of autonomy.

ADVANCED RESEARCH

However, we need to find out another ethical approach to avoid this conflict between paternalism and autonomy in medical setting. Besides finding out the conditions for ethical justification of paternalism we need to emphasize on the patient autonomy and in this context relational approach or case based approach may help us to overcome this debate.

ACKNOWLEDGMENT

I would like to express my sincere gratitude to my PhD supervisor Dr. Barada Laxmi Panda for her valuable suggestions for writing this paper. And I am also grateful for the reviewers of this journal for their valuable comments on earlier draft of this paper.

REFERENCES

- Arneson, R. J. (1980). Mill versus paternalism. *Ethics*, 90, 471-479.
- Blumer, I. (1999). *What your doctor really thinks: Diagnosing the doctor-patient relationship*. Oxford: Hounslow Book.
- Dworkin, G. (1972). Paternalism. *The Monist*, 56, 64-84.
- Feinberg, J. (1986). *Harm to self*. Oxford: Oxford University Press.
- Gert, B., & Culver, C. M. (1976). Paternalistic behaviour. *Philosophy and Public Affairs*, 6, 45-47.
- Gert, B., & Culver, C. M. (1979). The justification of paternalism. *Ethics*, 89, 199-210.
- Kant, I. (1958). *Groundwork of the metaphysic of morals*. New York: Harper and Row.
- Komrad, M. S. (1983). A defence of medical paternalism: Maximising patients' autonomy. *Journal of Medical Ethics*, 9(1), 38-44.
<http://www.jstor.org/stable/27716131>
- Parsons, T. (1951). *Definition of health and illness in the light of American values and social structure*. New York: Free Press.
- Pellegrino, E. (1979). Toward a reconstruction of medical morality: The primacy of the act of profession and the fact of illness. *Journal of Medicine and Philosophy*, 4, 32-56.
- Rawls, J. (1979). *A theory of justice*. Cambridge: Harvard University Press.
- Siegler, M. (1981). Searching for moral certainty in medicines: A proposal for a new model of the doctor-patient encounter. *Bulletin of the New York Academy of Medicine*, 57, 85.