

Medical Paternalism Serves the Patient Best

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(This Essay won the Singapore Medical Association Ethics Essay Award (Medical Undergraduate Category) in 2001.)

ABSTRACT

It seems obvious that in a post-modern, constructivist world where meaning and value systems are often subjective and relative, any absolutist view is likely to be questionable. This is more so if it relates to ethics, the foundations, interpretation and application of which have been and continue to be much debated.

So, in addressing the proposition, my efforts were directed at identifying a position that would mediate polarity. I examined the contention that the doctor, because he is better informed, may claim greater acuity and powers of judgment, and its defences against the charge of interfering with individual liberty and autonomy through various arguments such as the harm principle, the welfare, the principle of legal moralism and the appeal to uncertainty.

While there is some validity to the arguments proposed, absolute paternalism would seem incompatible with respect for individual rights. How satisfactory, then, is the paradigm shift from paternalism to the independent choice model where the doctor presents neutral statistics as little biased as possible by his own views and judgments and leaves the decision making entirely to the patient or his/her relatives. This clearly had its limitations too.

As with much of human experience, the answer would seem to rest in mediating the happy mean. Recognising a distinction between autonomy (self-determination) and independence (total freedom of choice without any interference) allows for a model of qualified independence or “enhanced autonomy” (Quill & Brody, 1996). This is predicated on doctor-patient dialogue, exchange of ideas/views, negotiation of differences, and sharing power and influence for the common purpose of serving the patient’s best interest. This model would seem to be a responsible and effective approach to management of clinical dilemmas, as well as one that in its pluralistic approach is consistent with

fundamental moral and philosophic propositions. It is by no means flawless, but in an imperfect world, there can be no perfect solution; constant negotiation with the realities – however uncomfortable – is an inescapable fact of life.

Actions are right in proportion as they tend to promote happiness: wrong as they tend to produce the reverse of happiness. (J S Mill, Utilitarianism)

On that supposition, I submit that guided paternalism is arguably what serves the patient best.

Singapore Med J 2002 Vol 43(3):143-147

In the post-modern world where meaning is subjectively constructed and value systems are often circumstantial and relative – where even “a God all mercy (would be) a God unjust”, as Edward Young observed in Night Thoughts – an absolutist statement such as the proposed topic invites deliberation. The more so as it relates to ethics, over the foundations, interpretation and application of which questions have been raised since the emergence of philosophic discourse. And not surprisingly, since it impinges on the very centre of our being and underscores all human activity. Particularly in the medical domain, its implications are most intimately felt, for while the practice of medicine is not all about life and death issues, it is the one profession that is, arguably, confronted more often than any other with such ultimates. When words are translated into deeds that determine life or death, the burden of responsibility is tremendous.

Hence, it is that doctors are often confronted with tough questions and decisions. Life as a medical student at NUS begins with the Hippocratic Oath, and this is reinforced by the guidelines furnished by the Singapore Medical Council. Similarly, ethical codes encapsulated in the Declaration of Geneva, the Declaration of Helsinki and other declarations in the same spirit still have widespread currency. Yet, in practice, there often are other items on the agenda that demand to be negotiated, making

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issues such as that of medical paternalism one that militates against simple definition and solution.

Does medical paternalism really serve the patient best? Is it predicated on an invariably sound principle? That there are a number of principles propounded – some mutually contradictory – would make a positive response to the latter appear doubtful and, by extension, undermine the claim implicit in the former. What best serves? Central to medicine is the belief in beneficence: the Hippocratic Oath commits the practitioner to using his/her special knowledge and skills to benefit the patient; it entrusts and obligates the doctor to do what is in the best interest of the patient. In concept this cannot be faulted; the devil is in the interpretation. What is the “best” interest? Considering that there are at least two parties involved – the doctor and the patient – how should “best” be best defined? This “bifocal” vision may well result in different perceptions and values; what the doctor sees as best for the patient may not coincide with the patient’s view.

Medical paternalism mediates these differences by arguing that the doctor, because he is better informed, may claim greater acuity and powers of judgment. It defends itself against the charge of interfering with the liberty and autonomy of another through various arguments such as:

- the harm principle
- the welfare principle
- the principle of legal moralism
- the appeal to uncertainty⁴

It is generally true that patients have not spent years pursuing a medical degree and specialisation and may therefore not be capable of understanding all the implications involved in making a sound medical decision. On the face of it, it would also seem perfectly logical for a doctor to act to prevent a patient from doing harm to himself, especially when the patient is not in a position to act voluntarily or autonomously, or when there is need to buy time while ascertaining if the person is acting voluntarily. An instance of what has been termed weak paternalism would be the emergency treatment of an apparent suicide attempt; prompt treatment must be administered immediately to save the patient’s life. There being at the critical moment no certain knowledge whether the attempt is autonomous and rational, interference may be considered morally justifiable.

Strong paternalism, on the other hand, might be more difficult to justify since it involves over-riding a clearly voluntary action, but it too has been argued on various grounds. The welfare principle, for instance, is founded on a desire for the greater good; hence

the doctor may decide that the autonomy of one patient should be restricted if substantial benefits to others may be expected as a result. In cases where the patient is effectively dead albeit sustained by major advances in medical science and technology, resources expended on this patient may be put to better use on others with more promising prognoses. Furthermore, what constitutes medical futility and the policies governing it is the subject of considerable debate and it remains a grey area. What should not be in doubt, however, is that such policies are incompatible with respect for individual rights.

Similarly, in compliance with the principle of legal moralism, the doctor may also act likewise in the interest of common good: it is necessary to restrict an individual’s autonomous action if it threatens the moral and social fabric. Again, the fact that many – including Hitler and, more recently, Richard Nixon and Bill Clinton – have exploited this argument that the end justifies the means should not blind us to the fact that others such as St Augustine, Kant and Cardinal Newman have questioned its validity. As Kant highlighted, problems arise when lying appears to be morally justified⁽¹⁾.

Paternalism is also argued on the appeal to uncertainty: medicine is a science but it is not an exact science. Diagnosis and prognosis cannot be made with absolute certitude; there have been occasions when despite taking conscientious care doctors have been mistaken. Hence, the question of whether or not to tell the truth to patients, for instance, is muddled by uncertainty of what constitutes truth. Sissela Bok⁽²⁾ (1978) explains that...the moral question of whether you are lying or not is not settled by establishing the truth or falsity of what you say...(but) whether you intend your statement to mislead.

The intention rather than the deed is the material point. On that supposition, (it) is meaningless to speak of telling the truth, the whole truth and nothing but the truth to a patient...because it is... a sheer impossibility⁽³⁾.

This translates in philosophic discourse into the practical impossibility argument, viz, given that:

- a. a patient is generally less well equipped to understand the medical issues,
- b. a patient may hear selectively when given bad news,
- c. at times diagnosis and prognosis can be no more than educated guesses.

It follows that:

- a. it is a practical impossibility to tell the patient the truth, the whole truth and nothing but the truth,

- b. it then follows that it is morally permissible not to tell the truth,
- c. therefore it is morally permissible for doctors to not tell the patient the truth.

Indeed, the argument may be taken further to claim that it would be harmful for the doctor to tell the truth to a seriously/terminally ill patient since this would cause fear, distress and loss of hope, thereby sapping energy and willpower to cope with the situation and arguably worsening his/her condition. The argument of therapeutic privilege "...if disclosure of the information seems to be harmful to the patient, the physician may be justified in withholding the information or even in using benevolent deception"⁽⁴⁾ is not unfamiliar and may be supported further by the contention that the patient has as much a right to know as not to know and if he prefers the latter his wishes should be respected. As T S Eliot observed:

Human Kind cannot bear very much reality
– Four Quartets: Burnt Norton (1959).

And truth telling in some circumstance is arguably an imposition. A reasonable case may be made therefore that, in some cases, not only is it morally permissible but it is morally obligatory to lie to a patient. This suggests a special, medical morality as opposed to ordinary morality. This suggests a special, medical morality as opposed to ordinary morality.

Such arguments are not without some basis, but there appears to be a fundamental flaw: if the premise is one of uncertainty or possible uncertainty, then the whole truth and nothing but the truth is not accessible by the doctor as well and he/she is no better placed to decide on the best course of action. A morally defensible position can only be assumed by a being who is all-knowing and infallible, whereas for fallible mankind, some questions are beyond its capacity to address. As Voltaire remarked: "If God did not exist, it would be necessary to invent Him".

Perhaps the strongest objection that has been raised to medical paternalism is that it endorses the playing of God by mere mortals, allowing an untenable superior power position of one human being over another, and in the process violating a primary principle, that of individual autonomy. In the volume *On Liberty*, J S Mill maintains that:

"Neither one person, nor any number of persons, is warranted in saying to another human creature of ripe years, that he shall not do with his life for his own benefit what he chooses to do with it"⁽⁵⁾.

The only allowable exception might be that of preventing harm to others. However, the reverse case of it being better for others – i.e. welfarist left sentiments – should not be countenanced, nor should

the principle of legal moralism apply since both these run counter to the right of the individual. Furthermore, even if others feel that the action/inaction is not "for his (the patient's) own benefit" they may not impose their views on the individual because, ultimately, the individual is the bearer of the consequence/s. It should be patently obvious that final say should reside with the person who has to live with the consequence of, for instance, resuscitation into a state that may be insupportable to the bearer. Withholding self-determination in such a situation would be wrongful deprivation. There are, of course, scenarios that are less clear-cut but the underlying principle should nonetheless be philosophically and morally sustainable.

Other justifications for paternalism might also be questioned. To claim, for instance, that patients may feel worse about knowing their true condition might prove so to some extent, but a patient who has affairs to tidy up may well feel more anxious not knowing how much time he may expect. While it is true that patients are generally lay-persons with limited medical knowledge, it should not be assumed that they are mentally deficient or non compos mentis and incapable of understanding if adequate explanations were offered, the debilitating effects of severe illness notwithstanding. As Roger Higgs reminds with salutary trenchancy:

"Every skilled person who is at the interface with the public must be able to explain what they are up to...To dress up simple ideas or uncertainties as mysteries is the sign of the charlatan"⁽⁶⁾.

The claim that a doctor's time is better spent on executing than explaining what may be complicated physiological or psychological processes and consequences cannot be acceptable if there is genuine respect for the patient.

Much of traditional practice has been based on an essentially unequal power relation: the doctor in the superior-indeed, sometimes supreme-position and the patient in the helpless and often hapless role. Increasingly, however, it has been felt that paternalism – especially unmediated paternalism – can no longer serve. With information more readily available in the Internet age, patients are becoming more knowledgeable. Consequently, they also become more vocal and involved in their own health care management, prompting doctors to recognise the prudence of not imposing their views lest they be the subject of lawsuits. Additionally, technological advancements have changed radically the options available. For instance, it is now possible to keep a brain-dead person technically alive, thereby raising complex and potentially contentious questions of the viability of

such existence. Such phenomena have propelled a swing from paternalism to the independent choice model where the doctor presents neutral statistics – as little biased as possible by his own views and judgments – and leaves the decision-making entirely to the patient or his/her relatives.

But beyond these practical considerations there still remain the familiar, larger issues of self-determination, respect and reciprocity, moral responsibility, etc. What the practical considerations have done, perhaps, is to catalyse growth in awareness of the need for greater transparency, discussion, and collaboration in the doctor-patient relationship. Ultimately, our interest in the debate of paternalism vs. autonomy is grounded in the more substantial engagement with first principles and the eternal verities in the predicament of human existence. The issue is not fear of punitive litigation; neither is it about control and power. Rather, the question is how one human being should treat another if both are to maintain integrity and humanity in their intercourse, given the complexity which informs human transactions and the imperfect human condition in a post-lapsarian world.

An emergent response is a paradigm shift from a doctor-directed to a more patient-centred approach with a view to correcting the traditional imbalance of power. It is a fairly radical shift and, as in all radical shifts, there is always the danger of an over-correction, either as an act of contrition for past sins, as it were, or being overwhelmed by the “consumer movement” with its dictum that the customer is always right. And as with much of human experience the answer is probably the happy mean. Identifying the happy mean is tricky, and the balance when found is likely to be precarious and one needing constant, adaptive fine-tuning to meet the realities of specific scenarios.

Finding some middle ground between paternalism and the “independent choice” model could start with a centrifugal movement from strong to weak paternalism on one end and, on the other, distinguishing between the concepts of autonomy and independence. Where autonomy is self-determination, independence is construed as total freedom of choice without any interference. The latter accords the patient maximum choice, on the assumption that any exercise of influence on the part of the doctor is an infringement of patient rights and diminishes patient power of choice. In the interest of philosophic rectitude and, possibly, prudential consideration, it substitutes control for competence; the patient abrogates the patient’s right to choose and to do so without undue influence even if that influence might be beneficial. The apparent down side is that in some instances this may

be tantamount to giving a patient rope to hang himself/herself.

To correct this, a model of qualified independence or “enhanced autonomy”⁽⁷⁾ has been advocated. It is built on doctor-patient dialogue, exchange of ideas/views, negotiation of differences, and sharing power and influence for the common purpose of serving the patient’s best interest. This active collaboration recognises that the dynamics of the doctor-patient relationship can be potentially positive. It recognises that the doctor is professionally equipped to give informed advice while respecting the patient as a person and his/hers wishes. It accepts “the physician’s power to offer recommendations while obligating the physician to fully understand the patient’s reasoning when those recommendations are rejected”⁽⁸⁾.

This model would seem to be a responsible and effective approach to the management of clinical dilemmas, as well as one that in its pluralistic approach is consistent with fundamental moral and philosophic propositions. Unfortunately, human nature tends to favour the path of least resistance, leading Yale Law Professor Jay Katz to argue that such a system would “ask for too much”, and that “perhaps even patients...may not wish to interfere with professionals on that basis”⁽⁹⁾. Supporting this contention is a large body of evidence that would suggest that many patients prefer the passive role, including a landmark study amongst Americans which showed that 84% were “at least somewhat satisfied” and 49% were “very satisfied”⁽¹⁰⁾ with that level of personal involvement. In an imperfect world, any dogmatic insistence and extremist view is problematic in any ethical debate; constant negotiation with the realities – however uncomfortable – is an inescapable fact of life. Monolithic definitions are clearly inadequate; only at the most rudimentary level is life unicellular, whereas most human experiences are composite in nature. Few things – if any – are completely bad, or completely good. Just as there is a flip side to any coin, positive and negative are not so much bi-polar as mutually dependent for their definition, positive being the relative absence of the negative and vice versa. Taken to logical conclusions, without their defining opposites each would be conceptually untenable. It follows, then, that there can be no single correct answer valid in all conditions. Paternalism for paternalism’s sake is often found to be no more practical – nor even practicable – than autonomy for autonomy’s sake. J S Mill’s system of utilitarian ethics thus offers this qualification:

“Actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness”.

Ultimately, good sense and judgement and discretion will have to guide all human decisions because the ethical arena is ambivalent. Restating the proposition made earlier, there are no absolutes. Given human nature and the nature of human existence, ethics cannot be a precise science; indeed, the Scottish philosopher MacKintosh, for one, argues that moral phenomena and beliefs are predicated on feelings – e.g. sympathy or antipathy – that are invariably, though not entirely, shaped by societal norms and needs. Hence the philosophic drift in the last century from Comtean positivism, through Darwinian evolutionism to socialism born in the epoch-shaking democratisation of the French Revolution, with the reinforcement of the concept of ‘sociality’ and concomitant acknowledgement that human existence within the increasing complexity of social milieus and behaviours, is of necessity arbitrated by rationalising.

So, how may the doctor best serve the patient? To reiterate, the first responsibility is to the patient; doing the best for and by one’s patient must be the paramount commitment, whatever the legislated injunctions. If we lose sight of that, we lose sight of our vocation and humanity. But we have to be prepared, too, for challenges to our capacity for resolving moral dilemmas. At such times, we have to hold firmly to, and be guided by, the fundamentals: beneficence, non-maleficence, justice and autonomy, while exercising the wisdom to know what best to do when

navigating grey areas, and having the courage to take difficult decisions.

There are two kinds of liberalism. A liberalism which is always, subterraneously authoritative and paternalistic, on the side of one’s good conscience. And then there is a liberalism which is more ethical than political; one would have to find another name for this. (Roland Barthes, French Semiologist, 1915-1980) Might the name “guided paternalism” serve?

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