# *Philosophical Medical Ethics*

## Paternalism and medical ethics

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In my last article I outlined different arguments supporting the principle of respect for people's autonomy and the Kantian requirement always to treat people as ends in themselves rather than merely as means to an end. An obvious and widely expressed counterclaim is that, although respect for autonomy may be important, it is often more important to do the best for people and especially one's patients—or at least to minimise the harm they suffer. To do this it may be necessary to override their wishes and to treat them merely as means to an end—for example, means to their own recovery.

Sometimes one has as a doctor to be paternalistic to one's patients—that is, do things against their immediate wishes or without consulting them, indeed perhaps with a measure of deception, to do what is in their best interests (see bibliography). Just as parents may sometimes have to make important decisions in a child's best interests against the child's will or by deception or without telling the child, so doctors sometimes have to act on behalf of their patients. As Dr Ingelfinger put it, "If you agree that the physician's primary function is to make the patient feel better, a certain amount of authoritarianism, paternalism and domination are the essence of the physician's effectiveness."[1] I shall look more generally at the principles of beneficence and non-maleficence subsequently; here I shall consider some arguments offered in support of medical paternalism.

### Arguments for medical paternalism

The first such argument is that medical ethics since Hippocratic times has required doctors to do the best for their patients. The Hippocratic oath requires that "I will follow that system or regimen which, according to my ability and judgment I consider for the benefit of my patients."[2] It says nothing about doing what patients say they want, not deceiving them, consulting them about their wishes, explaining likely consequences, good or bad, or describing alternative courses of action.

Put so baldly this way of expressing the duty to do the best for one's patients may not sound attractive. Put in terms of various real life circumstances, however, with patients terrified by their diseases, perhaps suffering great pain and other highly unpleasant symptoms such as breathlessness, intractable itching, disordered sensation, misery and depression, and, often, utter bewilderment, it becomes far more plausible to think, especially if one is that patient's doctor, relative, or friend, that the last thing one should do is add to the misery and worry by passing on the results of the biopsy, the risks of treatment, the unsatisfactory options, or whatever other nasty bits of information the doctor has up his sleeve. More plausible indeed, but how justifiable?

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Even if one accepts the claim that the overriding moral requirement is to do one's best to improve one's patients' health, minimise their suffering, and prolong their lives, it is by no means clear that these ends are furthered by, for example, false confidence, paternalistic decision making, evasions, deceit, and downright lies. Of course, such behaviour (the hearty slap on the back, "Well of course we're not magicians old boy but we'll do our best for you, you can rest assured of that, and we've had some excellent results . . .") greatly reduces the anguish for the doctor: honest discussions with people who, for example, have a fatal disease concerning their condition and prospects are emotionally demanding, as is the necessary follow up; it is far less difficult to "look on the bright side." The assumption, however, that this generally makes such patients happier is highly suspect.

What is more, it is often only the patient who is deceived and treated thus, while a relative or relatives are told the truth; the deceit that this imposes on the family (and also on other medical and nursing staff) may itself provoke considerable distress,[3] not to mention the breaking of normal medical confidentiality and the effects of doing so. Then there is the suffering of the patient who suspects that something nasty is afoot but cannot discover what. Finally, there is the suffering of a fatally ill patient on discovering that he or she has been deceived by his or her doctor and family.[4] What a way to go.

Of course, some patients really do want their doctors to shield them from any unpleasant information and to take over decision making on all fronts concerning their illness. Doing what the patient wants, however, is not (by definition) paternalism. My point is that not all patients want doctors to behave like this, and for those who do not it is highly dubious to suppose that their suffering is reduced by it or their health improved or even their lives prolonged. Skill, time, and effort are required to find out what the patient really wants,[5,6] whereas in practice it is often merely assumed that the patient "doesn't want to know".

A second line of justification of paternalistic behaviour is that patients are not capable of making decisions about medical problems: they are too ignorant medically speaking, and such knowlege as they have is too partial in both senses of the word. Thus they are unlikely to understand the situation even if it is explained to them and so are likely to make worse decisions than the doctor would.

Even if one were to accept that "best decisions" are the primary moral determinant it is worth distinguishing the sorts of decisions that doctors might be expected to make better than their patients from those where little or no reason exists to expect this. In the technical area for which they have been specially and extensively trained there is little doubt that doctors are likely to make more technically or medically correct (and hence in that sense better) decisions than their medically ignorant patients. The doctor who advises his patient that to continue her pregnancy would, because of coexisting medical conditions, be from her point of view appreciably more dangerous than to have a termination and that therefore a termination would be better may be giving medically sound advice based on superior medical knowledge. If he insisted or even advised that a termination would be better in some moral sense he would be

stepping outside his realm of competence: he is not better trained professionally to make moral assessments than is his patient, and even if he were many would object that it is not the doctor's role even to advise on his patient's moral decisions let alone make them.

### Doctors as assessors of happiness

The counterargument just offered meets the paternalist on his own ground by agreeing that there are some areas, notably the technical, in which doctors may be expected to make better decisions than their patients. It points out that in other areas, including the moral sphere, there is little reason to expect them to do so. A further matter on which it is doubtful whether doctors are qualified or likely to make better decisions than their patients concerns what course of action is likely to produce most happiness or least unhappiness for everyone, all things considered (the utilitarian objective).

Some doctors believe, for example, that in perplexing cases such as those of severely handicapped newborn infants it is up to them to "shoulder the burden," assess what course of action will produce the greatest benefit all things considered, and then implement it. As one paediatrician wrote, "In the end it is usually the doctor who has to decide the issue: it is . . . cruel to ask the parents whether they want their child to live or die."[7]

The philosopher Professor Allen Buchanan has pointed out that if a doctor undertakes to assess which of various available courses of action (including informing the parents of the options and asking them which they favour) is most likely to produce the greatest happiness all things considered he must consider an awful lot of factors.[8]

> ". . . [T]he physician must first make intrapersonal comparisons of harm and benefit of each member of the family, if the information is divulged. Then he must somehow coalesce these various intrapersonal net harm judgments into an estimate of total net harm which divulging the information will do to the family as a whole. Then he must make similar intrapersonal and interpersonal net harm judgments about the results of not telling the truth. Finally he must compare these totals and determine which course of action will minimise harm to the family as a whole."[9]

Buchanan makes a similar analysis for the doctor who tries seriously to assess whether it would be best, all things considered, to tell a dying patient the truth about his predicament. After showing the complexity of any such analysis and its necessarily morally evaluative components Buchanan concludes:

> "Furthermore, once the complexity of these judgments is appreciated and once their evaluative character is understood it is implausible to hold that the physician is in a better position to make them than the patient or his family. The failure to ask what sorts of harm/benefit judgments may properly be made by the physician in his capacity as a physician is a fundamental feature of medical paternalism."[10]

Of course, such assessments—moral and preference assessments—are difficult for anyone to make. The point is that there is no prima facie reason to suppose that doctors make them better than their patients. Even in the strongest case, that of technical medical assessments, the argument from patient ignorance is suspect for in practice many doctors can explain technical medical issues to their patients' satisfaction. Better postgraduate training in effective communication or delegation to colleagues who have these skills, or both, are alternatives to arguing that such effective communication cannot be achieved.

All the preceding counterarguments meet the defence of paternalism on its own ground by accepting its assumption that the overriding moral objective is to maximise the happiness of the patient alone, of the family, or of society as a whole. Kantians (for whom the principle of respect for autonomy is morally supreme) and pluralist deontologists (who believe that an adequate moral theory requires a variety of potentially conflicting moral principles including that of respect for autonomy) will argue that there are many circumstances in which a person's autonomy must be respected even if to do so will result in an obviously worse decision in terms of the patient's, the family's, or, even, a particular society's happiness. This conclusion is also supported by many utilitarians on the grounds that respect for people's autonomy is required if human welfare really is to be maximised.[11-14]

Sir Richard Bayliss movingly described the case of a Christian Scientist whose decision to turn to orthodox medicine for treatment of her thyrotoxicosis came too late to save her life.[15] Few who do not accept Christian Scientism can believe she made a "better" decision in relation to her longevity and health when she rejected the advice of her original doctor in favour of her cult's. Those, however, for whom the principle of respect for autonomy is morally important would not deny her the respect of allowing her to refuse medical help in the first place even though this was highly likely to be fatal and thus cause her family and medical attendants great anguish and even though paternalistic intervention could have saved her life.

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*In my capacity as a police surgeon I see women who have been raped by assailants whose medical histories are not known. I often give these victims the morning after pill to prevent conception and I advise them to attend a clinic for sexually transmitted diseases in two or three week's time for screening. Would it be reasonable instead to give a "morning after" antibiotic to prevent any infection developing? If so what drug or combination should I use?*

This important clinical problem is unfortunately becoming more common and the risks of infection with a sexually transmitted disease are probably increasing in victims of rape. In many instances the infection may be symptomless in the man or he may not have received adequate treatment for a known infection. Exclusion of a sexually transmitted disease is complex and requires skill and experience on the part of the doctor and cooperation from the patient. Extensive laboratory facilities are also required if the newer generations of sexually transmissible infections with agents such as *Chlamydia trachomatis*, *Herpes virus hominis*, or *Human papilloma virus* are to be eliminated. The medical principle of diagnosis before treatment is still of great importance in the management of rape victims. Otherwise the question of what antibiotic or combination of antibiotics should be used is reduced to pure guess work. The days are long since over when "a shot of penicillin" was believed to abort both syphilis and gonorrhoea, the only important diseases. Most sexually transmitted agents, particularly the viruses, are not sensitive to penicillin or other antibiotics, and an increasing number of such diseases are now known to be transmitted by the sexual route. Accurate diagnosis is both possible and desirable and exclusion of infection is one of the doctor's principal roles in managing such cases. The feelings and attitudes of the patient are of great importance in making decisions about surveillance and treatment. The earlier the victim sees a physician experienced in genitourinary medicine the quicker her anxieties about infection may be alleviated and suitable plans established to exclude infection and to provide her with support and understanding.—R D CATTERALL, retired physician in genitourinary medicine, London.