Paternalism In Medical Decision Making

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Abstract:
In this paper, I explore the historical and contemporary conceptions of paternalism, and consider the role that paternalistic action should play in medical decision-making. Principally, I argue that while liberty and autonomy are certainly instrumental to an individual’s conception of a good life, situations may arise in the context of a medical decision that may warrant soft paternalistic action. However, hard paternalism is, in my view, never warranted.

Keywords: paternalism, well-being, autonomy

I. Introduction

Discussions and debates on paternalism as applied to a medical context are a relatively recent topic in the philosophical literature. Conceptual issues in paternalism have applications to many topics, ranging from government to personal relationships, from environmental to medical considerations.

Its applications to the field of medicine and specifically to the policies that govern the conduct of physician-patient relationships have wide ranging and continuously evolving implications for how patients are cared for. Questions surrounding the nature and proper role (if any) of paternalism in the medical context are far from being answered. This thesis attempts to (1) establish a working definition for precisely what paternalism is in a medical ethics context, (2) to determine what effect, whether positive or negative, the exercise of paternalism can have on our well being, and (3) having explored (1) and (2), to come to a conclusion as to whether there is a justified place for paternalism in medicine.

As such, chapter one offers a brief historical overview of the tradition of paternalism in the medical context. Chapter two aims to lay the groundwork for paternalism’s claim that restriction of self-determination is justified by motivations for an individual’s well being by showing that the concept of promoting an individual’s good is
coherent and feasible. I do this by first taking a survey of the common notions of the
good from the philosophical literature. I then seek to determine what constitutes an
accurate picture of the “good” we seek in our every day lives. Working on the assumption
that there is indeed a good we should aim to promote, chapter three considers the
question of whether good is worth the tradeoff in terms of autonomy from a Millian
perspective on liberty. Chapter four offers examples of cases when individuals are less
than good at judging outcomes of situations and the implications of these empirical
results on our evaluation of paternalism. Chapter five considers some of the main
criticisms of paternalism and in particular, discusses Stanley Benn’s argument that any
decisions made by a competent agent should be respected. Finally, chapter six offers a
synthesis of the issues raised and attempts to prescribe a role for paternalism within the
medical context.

A. Historical Overview

Paternalism has a long history in medicine. Broadly, paternalism can be described
as any restriction of or interference with an individual’s will or desire, motivated or
justified by considerations for that person’s well being. Jay Katz, in his book, The Silent
World of Doctor and Patient, states that historically, “disclosure and consent, except in
the most rudimentary fashion, are obligations alien to medical thinking and practice”
(Katz, 1). Furthermore, Hans Jonas is quoted in saying, “the physician is obligated to the
patient, and no one else...we may speak of a sacred trust; strictly by its terms, the doctor
is, as it were, alone with his patient and God” (Rothman, 1). The unique relationship that

1 http://plato.stanford.edu/entries/paternalism/
exists between doctor and patient has rendered the field, for a long time, immune to the
criticism and scrutiny of outside regulators. Concepts such as disclosure, consent, and
autonomy that are seen to be valuable in today’s medical environment seem to be directly
in conflict with the role of physicians and of medicine as they were historically
conceived. As a result, as Rothman explicates in his book, *Strangers at the Bedside*, a
change from the paternalistic habits practiced by the medical establishment necessarily
originated from within.

These changes, however improbable, finally took place in the mid-1960s. The
series of events that unfolded ultimately replaced the predominately paternalistic system
with one that places much more emphasis on patient choice and autonomy. For the
purposes of this thesis, this transformation also helps to shed light on the proper role of
ethics in medicine toward the goal of protecting patients’ well being and the moral
integrity of physicians.

i. Early History

Medicine has had a history as long as human civilization has existed. Medical
traditions may be traced all the way back to the ancient Greek physician and philosopher,
Hippocrates. The modern version of the oath that bears his name has been widely adapted
by medical schools as a rite of passage for medical students as they prepare to begin their
careers as doctors. Among numerous guidelines for the ethical practice of medicine, one
line of the Hippocratic oath stands out, stating, “I will respect the hard-won scientific
gains of those physicians in whose steps I walk, and gladly share such knowledge as is
mine with those who are to follow. I will apply, for the benefit of the sick, all measures
[that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

Tracing the paternalistic roots of the Hippocratic Oath requires little more than a second glance at its language. In phrases such as “knowledge as is mine” and “benefit of the sick”…using “all methods required,” the emphasis is placed not on the patient’s choice of treatment but on leveraging the physician’s exclusive knowledge to benefit the sick, all the while being careful to tread the balance between “overtreatment,” and “therapeutic nihilism.” Medicine, as art or science, whether in historical or contemporary contexts, depends on the fundamental assumption that a physician has access to information to which the patient does not, and that it is the physician’s job to utilize this information to achieve benefit (or at the very least, to cause no harm) to the patient’s health and well-being.

ii. Challenges to the Status Quo

This paternalistic philosophy largely pervaded the medical establishment from the time of Hippocrates well into the 20th century until the mid-1960s, when tremendous changes to this established status quo occurred. Rothman summarizes the essence of these changes to be “the discretion that the profession once enjoyed [had] been increasingly circumscribed, with an almost bewildering number of parties and procedures participating in the medical decision making” (Rothman, 1). The assumption that a doctor’s relationship with his patient was a “sacred trust” that did not require any sort of

external regulation came to be questioned. Similarly, the assumption that doctors alone know what is best for patients was also questioned.

How and why did all these changes occur after so many centuries of undisputed paternalistic practices? In his book, Rothman outlines the progress of this transformation, first tracing the developments within the field of research ethics, which eventually spilled into the realm of patient care. Thus, though I will be focusing on the physician-patient interaction, I draw on the history of the changes that took place in research for their subsequent effects on changing the standards of patient care.

iii. From Within the Medical Establishment

The watershed event took place in June 1966, with the publishing of “Ethics and Clinical Research” in the New England Journal of Medicine. The author, Dr. Henry Beecher, was at the time Professor of Research in Anesthesia at Harvard Medical School. Beecher’s article was short as far as academic articles go, purposefully detached in tone, and professional in style. Ultimately, it was the article’s content, detailing numerous examples of experiments conducted under questionable ethical conditions, which immediately sent ripples through the scientific community.

What is particularly notable about Beecher’s article is the fact that in Rothman’s words, the “whistleblower” came from inside the medical establishment. As I have touched on previously, Rothman draws a strong distinction between inside and outside regulators of medical practice. He argues that medicine’s (and this is true for science in general) status as an isolated field, penetrable only through many long years of study and formal training, made it very hard for any criticism to come from the outside. “Physicians
almost exclusively defined the terms and arrived at the resolutions, giving the deliberations a self-contained quality…Thus, any effort to bring a new set of rules to medicine, to introduce into the world of therapy procedures that narrowed the prerogatives of the investigator, would bear a heavy burden” (Rothman, 102).

Around the time of Beecher’s article however, there came to be a decline in the trust previously inherent in the relationship between doctor and patient. Among other factors, this decline in trust may be attributed to a sudden and precipitous rise in income for physicians. Concurrently, the enactment of Medicare and Medicaid in 1965 helped to centrally organize the medical establishment and implement basic assessments of quality of care. Overall, the trend was to move away from the personal model of the friendly neighborhood doctor to a more impersonal establishment with regulatory bodies and standardized practices.

Rothman goes on to point out the flaws in this kind of system. “From the classical age onward, the most distinguishing characteristic of medical ethics was the extent to which it was monopolized by practicing physicians, not by formal philosophers” (102). As a consequence of this, “there was a strange blind spot about the ethics of health and medicine in almost all ethical literature.” The situation could be likened to a debating match in which one individual was simultaneously a participant and a judge. The conflict of interest in this simple example, much like the case of the research scientist, is quite clear; the debater wishes to win the debate at the expense of his opponent and similarly, the scientist may strive to obtain good research results even at the expense of the research subject. However, the conflict of interest is less obvious in the case of medicine. One could argue that patient-physician interactions do not encounter any conflict of interest
because both parties wish to do what is best for the patient. However, actual cases are more complex and highly nuanced. Both sides face problems of asymmetric information, as the physician has access to technical knowledge out of the patient’s reach, and the patient has access to personal preferences that are at times difficult to express. It is in encountering these challenges that questions of paternalism come into play. In a physician’s efforts to do what he considers to be best of the patient, the physician may advertently or inadvertently disregard a patient’s wishes.

**B. Types of Paternalism**

Having considered a brief overview of the history and background of paternalism’s role in medicine, I will now take a step back to look at what philosophers generally define as paternalism. Here, I provide a basic survey of the forms that paternalism may take in medical, and other contexts, grouped within the broad categories of negative or positive, active or passive, and hard or soft paternalism.

A simple example of paternalism might be when for safety considerations, individuals who fall below a certain height are not permitted on rides at amusement parks. This kind of restriction interferes with such an individual’s will or desire to go on the ride, but does so in order to protect that person’s well being. This example of an amusement park ride seeks to prevent harm, and is thus classified as negative paternalism. Alternatively, a form of paternalism that seeks to promote the good is classified as positive paternalism. John Kleinig gives as an example of positive paternalism, an individual who is “given a blood transfusion without her consent because it is judged that she will not otherwise survive the effects of necessary surgery” (Kleinig,
James Childress, in his book *Who Should Decide*, asserts that all else equal, it is morally easier to justify negative paternalism than positive paternalism. That is, it is intuitively easier to justify an instance of interference with an individual’s liberty to prevent said individual from eminent harm that it is to forcibly provide for the individual’s good.

Another distinction to be made is that between passive and active paternalism, where the active form requires action on the part of the paternalist, while passive paternalism requires *non-action*. Passive paternalism is, all else equal, considered morally easier to justify than active paternalism. The case of a surgeon who refuses to perform an excessively risky surgery that his patient demands, but that the surgeon feels uncomfortable performing, constitutes passive paternalism. A surgeon who performs a beneficial surgery against a patient’s wishes would constitute a case of active paternalism.

Cases of soft and hard paternalism are of particular interest in the medical context. In what follows, I will focus on this distinction. Soft paternalism may be distinguished from the more commonly cited form of hard paternalism on the basis of motivation. While hard paternalism is motivated by beneficence, or the good of the person restricted, soft paternalism is motivated not by the desire to avoid negative outcomes, but only by the desire to ensure that decisions are made by individuals who are competent and fully informed.

One example of soft paternalism might be a doctor who resuscitates a delirious patient who says that he wishes to die. Interference in cases of soft paternalism would be

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3 Childress relates this to Joel Feinberg’s idea that *legal paternalism* (to prevent harm to self) is distinct from *extreme paternalism* (to benefit the self).
permissible only to check that the patient has a rational and clearly determined reason for the expressed desire to die. If the physician finds that the patient is in fact competent to make this decision and has ample reason to do so, he would no longer have reason to interfere in this model. On the other hand, with a strong paternalist approach, the Doctor would be justified to prevent the patient from dying regardless of the patient’s wishes simply because this is determined to be the most beneficial outcome for the patient, as assessed by the doctor.

C. Example Case

An encounter described by Jay Katz in The Silent World of Doctors and Patients between Dr. Mark Seigler and his patient, called Mr. D., is one example of soft paternalism. Mr. D was a previously healthy 66-year-old black male who had been admitted to the emergency room with a case of pneumonia that was non-responsive to aggressive treatment with three antibiotics. The following course of events took place, according to Katz.

The next day, his condition worsened and his physicians concluded that two uncomfortable but relatively routine diagnostic procedures – a bronchial brushing to obtain a small sample of lung tissue and a bone marrow examination – might establish the cause of his illness. The patient refused permission for performing these tests and when his physicians repeatedly attempted to explain their necessity, Mr. D. ‘became angry and agitated by this prolonged pressure and subsequently began refusing even routine blood tests and X-rays. A psychiatric consult found him competent and concluded that “Mr. D. understood the severity of his illness…and that he was making a rational choice in refusing his tests” (Katz, 156).

Despite the psychiatrist’s evaluation of Mr. D.’s competence, statements made by Mr. D. often seemed contradictory. For instance, he replied to the physicians’ warnings that, “

\[^4\] This may require further definition of the terms competent, and ample reason
everyone has to die. If I die now, I am ready.” However, he seemed equally adamant in
his desire to recover, stating, “I want to be helped, I want you to treat me with whatever
medicine you think I need” (Katz, 156). Mr. D. continued to refuse tests even though it
was made clear to him that they were necessary to aid in his recovery. He ultimately
became semi-unconscious and underwent cardiorespiratory arrest as a result of the
infection. At his request, Mr. D was not resuscitated and subsequently died.

Cases of soft, hard, positive, negative, passive, and active paternalism all may be
found in medicine. I will later return to the case of Mr. D. to discuss the reasons why soft
paternalism is not only justified, but necessary in this particular situation. I will also
discuss the limitations on soft paternalism, and whether cases of hard paternalism may
sometimes be reasonably justified.

II. Common Notions of the Good

When doctors encourage a patient to accept a particular treatment, we understand
that the doctor’s motive is to affect a “good” outcome. Many believe that paternalism is
bad because an individual who is paternalistic attempts to restrict another’s freedom of
choice for the sake of that person’s good, even though it is impossible for the paternalist
to presume knowledge of what that good is. The claim is either that the concept of the
good for a person is implausible, or it is so subjective that no one would be able to
understand it other than the person himself. In order to properly assess the validity of this
common argument against paternalism, I take a conceptual step back to first understand
the nature of the good that paternalism is trying to achieve. In doing so, I attempt to
explain why this common criticism of paternalism is inaccurate.
While it is true that accounts of the good differ across individuals and are thus subjective, the fact that goods are subjective does not make them unknowable or impossible to communicate to others. It is possible to conceive of an objective notion of the good for each individual (this would imply that there are also things that are objectively bad for the individual). This concept of the good should be subjective in the sense that it varies depending on the psychological state of the individual, but objective in that what is good or bad for an individual is true or false independent of what the individual may believe.

Historically, many philosophers have tried to address this question of the good, with varying degrees of success. When we refer to something that is good for someone, it often seems to encompass many related, but slightly different concepts: happiness, pleasure (or the lack of pain), and well being, to name a few. As Daniel Haybron writes in *The Pursuit of Unhappiness*, all of these concepts of the good (often used interchangeably with well-being) consist of “normative or evaluative concept[s] that concern what benefits a person, is in her interest, is good for her, or makes her life go well for her,”…that is, all these concepts make value judgments about how individuals’ lives are going. Is there a “right” way to make such value judgments?

One method, recently presented by Derek Parfit in the appendix of his book *Reasons and Persons*, classifies these broad ideas into the following categories: (1) theories of hedonism/happiness (2) desire theories, and (3) objective theories. Here I define these common views of the good, and move on to consider whether it is possible to predict what might be good for others.
A. Hedonism

Many factors play a role in value judgments about a person’s life. One of the first factors that comes to mind in evaluating whether a person’s life is going well is simply if that person is experiencing pleasure and avoiding pain. Pleasure is a psychological state, and a view that appeals to pleasure as the greatest contributor to an individual’s well-being is a hedonistic theory. Hedonists thus try to maximize the amount of pleasure, while minimizing the amount of pain experienced over a lifetime.

This certainly has relevance in medical cases. Consider the case of Dax Cowart, an individual who suffered severe and disabling burns over most of his body following an incident where his car was lit on fire. His injuries were extensive, and included the loss of both hands, eyes, ears, and third-degree burns over almost 70% of his body. Cowart felt that given his condition as a severely disabled individual, life would no longer be worth living. Because he did not think that such a life would give him adequate pleasure to balance out the pain that he was experiencing on a daily basis, he requested to be allowed to die. If his conclusion is correct, a hedonist would agree that further treatment would not be warranted, and that Cowart should be allowed to die.

However, hedonistic views are also often problematic in medical contexts in the way that they elevate the psychological experience of pleasure above the many other desires and convictions of the person. Parfit cites Freud as one such case that would be problematic for the hedonistic theory. Near the end of his life, Freud refused delirium-inducing painkillers because he preferred to think in pain rather than to be confused but without pain. Though we generally view pleasure as desirable (and pain as undesirable)

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5 University of Virginia, October 2, 2002. Retrieved April 20, 2010
by definition, there are instances where we may be compelled to sacrifice pleasure in order to gain or preserve something else that is seen as more valuable. Freud valued his intellect and ideas; thus for him it was preferable to be able to think even if this meant facing tremendous amounts of pain. Hedonism thus accounts for only part of how we make value judgments with respect to our lives.

Another example that may be problematic for hedonistic view is the case of a Jehovah’s Witness who suffers from a particularly acute form of anemia. A blood transfusion would be a simple, relatively painless method of resolving this potentially life-threatening condition. By refusing the transfusion, the individual displays a willingness to risk death in order to preserve her religious beliefs. A hedonist would have trouble with this example because in risking death, the Witness is presumably forgoing many years during which she could have experienced additional pleasure. While many might argue that such an individual is simply being irrational, there is something to be said for upholding beliefs that are literally worth the price of one’s life. This is a notion that anyone with strong religious or personal convictions can understand, but that hedonism does not account for.

One important distinction to be made is that between pleasure and happiness. As Haybron points out, hedonistic views are not good accounts of happiness, as certain experiences that are pleasurable may be irrelevant to a person’s overall happiness. The type of happiness referred to here consists of the long-term psychological state of overall happiness, to be distinguished from the short-term emotion or mood. He points to examples of individuals who have pleasurable experiences but are at the same time deeply unhappy in the well-being sense. Furthermore, he argues that even a restrictive
view (inclusive of only the most deep forms of pleasures and pains) is not directly representative of a person’s happiness.

Though I do not directly refer to theories of happiness in this account of notions of the good, it remains an important component of this concept. The idea of happiness underlies or forms a part of all of the theories of the good considered in this chapter: happiness is closely associated with pleasure, is a universally desired component of the good life for all individuals, and is also included in most objective list theories. As such, the concept of happiness held as distinct from pleasure is helpful in considering the good of an individual’s life. An individual such as Freud or the Jehovah’s Witness may be in physical pain, but still retain the ability to be happy because there are clearly other factors and values at play.

B. Desire-fulfillment Theories

Desire-fulfillment theories are also commonly referenced in the literature on well-being. In the simplest terms, this theory asserts that what is best for someone would be to successfully fulfill a maximum number of his or her desires (this simple version of the theory is known as the unrestricted theory). Desire based theories are more sophisticated than hedonistic theories because they allow for cases where an individual may desire to forgo pleasure for another good (tradeoffs). It is also more flexible to assigning value to the overall shape of an individual’s life, as a person may have a preference or desire that applies to his or her life as a whole.

However, as Parfit points out, there are significant problems with this type of theory. He cites an example of an individual who meets a person with a fatal illness. The
individual feels for this stranger, and desires that the illness be cured. According to the unrestricted desire theory, the individual’s life would be better in the event that the stranger’s illness is indeed cured, even though it has no fundamental impact for our evaluation of how well the individual’s life goes. Parfit argues that this is implausible and that we should thus reject unrestricted desire-fulfillment theories. Instead, he advocates the greater plausibility of a second subset of desire-fulfillment theories (what Parfit calls success theories) that “appeal to all of our preferences about our own lives.” As such, a question of whether or not the stranger’s illness is cured would be little more than a fleeting event in the individual’s life with negligible impact on his overall well being. On the other hand, desires that we have regarding our own lives, such as family, career, and health (for ourselves and our loved ones) have a much larger impact on an evaluation of our well being.

Consider a patient with a terminal illness who desires a dignified and quiet death. While he is still in a state of consciousness, he is assured that his wishes to end treatment and start palliative care when deemed appropriate will be respected. It turns out that when his illness progresses to the point where he loses consciousness, his family members decide to continue treatment. His desires are not met; however he has no knowledge of this at his time of death.

Under the hedonistic theory anything that happens while the patient is unaware would have no repercussions for the evaluation of how life turned out. To have effect, these features must be “introspectively discernible” or otherwise have an impact on the individual’s psychological state of mind. By contrast, according to the success theory, the individual’s life was in fact negatively affected by this turn of events. The events of the
end of his life were altered against his wishes and thus his desire for a certain specific life trajectory was not fulfilled. By this view, the patient is worse off regardless of whether or not he knew it to be the case.

The distinguishing feature between success theories and hedonistic theories is that whereas the latter only take into account our perceptions, the former considers reality to be a deciding factor in whether “success” has been realized or frustrated. Whereas according to the hedonistic theory, my life is going well if I believe it is going well, success theories also take into account failures in judgment and instances of deception or fraud. Hedonistic theories seem implausible given that one cannot hope to be successful in achieving a desire if one is being fooled or deceived. As such, full information is required in any instance of effective and successful decision-making. These frameworks have many implications for how we should make medical decisions for individuals who write advance directives regarding their care or those who express certain desires but rely on others to carry out these desires. For instance, it seems implausible to suggest via a hedonistic theory that the events at the end of the patient’s life have no effect simply because he was not conscious to witness it. Similarly, most of us would disagree that an individual who deeply believes he has a loving family and a successful career (when in fact his family loathes him and his business is failing) is truly successful merely because he believes it to be true and never finds out he is mistaken.

C. Objective Theories

Finally, the objective list theory states that certain things are intrinsically good or bad for individuals. Immediately, one common criticism is that these types of goods are
difficult to define – what does it mean to be intrinsically good or bad? What distinguishes a quality as intrinsic over another quality that may be merely consequential? In fact, many of what are commonly deemed objective goods, such as happiness, meaningful work, rewarding relationships, and health, overlap with the conclusions reached using the hedonistic or desire-fulfillment frameworks. The only difference lies in the order of explanation. Whereas hedonism deems good anything that results in pleasure and desire-fulfillment deems good anything that satisfies one’s desires, objective goods are good independent of their resulting effects. In medicine, health is treated as an objective good as it is often pursued, even when this pursuit of more health via more aggressive treatment may actually net greater amounts of pain or result in a lower quality of life. Health can also be considered an instrumental good because it allows us to engage in other activities of living.

D. Overlap among the theories

Having surveyed a range of theories of the good, we are now in a better position to determine if there are any common threads flowing through the major theories. All of the theories agree that there is a concept of welfare that matters and that is valuable. Overall, it seems fair to conclude that we care about and act to pursue pleasure, but are willing to give it up for certain things we deem to be more important. These values vary from person to person, and the willingness to sacrifice, in Millian terms, “lower” pleasures, for “higher” ones will also vary. Additionally, we desire our lives to follow a

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6 Mill’s differentiates between higher and lower pleasures, with lower pleasures consisting of bodily pleasures such as food, drink, and sex and higher pleasures consisting of art, music, and literature. The idea is that higher pleasures are inherently more valuable and cannot be compared on a similar scale with lower pleasures.
certain trajectory and thus we consider individuals to be better off if this desire is carried out, and worse off if not. Finally, there are things that are universally desired, such as respect, freedom, and autonomy. And general we should seek to promote these “universal goods.”

As imperfect beings we are often wrong about what we think will be “good” for us and often make decisions that are inconsistent with our own values. Similarly, there are many instances when patients make decisions that are inconsistent with what they have indicated to be their values all along, and that seem to be objectively wrong for them. In these cases, it would be wrong to impose a decision on the patient because this would not be respectful of the patient’s autonomy. Instead, we should aim to abide by the individual’s desires for the shape of his/her life, keeping in mind that individuals’ desires will vary depending on circumstances and personal preferences. However, it would also be wrong to allow the patient to make a decision that would be detrimental to him, where is sole reason is to preserve his full autonomy. There must be a balance between our efforts to promote this “semi-objective” sense of the good and still remaining respectful of an individual’s autonomy.

Given that there does appear to be a real good to promote within the context of paternalism, the question then, is whether the good paternalism aims to promote is worth the often necessary tradeoff in terms of autonomy and self-determination. In addressing this issue, I refer back to the ideas of John Stuart Mill.
III. Mill on Paternalism

As I have mentioned, a common criticism of paternalism is that its exercise often prevents or limits an individual’s liberty and ability for self-determination. The struggle and apparent trade off between liberty and authority has historically been considered within the context of government and politics but also has implications for medical ethics and the interactions between physicians and patients. Are we free to make decisions regarding our own health care? Or are there – and should there be – limitations to this freedom?

A. Why is individual freedom a good?

As defined by John Stuart Mill in his work *On Liberty*, liberty refers to “protection against the tyranny of political rulers...” with rulers being “conceived as in a necessarily antagonistic position to the people whom they ruled (I.2). Mill saw it as necessary to rein in governmental power in order to preserve the expression of the individual. Protection was needed against “the tyranny of prevailing opinion and feeling; against the tendency of society to impose, by other means than civil penalties, its own ideas and practices as rules of conduct on those who dissent from them” (I.5) Clearly, Mill felt that individual freedom was valuable and deserving of preservation. However, the value of this freedom is not always obvious and the importance that Mill ascribes to individuality has not always been acknowledged. “Individual spontaneity is hardly recognized by the common modes of thinking, as having any intrinsic worth, or deserving any regard on its own account” (III.2).
In the context of government, individuality and spontaneity have often been seen as counterproductive to the progress of society, or even dangerous to its stability. Governments have passed laws and issued propaganda to curtail opinions and actions of its citizens. Customs have been established to define the proper course of thought and behavior. Regarding custom, Mill comments, “no one would assert that people ought not to put into their mode of life, and into the conduct of their concerns, any impress whatever of their judgment, or of their own individual character” (III.3). The problem with the adherence to culture, according to Mill, goes beyond individual’s lack of motivation in asserting their character, and extends more deeply, to a structure where individuality is no longer encouraged or necessary. Behavior based on established cultural values do not require personal thought, judgment, or reflection and as such, do not aid in the cultivation of character. “Though customs may be good as customs, and suitable to him, yet to conform to custom, merely as custom, does not educate or develop him in any of the qualities which are the distinctive endowment of a human being” (III.3).

Over time adherence to culture, whether voluntary or involuntary, deprives society of the wealth and value inherent in a wide variety of perspectives. As such, one reason to preserve personal liberty is to promote a more interesting and diverse society. Diversity of opinion and perspective has positive ramifications for the development of a more prosperous society. But on an individual level, personal liberty is important because it allows for the development of a person’s distinctive talents and capabilities. In essence, liberty is essential to the development of one’s character. “A person whose desires and impulses are his own – are the expression of his own nature, as it has been developed and
modified by his own culture – is said to have a character” (III.5). An individual who has no character is no better than a machine, and can’t be adequately representative of a human being. Mill accepts that while traditions and customs are important aspects of an individual’s experience, it is also important to “use and interpret this experience in [ones’] own way” (III.3).

B. How can liberty be protected?

Having looked at the reasons why liberty is valuable despite society’s tendencies against it, I now turn to a discussion of how liberty may be preserved. In order to preserve liberty, it is necessary to conceive of checks on the ruler’s position of power, represented by Mill as natural rights, protected via constitutional checks. As forms of government transitioned away from feudalism and monarchy toward forms of representative government, checks on governmental power were thought to be less necessary. “In that way (meaning representative government) alone, it seemed, could they have complete security that the powers of government would never be abused to their disadvantage.” As such, it was thought unnecessary to limit rulers’ power because “rulers should be identified with the people; that their interest and will should be the interest of the nation. Rulers should theoretically do only what is good for the people. The nation did not need to be protected against its own will.”

This idea has parallels to medicine. The relationship between a physician and a patient may in some ways be compared a country’s government and its people. In the case of a representative government, rulers (as representatives of the people) theoretically have the best interests of the citizens in mind just as doctors should have the best interest
of their patients in mind. Certainly, the importance of liberty plays a large role in both of these relationships.

In the case of government, as Mill points out, representation is not quite so simple. “The people who exercise the power are not always the same people over whom it is exercised.” Even representative government offers no guarantee of self-determination. In a situation of rule by the people, people themselves may become tyrants in molding the behavior of individuals within society to agree with the larger group. Thus “the tyranny of the majority” has become a commonly used phrase to illustrate this danger, as the pursuit of power within a society leaves little room to encourage dissenting opinions. There is thus an inherent conflict of interest between the rule of law and the expression of individual thought and action. Mill suggests that a balance between the two can and must be achieved. To address this, he asserts as his central principle, “that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over many member of a civilized community, against his will, is to prevent harm to others” (I.9).

According to Mill, in situations that concern only the individual himself, he should be completely sovereign. Thus, the realm of thought and opinion should never encounter interference from external regulation so long as they remain insulated. Actions, as they have unavoidable effects on others and on the individual himself (even opinions that become publically influential), are more complex. As a strict limitation on the liberty of action he states, “acts of whatever kind, which, without justifiable cause, do harm to others, may be, and in more important cases absolutely require to be, controlled by the
unfavourable sentiments, and, when needful, by the active interference of mankind” (III.1).

Mill offers the additional caveat that this doctrine should only apply for competent adults who are fully capable of rational thought and are of sound mind. He states that individuals who do not meet this requirement, such as children and the mentally impaired, “must be protected against their own actions as well as against external injury” (I.10). While he considers acts of paternalism to be unacceptable for rational adults, here it is clear that Mill not only advocates, but requires paternalistic action toward individuals who are deemed incompetent to make their own judgments.

C. Should liberty be preserved even in cases where an individual may harm himself?

Is Mill right to support paternalistic action only in instances where the individual has been deemed incompetent? It is pretty clear that small children require protection from actions that could potentially be harmful to themselves, such as running into incoming traffic. It is less obvious what we should do in cases where competent adults seem to make ostensibly bad decisions. On this subject, Mill explicitly states that “his own good, physical or moral, is not a sufficient warrant” for interfering with the liberty of action. This argument depends on the assumption that society is more often wrong than right about an individual’s well being. The idea is that since no one knows his preferences better than the individual himself, it is better to allow individuals to act on their preferences without intervention. What Mill has in mind aptly applies in cases of government intervention against certain actions of citizens. Mill is against government legislation of aspects of life, including when and who individuals should marry, what
students can and should learn, and any limitation whatsoever on the spread and discourse of ideas. He is thus also against the censoring of books, music, and of media in general because the act of dictating what ideas should or should not remain in the public discourse will be limiting to the creativity and variety of perspectives that are integral to the progress of a society.

D. Does Mill consider fully all elements of good prudential judgment?

Mill thinks that liberty is important because greater amounts of liberty, by his logic, lead to better outcomes for society. Thus, Mill’s argument is essentially outcome based. This argument seems to make sense on the macro level, but does it necessarily hold true when applied to individuals? We are best at judging our own preferences, who we are best suited to marry, where we want to go to school, and what majors to pursue etc., but preference is often not the only factor to consider in making a decision. In medicine, situations arise where a treatment decision must take into account both the patient’s preferences and the physician’s expertise regarding the outcomes for all possible interventions. The decision making process must take into account the notion of objectivity, considered within the context of respecting individual preferences.

With regard to medical decisions, situations where patients may be objectively making a bad decision relative to their own preferences are commonly observed. Atul Gawande, in his book *Complications*, presents the case of a patient he calls Joseph Lazaroff, who had an aggressive and terminal cancer, and was to receive spinal surgery in an effort to slow the progression of his spinal cord damage. Gawande emphasized that the procedure, which involved collapsing Lazaroff’s lung to get access to his spine, involved
significant risks, a long, painful recovery, and was potentially fatal. Though Lazaroff had previously indicated that he desired a peaceful death, in his desperation to recover, had become adamant about “doing everything” and opted for the surgery despite the doctors’ warnings. Though Lazaroff’s surgery was technically successful, he ultimately succumbed to complications and died with tubes connected to every orifice of his body, precisely the way he did not want to die.

Gawande presents this case as an example of a patient who had “chosen badly,” not because Gawande is passing judgment on the patient’s preferences, but because his choice to undergo risky surgery went against those very preferences. Within the subjective framework of his own interests, Lazaroff had made an objectively bad decision.

Mill does not consider cases where one action would lead the individual to afflict certain harm upon himself, and where an alternative intervention would lead to a better outcome. His account of liberty considers only personal preferences, but does not take into account necessary external influences on those preferences. Given Lazaroff’s case, Mill’s outcome based argument falls apart because the liberty to adhere to ones preferences may not lead to a better outcome. Though we as individuals have well formed preferences based on our experiences in the past, we are not necessarily good predictors of the future. And though we may have a great understanding of our own priorities in life, and of what makes us most happy, we are not necessarily well equipped to make decisions in our lives that will lead to the outcomes that we want.

Freedom, as such, is clearly important, but is not the end all be all of decision making. Doctors, for one, are much more clearheaded about the options and the
IV. Empirical Research and Implications for Paternalism

I have thus far suggested that though we as individuals are good at knowing our own preferences and desires, we are not so good at evaluating the conditions that will lead to the realization of those desires. To support this claim, I have taken a sample of empirical studies that are indicative of this conclusion. I then discuss the implications of this claim on our evaluation of the values and drawbacks of paternalism.

A. How good are we at evaluating our current and future experiences?

In Daniel Gilbert’s Book, *Stumbling on Happiness*, the author presents a light-hearted account of how we often evaluate the future. Perhaps in a bout of wishful thinking, individuals often overestimate the amount of good that will happen in the future and tend to be unrealistically optimistic about the outcomes of various plans and goals we have made. As a case in point, Gilbert cites a study by Weinstein (30) that concludes, “American college students expect to live longer, stay married longer, and travel to Europe more often than average.” Another study by Stieglis (34) found that cancer
patients are surprisingly more optimistic about their futures than healthy individuals. A possible explanation for this sometimes unreasonable optimism is simply that it feels good to anticipate positive outcomes. Cancer patients may envision their own recoveries as coping mechanism, which may in fact have a therapeutic effect (David, 2008). Conversely, it may also be helpful to imagine the worst, even if such events are not likely to happen. Gilbert cites a study where some individuals were warned before they received an electric shock to their ankles while another group was not warned (Arntz, 1992). The researchers found that three big jolts that were not forewarned were deemed to be more painful than twenty big jolts that were forewarned. Thus it seems that the anticipation of adverse events may actually help to minimize their bad outcomes.

This desire to be able to predict future events is indicative of the need for control over the events in our lives. Ironically, individuals often distort reality by being overly optimistic or pessimistic about situations as a result of these mental efforts to preserve a sense of control. Particularly in situations where health is concerned, anxiety results whenever outcomes of treatments that we hope will be effective, but fear will be futile, are unknown. Since we are often not the best at judging the outcomes of situations, it is important to consider closely the possible consequences of this faulty judgment on the decisions we make and whether they lead to our own well being.

**B. The Disability Paradox**

It is worth looking at a few more examples on this topic. A study on the quality of life of disabled individuals posed the question, “why do many people with serious and persistent disabilities report that they experience a good or excellent quality of life when
to most people these people seem to live an undesirable daily existence?” (Albrecht, 1999) This question hits at our general understanding of well being and what it means to live with a good quality of life. Commonly, this is characterized by “being in good health and experiencing subjective well-being and life satisfaction” (Goode, 1994). Thus, to understand subjective well being and life satisfaction as arising from good health is to preclude individuals of poor health and those who are disabled from the concept of doing well. Indeed it seems odd intuitively to say that a person of poor health is subjectively “doing well” by those standards.

Empirical research seems to suggest a more complex picture. Numerous studies by Albrecht and others have indicated, “patients’ perceptions of personal health, well-being, and life satisfaction are often discordant with their objective health status and disability” (Albrecht and Higgens, 1997; Albrecht, 1994). This is known as the disability paradox. Responses to questionnaires indicated that 53% of individuals with serious disabilities reported an excellent or good quality of life (Albrecht, 1999). Albrecht suggests a possible explanation for the disability paradox is that “the high quality of life reported by many respondents could be due to a secondary gain which occurs when individuals with impairments adapt to their new conditions and made sense of them.” As such, these studies posit that quality of life consists of more than notions that are related to health and instead, should comprise the balance of an individual’s social psychological, and spiritual well being. Certainly, disability is a factor in an individual’s life that must be acknowledged and considered on a day-to-day basis. However, the upshot of this research is that disability does not need to define an individual’s overall
well being. By taking a more holistic view, we may account for more facets of an individual’s life than just by considering health care outcomes.

**C. Relative Happiness**

In another study looking at the happiness accruing to lottery winners and accident victims posed the age old question of whether happiness is relative, and set out to investigate it empirically. “If happiness were completely relative, groups that had received extremes of good and bad fortune in life – winning a million dollars versus suffering a crippling accident – should differ from one another in happiness much less than we might expect” (Brickman and Coates, 1978). This idea is based on the adaptation level theory (Helson, 1964), which states, an individuals judgments about current levels of happiness are made against prior levels of stimulation to which they are accustomed. This theory presents contrast and habituation as the two main factors to explain why lottery winners and accident victims are not expected to have large differences in happiness levels. First, we take the example of the lottery winner. Winning the lottery, constituting an extremely positive event, is expected to cause a shift upward in the individual’s “adaptation level.” This means that by contrast, pleasant events that previously had a certain positive association are now comparatively considered less positive. Second, the effect of habituation predicts that the excitement caused by winning the lottery will gradually lose its impact as the individual reconfigures his understanding of the norm to include the experience of winning the lottery. Thus, an event such as winning the lottery is thus seen not to have a lasting effect on the individual’s happiness.
The accident victim experiences the same processes in reverse. The extreme negative effects of the accident cause the person to perceive everyday pleasures as more positive. Over time, the accident is simply absorbed into the individual’s understanding of the norm as habituation occurs. Thus the common expectation that winning the lottery would serve to make us significantly happier or that suffering the adverse effect of an accident will make us significantly less happy turns out to have no scientific basis.

It is clear from the studies considered here that our lives are often better or worse in reality than we may anticipate, and that we are more often than not wrong in our perception of the present and future. The upshot of this conclusion is that our inability to make accurate judgments has a significant impact on our efficacy as decision makers, specifically considered in the medical context. The tendency to imagine situations as better or worse than they actually are affects the interventions that we choose or do not choose. It also has an impact on how receptive we may be to advice from physicians for or against a risky procedure. Individuals with an overly negative view may refuse to properly consider their treatment options and may simply give up hope even when the situation is far from dire. Conversely, individuals who are overly optimistic may opt for treatments that are excessively risky. In these situations, it is then the doctor’s role to step in and provide a more balanced and unaffected view. In situations where a patient’s assessment of his own condition is distorted, paternalism may be justified to prevent an unnecessary adverse outcome.
V. Common Criticisms and Justifications of Paternalism

A. Good-based and respect-based justifications of paternalism

Joel Feinberg offers a view on the question of what constitutes a justification for paternalism in his paper, *Legal Paternalism*, prefacing his ideas by stating that his aim is to “formulate the most plausible liberty-limiting principles that might yet be called, with historical and linguistic propriety, liberal” (Feinberg, 3). He goes on to explain that “liberalism is the view that the harm and offense principles, and only these, state good and relevant reasons for state coercion by means of the criminal law” (3). As is consistent with Mill, Feinberg’s liberalism defines harm to others as a valid impetus for liberty-limiting intervention, but excludes the “prevention of harm to the actor himself to be a justification for invading his liberty.” Mill’s position is that such paternalistic actions are never justified because individuals are better judges of their own good than they are judges of other people’s good. Mill believes that society would be able to achieve the maximum amount of good if all individuals were just left to their own devices. These kinds of arguments appeal to the greatest good for society; I will refer to these as *good-based arguments*.

Though Feinberg overlaps with Mill in his view of liberalism, Feinberg frames the issue of paternalism differently. He divides paternalism into two broad categories, what he calls presumptively blamable, and presumptively nonblamable. The former “consists in treating adults as if they were children, of older children as if they were younger” while the latter “consists of defending relatively helpless or vulnerable people from external dangers.” The presumptively blamable category
benevolent, if the paternalistic action is in the individual’s interest and nonbenevolent, if the paternalistic action is in someone else’s interest.

From this description it is fair to conclude that for Feinberg, the main distinction between blamable and nonblamable paternalism is not the outcome of the paternalistic action but rather the assumptions going into the decision to act paternalistically. That is, paternalism is presumptively blamable if we move away from treating individuals as autonomous, and with respect for their personal choices. Like Mill, Feinberg’s ideas arise from a liberal starting point. However, Feinberg’s discussion of paternalism differs from Mill in that it is based on the arguments that largely appeal to respect for individuals rather than the good of those individuals. I will refer to this as the respect-based view.

B. When is paternalism justified?

The above discussion of the similarities and differences between the representative good-based and respect-based views are helpful in evaluating instances of paternalism in a medical context. Though Mill argues for the efficacy of good-based views, it is quite clear that considerations for one’s good and one’s ability for self-determination but do not always correspond. Much of the empirical evidence that I have cited in part V leads to the conclusion that as imperfect human beings we do not always know what is in our own best interest.

Thus, an evaluation of whether paternalism is justified seems to depend on whether good based or respect based arguments are leveraged. Good-based arguments consider well being to be the main reason in support of self-determination because they assume that self-determination will ultimately lead to the greatest amount of good. Given
the evidence that self-determination can and does come apart from one’s overall well-being, Mill’s argument for a good-based view is effectively undermined. Here, paternalism would seem to be justified whenever it may effectively lead to greater amounts of well-being. Alternatively, where self-determination and autonomy are considered to be more important, paternalism would seem not to be justified, regardless of the consequences for one’s well-being.

C. Objections to paternalism

Many common criticisms of paternalism align with one or both of the views presented above. First, those that appeal to the good-based view may argue that paternalism should not be exercised because it does not lead to the greatest amount of good. It is difficult to contest the claim that a person knows herself better than anyone else can since she alone inhabits her own mind and body. However, in the context of medical decisions, the concept of “knowing what is best” must be divided into two parts. First, knowing what is the best (which may mean practical, effective, efficient, depending on the context) from a scientific and technical perspective falls within the jurisdiction of the physician, based on years of training in the field. Second, knowing what is best for the patient personally, given his or her desires, ideas, and beliefs all fall within the jurisdiction of the patient. Any medical decision requires a balance of these two components. In instances where a recommendation based on the doctor’s expertise would clearly result in a better outcome than an individual’s ill-founded or uninformed preferences, good-based arguments against paternalism fall apart. As a case in point, under a good-based view, Mr. D.’s decision to refuse the tests ultimately led to his death.
whereas the Doctor’s suggestion could have saved his life. If the good we are interested in is the well being of the patient, then paternalism is strongly supported in such a view.

Respect-based views, on the other hand, are more resilient in their arguments against paternalism. A situation such as Mr. D.’s, where a doctor’s recommendation would lead to a better outcome does not challenge a criticism of paternalism when its focus is on maintaining the individual’s autonomy. Arguments from self-determination hold regardless of whether or not the outcome contributes to the patient’s well being. In keeping with these views, Feinberg rejects hard paternalism that in any way limits an individual’s autonomy.

In *Freedom, Autonomy, and the Concept of a Person*, S.I. Benn asserts a particularly compelling version of the respect-based view. To make his point, Benn refers to what he calls the *principle of non-interference*, which states, “no one may legitimately frustrate a person’s acting without some reason.” He emphasizes that this principle locates the burden of justification on the individual doing the interfering, whereas the individual whose action may be interfered with needs no justification. Benn’s views are consistent with liberal tradition that maintains the importance of objective choice conditions, that is, freedom to choose without duress or constraint in any way.

Benn puts certain limitations on his principle, stating that it does not apply to psychopaths and paranoiacs because they lack the ability to rationally link means to ends. Thus he defines the degree of competence that is necessary, what he calls the condition of *autarchy*, falling somewhere on the spectrum between the condition of *being impelled*, where one is not in control of any of one’s own decisions, and that of being fully *autonomous*, where one is in full control of all of one’s own decisions. An autarchic
individual is simply any individual capable of acting as an agent and making choices for himself. As such, Benn asserts that any decision made by an autarchic individual should be respected. It is important to note that such an individual is not fully autonomous, as conditions for autonomy are much more severe, and require that the individual not only be autarchic, but also fully reflective and uninfluenced by society. Thus, decisions made by autarchic agents do not necessarily have to be wise or prudential.

In this way, Benn assigns greater importance to an agent’s process of decision-making than the outcome of that decision. He believes that all competent, autarchic individuals should be at liberty to make all kinds of judgments, both good and bad. Benn claims, “for someone who has a normal conception of himself as a natural person in a world of natural persons, the conceptual sacrifice to which he would be committed by denying the principle of non-interference would be extremely punishing” (Benn, 117).

To justify his view, Benn argues that we as autarchic individuals understand ourselves as agents with goals and motivations that we may make choices to work toward. In recognizing this as a valuable component in our own lives, we may then extrapolate that the ability to form decisions without interference is also valuable to others, and that “persons owe respect to one another’s autarchic natures.” Without this mutual respect, “there could be no love or friendship between [individuals] as equals, since none would acknowledge the goals and values which gave point to the conduct of others as capable of generating any reasons for action for him” (Benn, 120). Having established the importance of autarchy, it follows then that any act interfering with the autarchy of others is considered morally wrong, even if this act is in the best interest of the agent.
V. Conclusion

Having considered a range of common objections and justifications of paternalism, I return one more time to the case of Mr. D. presented in chapter one. To summarize, Mr. D. presented with a case of severe infection that was nonresponsive to an aggressive course of three different antibiotics. He subsequently refused routine tests that were necessary to target his rapidly progressing infection for reasons that were not fully understood. A psychiatric evaluation indicated that he was, in fact, competent and fully aware of the risk he was taking in refusing the tests. Dr. Seigler, the physician in charge of this case, decided to respect his patient’s liberty of choice, even if that choice would eventually lead to his death. After considering this situation, Katz advocates a different approach. He writes, “I might not have deferred to Mr. D.’s wishes, if he had without any explanation persisted in his refusal to undergo diagnostic tests…Seigler’s account of his and the psychiatrist’s interviews are devoid of any data as to why Mr. D. was so adamant in his refusal” (Katz, 157).

This emphasis on rationale in decision making is a hallmark of the soft paternalist approach. Katz acknowledges the gravity of a decision to overrule a patient’s choice, but he does not believe that this choice is absolute. Thus, Katz requires that two conditions be met before resorting to paternalistic measures. First, that “the consequences of non-intervention pose grave risks to a patient’s immediate physical condition” and second, “the process of thinking about choices is so seriously impaired that neither physician nor patient seem to know what one or both wish to convey to the other” (Katz, 157-158).

7 My emphasis
The first condition places emphasis on the seriousness of a situation that would warrant overriding a patient’s decision. “For example, time may not be available when without intervention, death or injury are imminent” (158). The second condition draws attention to the lack of full understanding of the situation for both the physician and the patient. Katz advocates a stronger version of soft paternalism than Seigler, whereby it is not enough to defer to a patient’s decision merely on the grounds of the patient’s competence and awareness of the consequences of his decision. Katz additionally requires that the physician fully understand the patient’s reason for making that decision.

At the core of his argument, Katz is encouraging more communication to aid prudent medical decision making. With regard to Mr. D.’s case Katz states, “I would have insisted on our talking together as long as time permitted in order to clarify our respective positions. I would have promised him that I had every intention of ultimately respecting his wishes, but that I could not make an absolute promise to do so, for it could turn out that the acuteness and seriousness of his condition might require an intervention prior to our having made ourselves understood to one another” (158-159).

While I have argued that paternalism, in its soft manifestation, is appropriate and constructive for use in situations similar to Mr. D.’s case, there are also necessary checks and balances to be placed. Following Benn’s logic, any autarchic individual such as Mr. D. should have a right to make his own decisions, even if those decisions will clearly lead to bad outcomes. Soft paternalism remains respectful of an individual’s desires because it stipulates that intervention is acceptable only to the point where the individual’s intentions become clear. Though it is necessary to acknowledge the difficulty inherent in attaining full understanding of an individual’s desires, I have argued that it is possible
with adequate communication. By contrast, hard paternalism does not attempt to take into account an individual’s desires, and places beneficence above autonomy in all cases. For this reason, I find no instances of hard paternalism to be justifiable.

While Benn’s argument is compelling because it appeals to our intuitions as individuals who value the freedom of decision-making, it is ultimately not incompatible with soft paternalism. We value and cherish the freedom to decide where to live, what careers to pursue, and who to spend our lives with. These kinds of decisions are solely dependent on our individual preferences and the outcomes that follow from such decisions have significant impact and meaning for our own assessments of how well our lives have gone.

Medical decisions, as I have considered them in the context of this paper, also carry a significant level of importance, as decisions made about how we are to be cared for impacts our quality and the possible duration of our lives. However, unlike the types of decisions considered by Benn, medical decisions seem not to be the types of decisions that are most instrumental to defining someone’s life. The trade off to be considered in many medical decisions requires a great deal of technical expertise, and at the end of the day, do not have meaningful effect on an individual’s judgment of his own life. While the application of soft paternalism does limit the full exercise of an individual’s ability to make medical decisions for himself, I argue that it does not rob that individual of his ability to define the course of his life.

Furthermore, medical choices are not the only ones that may sometimes not be our own to make. As one simple example, colleges require students to complete requirements across a wide range of disciplines, as opposed to only taking the classes that
most appeal to them. At any liberal arts institution, curriculum requirements are in place to foster a more well-rounded and diverse skill set. Students of the humanities who are required to take statistics courses may object to being pushed so far out of their comfort zones, but most recognize some value in being paternalistically forced to accomplish something that they would never do of their own accord. That students who enroll in degree programs willingly subject themselves to the university’s paternalistic authority further illustrates that we recognize the value of paternalistic direction in certain situations. Though patients who enter into relationships with their physicians do not readily agree to paternalistic treatment, here we should remain open to the possibility that there may be value in some paternalistic direction as well.

Most of us recognize the fact that we are not always the best judges of which medical decision will yield the best outcomes. As such, soft paternalism does (and should) play a necessary role in medical decision making. Appropriate amounts of soft paternalism serve to protect patients such as Mr. D. from irrevocable decisions that may needlessly cost them their lives. At the same time, the application of soft paternalism needs to be closely watched so that such actions stay within the defined limitations. As I have stated, soft paternalism’s goal is not the good of the patient, but rather to make sure that the patient is competent and able to make the decisions that are true to his own desires.

Respect for autonomy of competent individuals remains the core driver for this idea. In this sense, even bad decisions must be respected as long as the chooser is both competent and fully aware of the choice that is being made. In essence, soft paternalists merely try to raise one final red flag to confirm that the choice at hand is one that is truly
intended, but do not actually attempt to stand in the way of the choice itself. By contrast, hard paternalistic theories that are motivated by the good of the individual rather than the decision making process itself are fundamentally inconsistent with the value we seem to place in the ability of a competent person to live according to his desires and are thus in this view, unjustified.
VI. References


