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Ethical Considerations Regarding Paternalism in Medicine

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Abstract

Paternalism and autonomy are typically conceptualized as opposing theoretical frameworks. With respect to medical ethics, autonomy is practiced by the patient when he/she has liberty and control over his/her own medical matters, and his/her opinions supersede those of the physician. Paternalism is practiced by the physician when he/she restricts the patient's autonomy (sometimes against the patient's will) to promote health and well-being while discouraging undesirable behaviors. This paper details and analyzes a number of cases of medical paternalism in practice, both from the past and in the present day, with the purpose of examining associated ethical considerations. Attention is given to paternalistic cases regarding the mentally ill, and regarding Croatia as it undergoes political, economic, and technological changes. Ultimately, it is theorized that both complete autonomy and complete paternalism are unethical in medical practice because following one of these frameworks exclusively often leads to neglect of critical ethical concepts such as informed consent and shared decision-making. This paper also refutes the notion that paternalism and autonomy are opposing frameworks; it argues that the frameworks are instead complimentary to one another in medical ethics.

Keywords: paternalism, autonomy, medical ethics

I. Introduction to Theoretical Frameworks and Ethical Concepts

Autonomy and paternalism are often described as conflicting theoretical principles of ethics. With respect to medicine and medical ethics, autonomy virtually always refers to and is practiced by the patient, while paternalism is used by the medical doctor(s). In many cases, the relationship between patient and physician is strained due to differing ethical viewpoints and, frequently, a knowledge gap between both parties.

Increasing patient autonomy entails that the patient has more liberty and control in his/her own medical matters. On the contrary, medical paternalism is practiced when physicians rank their own beliefs and choices over those of the patient. Under paternalism, autonomy is restricted (with or without consent from the oppressed party) to promote well-being and decrease undesirable behaviors. In terms of medicine, the physician is deemed superior, and the patient becomes a subordinate.

The practice of medical paternalism to the fullest extent is unethical because completely paternalistic physicians lack regard for crucial ethical concepts such as informed consent and shared decision-making. However, comprehensive patient autonomy is also unethical in medicine because, again, it would not allow for utilization of these two concepts. An individualized balance of autonomy and paternalism is imperative to achieve ethical medical practice.

Incorporation and application of informed consent and shared decision-making are of the utmost importance in all clinical procedures, including screening, diagnosis, and treatment. Informed consent is the granting of permission (usually by a patient to a practitioner) to perform any sort of intervention measure or information distribution while knowing all possible consequences of the action. This typically entails the physician educating the patient on all

potential risks and/or benefits of a procedure on the patient's health (Gossman *et al.,* 2019). Informed consent allows all parties to be knowledgeable of the medical matters at hand, so that an appropriate course of action is selected to provide an optimal outcome. Neglect of this concept can result in misdiagnoses and improper treatment measures.

Informed consent is a precursor to shared decision-making. The collaboration between patient and provider(s) allows for expression of the patient's preferences and discussion of current scientific evidence. This partnership accounts for the interests of both parties and aims to provide a well-formulated decision that is conducive to the success of the patient and physician (Gossman *et al.,* 2019). Disregard for shared decision-making, like informed consent, can lead to misdiagnoses and poor treatments. However, it can also widen the knowledge gap between patient and provider and ultimately damage the patient's self-esteem, which can be detrimental in the healing and recovery process. Generally speaking, failure to practice these two key ethical constructs can worsen a patient's outcome, which cannot be considered an ethical act.

II. Paternalism for the Mentally Ill

Much of present-day Western medicine has transitioned away from strong paternalism and adopted a more autonomous patient approach to medical ethics. However, decades ago, medical paternalism was not only the norm; it was celebrated. Paul Offit tells the paternalistic and unethical story of the lobotomy procedure in the fifth chapter of his book *Pandora's Lab* (Offit, 2017). In 1935, doctors Egas Moniz and Almeida Lima performed the first human lobotomy on a woman from an insane asylum who suffered from severe anxiety and paranoia. After the surgery, Moniz declared that the patient was "cured" because she no longer felt anxious on a daily basis. However, the doctor failed to report that following the procedure, his patient suffered unfavorable health effects unrelated to her original psychiatric disturbances. Soon after,

he performed many more lobotomies in attempt to cure a variety of mental illnesses. In 1949, he received a Nobel Prize for his surgical invention (Offit, 2017).

Shortly after the introduction of the procedure, Dr. Walter Freeman began performing lobotomies in the United States with his first patient, Alice Hammatt. The patient verbally refused to have the operation; racked with anxiety, she feared the lobotomy would require that the doctors shave her head. Freeman assured her that he and the other doctors would spare her hair, but as soon as she was unconscious, they shaved her and drilled into her skull. The first American lobotomy was a direct result of coercion and deception. Nevertheless, Freeman boasted great success after performing numerous lobotomies. He spoke across the country, claiming that he could cure mental illness. Though, he neglected to share the horrendous side effects of his lobotomies, such as seizures, aggression, and death (Offit, 2017).

The lobotomy procedure became famous rather quickly. Other physicians scorned the barbaric surgery, but the media perpetuated its popularity by only reporting the positive outcomes, and idolizing Freeman. People from all around the world looked to Dr. Walter Freeman to "cure" them of their various mental ailments. Freeman thrived on the fame and fabricated success; though, it soon became overwhelming. The immense desirability of removing mental illness by surgery eventually gave rise to the "icepick lobotomy." This procedure, invented by Freeman, took mere minutes, which allowed him to perform numerous surgeries on numerous patients. The doctor simply inserted an icepick into the orbital cavity of his patient to disrupt the prefrontal cortex, which he believed would cure mental illness. This procedure was impossibly quick, unsterile, and careless. Freeman completely lacked regard for the safety of his patients, many of whom suffered severe consequences from the surgery.

Tragically, several of the children who underwent the icepick lobotomy did not survive (Offit, 2017).

The rise of the lobotomy is case of paternalism in practice. Because the patient pool was comprised of the mental ill, patients had virtually no autonomy in their procedures. Doctors Moniz, Lima, and Freeman saw this lack of autonomy as an opportunity to experiment without much caution. The stigma that the mentally ill cannot and should not make their own decisions encouraged the doctors to believe that they knew better than their troubled patients. They ignored many of their patients' wishes, and instead, carried out their own. All three doctors failed to exercise informed consent, as they did not obtain direct permission to operate from many of their patients. Additionally, the three doctors did not practice shared decision-making, as they failed to communicate the complete details of the treatment procedures and, generally, respect their patients.

Ironically, some now believe that Dr. Walter Freeman, who desperately sought to cure mental illness, actually suffered from some sort of psychiatric condition, or even sociopathy. Without obtaining consent, he butchered human brains with one goal in mind: fame and success. Though, Freeman clearly did not care for, nor respect the patients and lives that gave him what he so wildly craved.

Fortunately, the lobotomy is no longer practiced in modern medicine, as the horrific side effects and death tolls following the surgery eventually came to light in the public eye and medical boards. However, paternalism is still readily practiced upon the mentally ill in the present day. Though perhaps not as severe as drilling into the brain, many mental health facilities across the world use paternalism by means of compulsory admission. This is the action of admitting and detaining a person in a mental health institution without his/her consent.

Compulsory admission, by definition, ignores the ethical principle of informed consent, but stays true to paternalism in that means for application include the "interests of the patient's health or safety or protection of others" (Siu *et al.,* 2018). Authors of a 2018 study claim that paternalism in this case is only ethical when the patient's decision-making ability is significantly compromised due to mental illness or disability. Even so, when the patient can no longer make sound decisions, it is the duty of the responsible clinician to give precedence to the present desires of said patient.

Although, when a patient poses risk to him/herself and/or others, it becomes a paternalistic "duty to detain" the risk-bearing patient in order to prevent harm. The authors state that "interference with an assailant's autonomy preserves both the autonomy and the physical integrity of any potential victims" (Siu *et al.,* 2018). This ideology is representative of deontological and utilitarianism theoretical frameworks, which is unique, as these two frameworks usually do not coincide because deontology is consequentialist theory and utilitarianism is non-consequentialist. Nonetheless, it is the duty of the mental health institution and the responsible clinician to protect the at-risk patient and all other persons who may be at risk by restricting the rights of the patient to produce a greater benefit for the majority.

The collaboration of theoretical frameworks in this case may raise several ethical concerns, though; for example, it invites an evaluation of the physician's rights. In a hypothetical scenario wherein a patient is physically violent, is it still the duty of the doctor to provide care, even though the doctor may undergo harm doing so? Moreover, is it a violation of informed consent if the doctor administering care does not fully understand the violent capabilities of the mentally ill patient? Should doctors value their own well-being above that of

their patients? Paternalism, when enforced by policy, can obstruct not only the rights and safety of the patient, but also those of the physician.

As of now in Hong Kong, a judge or magistrate must approve a compulsory admission of a patient to a mental health institution (Siu *et al.,* 2018). Although, some professionals are currently suggesting that this requirement be removed, on the grounds that it can delay treatment of the patient. However, excluding a judge from this application would drastically increase the power of the clinicians involved, thus, empowering paternalism. The authors believe that "medical professionals should be involved in the decision for compulsory admission," but as with most things, there are a number of ethical considerations (Siu *et al.,* 2018). A critical consideration is the rights of inpatients of these facilities. The Mental Health Ordinance in Hong Kong "is to re-emphasize the patient's human rights," as there have been reported complaints and violations (Siu *et al.,* 2018). Medical superintendents once had the power to deny patient communication to the outside world. Additionally, many relatives of patients have voiced complaints and concerns regarding the treatment of patients inside the facilities, and the patients, themselves, have reported coercion and unwanted consequences of their compulsory admissions (Siu *et al.,* 2018). When paternalism breaches human rights, it cannot and should not be considered ethical (see Appendix A).

III. The Overlap of Political Ideology and Medical Ethics

Presently in Croatia, there is something of a national discrepancy regarding medical ethics (Murgic *et al.,* 2015). Physicians are instituting paternalistic practices, while patients are criticizing their healthcare experiences and arguing that they should have more liberty and better treatment. This issue may be reflective of Croatia's relatively recent economic and political transition from communism to democracy. Under traditional Marxist communism, individuals

should not be able to control and overpower others simply because of their occupations. Though this mainly applies to finances and economic policy, the principle may be extrapolated to societal behaviors. Such behaviors may be causing the medical ethics issue in Croatia.

Communist policy enforces equality amongst all workers and discourages the formation of social classes and a wage gap. Thus, all individuals are to be considered equally valuable. In relation to medical ethics, the unwanted wage gap may be comparable to the previously mentioned "knowledge gap" between physicians and patients. Even though communism is intended to make workers equal in economic value, it may have inadvertently created a sense of equality in value in other aspects in the Croatian society. Thus, patients feel as though their opinions, experiences, knowledge, and feelings are of equal importance to those of the doctor. Though, the fall of communism has resulted in democracy, in which there exists a hierarchy of power, both in government, and in society. This is reflected by physicians implementing paternalistic practices, because they believe themselves to be of a higher intellectual stature than their patients. However, patients still long for equality, and by extension, autonomy in their medical matters.

Currently in Croatian medical practice, there is a greater focus on beneficence from paternalism rather than patient autonomy. These ethical viewpoints may be shifting, though. Patients have begun voicing complaints about various aspects of medical paternalism throughout the Croatian healthcare system. Many feel as though there is a lack of privacy in multiple areas, including physical hospital settings and through the use of advanced medical technologies and electronic records. Whether it be a political ideology shift or advancement in technology, it is evident that patients may feel uncomfortable with change that affects medicine. While this may

not be a direct result of paternalism, patients report that these privacy issues are worsened by "paternalistic mentality" and neglect from physicians (Murgic *et al.*, 2015).

Perhaps even more disconcerting, there have been reports of physicians and medical personnel "purposefully omitting a diagnosis" for patients, to give said patients a semblance of "discretion" or protection (Murgic *et al.*, 2015). Some physicians claim that telling a patient the complete truth of his/her diagnosis is unethical, because it can ultimately have a negative effect on the patient by means of psychological harm, which can become physical in some cases. In turn, the physicians stated that lying to their patients reaped a positive effect by eliciting hope, under certain circumstances. Regardless, studies show that patients prefer to be informed to the fullest extent regarding their medical conditions (Murgic *et al.*, 2015). Thus, the act of a physician lying or withholding information from a patient is generally not in alignment with the patient's will. Neglect to share information is a form of paternalism that may be considered unethical in that it goes against patients' wishes, violates the principle of informed consent, and does not allow for shared decision-making (see Appendix A).

Medical doctors willfully withholding information and lying is indicative of the development of a "god complex:" a colloquial term used to describe a mentality in which an individual assumes god-like power over others. In this case, the physician is deciding what the patient should and should not know, which is an obnoxious exertion of power. Whether it be a result of societal standards influenced by new policy, or simply personal, adopting this sort of god-complex is an example of rampant paternalism that may be dangerous.

IV. Limiting Paternalism

In some cases, paternalism, or a variation of it, may be justified, or even beneficial. This is observed when a person cannot care for his/her own interests or make sound decisions, and by

extension, needs protection. Circumstances such as these are often a result of severe physical or mental illness, and paternalism is nearly "obligatory" to ensure patient safety (Kopelman, 2004). Additionally, paternalism is considered justifiable under the harm principle; if a person poses a threat to others, restricting his/her autonomy, and liberty, is admissible. This is an extension of the previously discussed collaboration of deontological and utilitarian frameworks regarding treatment of the mentally ill.

However, when a person is considered to be fully and legally competent and capable of decision-making, medical paternalism is unethical and not supported by law. This is simply because competent persons are usually best-suited to determine what is in their best interest via self-evaluation. Moreover, a physician may wholeheartedly believe one course of action is best for a competent patient, but sometimes, the physician is wrong just because he/she will never fully understand the patient's experience. The physician may still have benevolent intentions, but acting paternalistically in this case would be unethical, as it is not in the patient's best interest. Generally, competent people achieve intrinsic value from living autonomously, so medical paternalism for these people is virtually never ethical (Kopelman, 2004).

As previously mentioned, variations of paternalism may be justified in a number of situations. Doctor Mark S. Komrad argues that "limited paternalism" is the "only type of paternalism that is appropriate to the clinical setting" (Komrad, 1983). In fact, he argues that it is not only appropriate, but necessary to rescue a patient's autonomy and eventually strengthen it. Paternalism is not so much an opposing idea to autonomy that aims to strip people of rights, rather, it is a reaction to decreased or "incomplete" autonomy. Physical and mental illness embody the concept of incomplete autonomy, because when ill, a person is in need of help. Naturally, the patient somewhat implores the physician to act paternalistically. Komrad argues

that the entire patient-physician relationship is based upon "diminished autonomy and compensatory paternalism," respectively (Komrad, 1983). One would not go to a doctor's office if he/she did not want medical advice from a medical professional.

There is variation in the degrees to which both autonomy and paternalism are practiced. As such, the desired degrees of autonomy and paternalism varies with individual patients, and within a society. Thus, there is no exact "formula" for paternalism that physicians ought to follow, as the concept in practice is highly conditional. To ensure ethical balance of paternalism and autonomy in medicine, continual communication between patient and physician is necessary. It should be noted that most patients, whether consciously or not, want some degree of paternalism from their physicians (Komrad, 1983). Otherwise, they would not seek medical help in the first place.

V. Conclusion

It can be avowed that complete autonomy in medicine is ethically impossible. In a state of complete patient autonomy, the physician would not be permitted to give medical advice to the patient, which hinders shared decision-making and informed consent, and may ultimately cause the patient harm. Moreover, autonomy in any form is impermanent. Daily occurrences, such as contracting a common cold, reduce autonomy temporarily. Complete paternalism and complete autonomy, both, are unsustainable. Furthermore, the two concepts are dependent on one another, and cannot exist without each other. In medicine, balance between paternalistic behaviors and patient autonomy is necessary to ensure optimal and ethical results. This is only achieved through patient-physician communication. Unfortunately, there is no immediate remedy to solve all miscommunicated ethical disputes in medicine. Though, improving patient outcomes may be an easier task than many scientists would believe. Reallocating emphasis from

technological advancement to something as seemingly primitive as conducive communication may reduce occurrences of misdiagnoses, improper treatment, and dissatisfaction of patients worldwide.

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Appendix A

Chart 1. Review of Literature

	Gossman *et al.*, 2019	Komrad, 1983	Kopelman, 2004	Murgic *et al.*, 2015	Offit, 2017	Siu *et al.*, 2018
Theme: Patient-physician communication is imperative.	Informed consent cannot occur without effective communication.	Communication is the key to achieving ethical balance of paternalism and autonomy.	Physicians should be well-informed of patients' wills, should the patients be unable to make sound decisions.	Some doctors withhold diagnoses and communication from patients, even though patients generally prefer to be informed.	Doctors lied to patients to coerce them into surgery. Some patients did not give consent to operations. There was no shared decision-making.	If a patient becomes unable to make decisions, his/her original desires should still be honored.
Theme: Paternalistic physicians have benevolent intentions but can be wrong.	Doctors may use assume consent from a patient, if the patient is unconscious or unable to verbalize consent.	Patients sometimes imply that they want "paternalistic blackmail," and then blame physicians for negative health outcomes.	There is no way to know what is truly best for someone else; humans cannot share exact experiences.	Doctors withhold medical information from patients because they believe it could cause negative effects.	Doctors believed that lobotomies would cure mental illnesses; the adverse effects were unintended.	Inpatients are often protected in facilities but complain about having restricted rights.
Theme: Paternalism is justifiable in varying degrees.	Using shared-decision making can make paternalism ethical and even necessary.	Limited paternalism is appropriate and necessary in medical ethics, especially if autonomy is a goal.	Incompetent persons should be restricted if they pose harm to themselves and/or others.	Paternalism can create a sense of comfort and promote efficiency.	Doctors performed lobotomies with benevolent intentions and hoped to cure many people of mental illnesses.	Inpatients should have restrictions if it protects themselves and/or others.
Theme: Complete patient autonomy is impossible.	There is no informed consent under a state of complete patient autonomy.	Autonomy will always be interrupted by daily, random occurrences.	Autonomy should be sacrificed if it means protecting more people.	Societal and political influences make balancing autonomy and paternalism a challenge.	When institutionalized, inpatients lose much of their autonomy in hopes to get "better."	Inpatients lose autonomy for their own protection, and protection of others.