

## WHAT IS PATERNALISM? IS IT EVER OK TO BEHAVE PATERNALISTICALLY?

Bioethics: Course Notes | Brendan Shea, PhD ([Brendan.Shea@rctc.edu](mailto:Brendan.Shea@rctc.edu))

In this lecture, you'll learn to:

1. Define paternalism, and distinguish between soft and hard paternalism.
2. Identify current issues in bioethics that involve conflicts between respecting patient autonomy and promoting patient welfare.
3. Analyze current issues related to paternalism, and explain the benefits and drawbacks of different policy interventions.

In ordinary English, a *paternalistic* government or institution means “one that makes decisions for its subjects in the way a father [or parent] would for his children” (OED). A paternalistic government treats its citizens as “children,” and will overrule citizens’ desires “for their own best interest.” In the context of biomedical ethics, **paternalism** can be defined as “the intentional overriding of one person’s preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefitting or of preventing or mitigating harm to the person whose preferences or actions are overridden” (BC). Some examples of paternalistic actions include.

1. Making some drugs available *only* by prescription, and refusing to give them to some patients who want them.
2. Taxing other drugs (such as alcohol and cigarettes) in order to make people use them less, which can help their health.
3. Forcing medical treatment on children, dementia patients, or other persons with low cognitive function.
4. Refusing to carry out some medical treatment *because you think it would harm the patient* (for example, refusing to give assistance to a depressed person who wants help committing suicide).
5. Some hospital safety regulations, such as requiring certain patients to use wheelchairs, etc.
6. Making people save money when young and working (in the form Social Security taxes) for living expenses they will have when they are old.
7. Requiring that people wear motorcycle helmets, buckle their seat belts, etc., in order to prevent injuries.

Since nearly all of our actions (e.g., to abuse drugs or to not wear a seatbelt) affect other people as well (such as children, taxpayers, etc.), none of these laws is “purely” paternalistic. However, all of them seem to be at least partially paternalistic—at least part of the reason they were passed was to stop people from doing things that might harm *themselves* in the long run<sup>1</sup>.

### SOFT PATERNALISM: MAKING DECISIONS FOR THE NON-COMPETENT

Many laws governing children are blatantly paternalistic—they cannot buy alcohol or cigarettes, must go to school, cannot consent to marriage (or sex), and so on. All of these laws are “for the children’s own good.” This is considered **soft paternalism**, since children are “incompetent” and many of their actions are “non-voluntary.” Other groups affected by soft paternalism include patients with severe dementia or developmental disabilities, and people who are temporarily incompetent because of drugs, fear, and so on. Almost everyone agrees that soft paternalism can be morally justified in many cases, since the people affected are not autonomous. Medical professionals and surrogates should not feel obligated to “obey” the expressed wishes of incompetent patients. **Surrogates** sometimes practice soft paternalism when they make decisions for incompetent patients (e.g., parents make decisions for children; spouses make decisions for each other). B-C argue that surrogates ought to

1. obey a previously competent patients’ wishes if these are known (the **pure autonomy standard**);
2. when these wishes are NOT known, act in the patient’s best interests (the **best interest standard**) by
3. asking themselves “What would the patient want?” (the **substituted judgment standard**).

So, B-C that ALL THREE standards have a role in determining the treatment of non-competent patients.

### HARD PATERNALISM: THIS IS FOR YOUR OWN GOOD

Not all paternalism is limited to non-competent patients, however. For example, we have laws preventing adults (even well-educated, perfectly competent ones) from selling their organs or serving as prostitutes. These actions are prohibited, at least in part, “for the person’s own good.” This makes them *different* from laws prohibiting murder or theft (which are in the interest of *other* people). This is called **hard paternalism**, since the people affected are perfectly autonomous and may even offer reasoned arguments that they *want* to use heroin, sell their organs, or whatever. In medicine, hard paternalism occurs when caregivers “make” competent patients do something they would not consent to (but which will benefit them) by lying, manipulation, or simply refusing to go along with their wishes. Since this conflicts with the principle of autonomy, these actions need to be considered carefully.

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<sup>11</sup> For an intro to current economic/philosophical/medical debates over paternalism, and how we might “permissibly” convince people to make better decision about their health, finances, etc. see Gerald Dworkin, “Paternalism,” in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Winter 2017 (Metaphysics Research Lab, Stanford University, 2017), <https://plato.stanford.edu/archives/win2017/entries/paternalism/>; Adrien Barton and Till Grüne-Yanoff, “From Libertarian Paternalism to Nudging—and Beyond,” *Review of Philosophy and Psychology* 6, no. 3 (September 1, 2015): 341–59, <https://doi.org/10.1007/s13164-015-0268-x>.

Beauchamp and Childress argue that hard paternalism *can* be justified in medicine, but only in very special circumstances. To see how this works let's consider the case of a controlled substance (such as morphine):

REQUIREMENT (from BC ch. 6)	EXAMPLE <sup>e</sup>
1. "A patient is at risk of significant, preventable harm."	Morphine carries a high risk of addiction. Allowing patients to buy it would put them at risk of harm.
2. "The paternalistic action will probably prevent the harm."	Limiting access to morphine will help prevent this. (Though there will always be a black market).
3. "The prevention of harm to the patient outweighs risks to the patient of the action taken."	People who are in severe pain can get a prescription. So, there is minimal risk.
4. "There is no morally better alternative to the limitation of autonomy that occurs."	There is no way to secure the benefit (preventing morphine addiction) that doesn't restrict autonomy (patients are not allowed to buy it).
5. "The least autonomy-restrictive alternative that will secure the benefit is adopted."	Most people have access to a physician, so it is not a <i>huge</i> loss of autonomy.

While these criteria seem simple enough, applying them in practice can often be difficult, not least of all because it's often tough to judge how effective our paternalistic action will be, and/or what harmful side effects might occur (the "unknown unknowns"). For example, during **Prohibition** the US government banned alcohol (at least partially at paternalistic grounds), but eventually had to repeal this ban, because of both inefficacy (people kept drinking) and crime (gangsters, smugglers, etc.).

**Other issues re: paternalism.** In some cases (such as when a person attempts suicide), a **temporary intervention** may be justified in order to "make sure this is really what the person wants to do." **Passive paternalism** involves a caregiver refusing to go along with a patient's stated request "for the patient's own good." While this can be a form of hard paternalism, it is often easier to justify than active paternalism.

## HOW SHOULD WE EVALUATE THE EFFECTIVENESS OF MEDICAL TREATMENTS?

The principle of beneficence requires that we try to produce the best possible *outcome*. In order to do this, however, we have to figure out some way of determining how "good" or "bad" the likely outcomes of an action are, and how these compare to the outcomes of other possible actions we might do instead. This becomes especially important when institutions (such as hospitals, HMOs, health insurance providers, and governments) want to determine which policies are best. Here are some of the basic concepts:

**Costs** includes "the resources [money, time, facilities] required to bring about a benefit [saving a life or improving health], as well as the negative effects [injury, lost opportunities] of pursuing and realizing that benefit." A **risk** is a "possible future harm," where **harm** is defined as a setback to interests, particularly in life, health, or welfare."

In order to evaluate a policy, we need to know FOUR things:

1. If the policy is adopted, how probable is it that the "benefit" will actually occur? (Low or high probability?)
2. Just how good would the benefit be? (A minor improvement? A major improvement?)
3. If the policy is adopted, how probable is it that the "harm" will actually occur? (Low or high probability?)
4. Just how bad would the harm be? (A minor inconvenience? A major setback?)

These considerations are often used to make decisions about new drugs and treatments. For example, suppose there was a new painkiller that caused severe kidney problem in 50% of people. A policy of allowing people to take this pain killer would have a *high* probability (the pain killer almost always worked!) of a *small* benefit (after all, there are other pain killers available). By contrast, there was a *high* probability of a major harm. Most governments would NOT approve this drug.

**Cost-effectiveness analysis (CEA)**<sup>2</sup> is one way of measuring benefits and harms in nonmonetary terms. One popular measure is **quality-adjusted life year (QALY)**, which is a "measure of health outcome which looks both at length of life and quality of life. QALYs are calculated by estimating the years of life remaining for a patient following a particular care pathway and weighting each year with a quality of life score." So, if a year of life in perfect health has QALY of 1, we might say the following:

- Example 1: A year of life in chronic, but bearable, pain = QALY of 0.5 (so, most patients would be willing to trade TWO years of life like this for ONE year of life in perfect health). Five years of life like this would be equal to 2.5 QALY.
- Example 2: A year of life in chronic, unbearable pain = QALY of -1 (so, most patients would prefer to die rather than be forced to endure life under these circumstances, and may even consider assisted suicide *before* things got this bad.)
- **ADVANTAGE:** This doesn't count rich people as "worth more" than poor people

<sup>2</sup> For more on how CEA relates to other ethical considerations, see F.M. Kamm, "Cost Effectiveness Analysis and Fairness," *Journal of Practical Ethics* 3, no. 1 (June 2015): 1–14. <http://www.jpe.ox.ac.uk/papers/cost-effectiveness-analysis-and-fairness/>

- **DISADVANTAGE:** This will (generally) favor saving young people over old people (since the young have more life remaining). Some people have claimed that it seems too “subjective.”

## REVIEW QUESTIONS

1. Hard paternalism, unlike soft paternalism, involves overruling the decisions of a *fully competent* person: i.e., one who fully understands the consequences of their choice. Under what conditions, if any, is this acceptable?
2. Choose an example of a paternalistic law or policy that interests you, preferably one that involves health in some way. This could be one that is already “on the books,” or it could be one that people have discussed. Now, consider what the best arguments FOR and AGAINST this law might be. You should definitely include a discussion of soft/hard paternalism (and of the potential conflicts between autonomy and beneficence), but you can also bring up other ethical considerations from the class material that you think are relevant, as well as from online research. Some examples include (please choose just ONE specific issue or law).<sup>3</sup>:
  - a. Laws requiring (or prohibiting) medical and social work professionals to overrule parents’ religiously-grounded refusals of treatment, when it comes to their children. For example, do parents have a right to refuse a life-saving blood transfusion *for their child*, if this goes against their religion?
  - b. Prohibiting the following activities for people’s “own good”: hard drugs, prostitution, marijuana, or selling one’s kidneys.
  - c. Laws allowing/prohibiting “commercial surrogacy” (paying a woman to become pregnant, carry children to term, and then give them to the intended parents.)
  - d. Taxing the following sorts of goods in an effort to promote health: cigarettes, alcohol, soda, red meat.
  - e. Vaccine requirements for schoolchildren, government workers, or people generally.

## BIOETHICS AND THE LAW: BOUVIA VS SUPERIOR COURT OF LA COUNTY<sup>4</sup>

Petitioner is a 28-year-old woman. Since birth she has been afflicted with and suffered from severe cerebral palsy. She is quadriplegic. She is now a patient at a public hospital maintained by one of the real parties in interest, the County of Los Angeles. Other parties are physicians, nurses and the medical and support staff employed by the County of Los Angeles. Petitioner’s physical handicaps of palsy and quadriplegia have progressed to the point where she is completely bedridden. Except for a few fingers of one hand and some slight head and facial movements, she is immobile. She is physically helpless and wholly unable to care for herself. She is totally dependent upon others for all of her needs. These include feeding, washing, cleaning, toileting, turning, and helping her with elimination and other bodily functions. She cannot stand or sit upright in bed or in a wheelchair. She lies flat in bed and must do so the rest of her life. She suffers also from degenerative and severely crippling arthritis. She is in continual pain. Another tube permanently attached to her chest automatically injects her with periodic doses of morphine which relieves some, but not all of her physical pain and discomfort.

She is intelligent, very mentally competent. She earned a college degree. She was married but her husband has left her. She suffered a miscarriage. She lived with her parents until her father told her that they could no longer care for her. She has stayed intermittently with friends and at public facilities. A search for a permanent place to live where she might receive the constant care which she needs has been unsuccessful. She is without financial means to support herself and, therefore, must accept public assistance for medical and other care.

She has on several occasions expressed the desire to die. In 1983 she sought the right to be cared for in a public hospital in Riverside County while she intentionally “starved herself to death.” A court in that county denied her judicial assistance to accomplish that goal. She later abandoned an appeal from that ruling. Thereafter, friends took her to several different facilities, both public and private, arriving finally at her present location. Efforts by the staff of real party in interest County of Los Angeles and its social workers to find her an apartment of her own with publicly paid live-in help or regular visiting nurses to care for her, or some other suitable facility, have proved fruitless.

Petitioner must be spoon fed in order to eat. Her present medical and dietary staff have determined that she is not consuming a sufficient amount of nutrients. Petitioner stops eating when she feels she cannot orally swallow more, without nausea and vomiting. As she cannot now retain solids, she is fed soft liquid-like food. Because of her previously announced resolve to starve herself, the medical staff feared her weight loss might reach a life-threatening level. Her weight since admission to real parties’ facility seems to hover between 65 and 70 pounds. Accordingly, they inserted the subject tube against her will and contrary to her express written instructions.

Petitioner’s counsel argue that her weight loss was not such as to be life threatening and therefore the tube is unnecessary. However, the trial court found to the contrary as a matter of fact, a finding which we must accept. Nonetheless, the point is immaterial, for, as we will explain, a patient has the right to refuse any medical treatment or medical service, even when such treatment is labelled “furnishing nourishment and hydration.” This right exists even if its exercise creates a “life threatening condition.” **The court held that Bouvia had a**

<sup>33</sup> You should be able to find quite a few arguments on both sides of these issues. On the general issue of drug legalization, you can start with the following articles, written from opposing points of view: Dan Baum, “Legalize It All,” *Harper’s Magazine*, April 2016, <https://harpers.org/archive/2016/04/legalize-it-all/>; German Lopez, “Should America Legalize All Drugs? This Story Should Give Supporters Pause,” *Vox*, August 6, 2018, <https://www.vox.com/policy-and-politics/2018/8/6/17649036/fda-fentanyl-opioid-epidemic-drug-legalization>. For more on the debate over pornography, prostitution and related “sex market” issues, see Laurie Shrage, “Feminist Perspectives on Sex Markets,” in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Fall 2016 (Metaphysics Research Lab, Stanford University, 2016), <https://plato.stanford.edu/archives/fall2016/entries/feminist-sex-markets/>.

<sup>4</sup> *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127 (Court of Appeal, 2nd Appellate Dist., 2nd Div. 1986).

right to refuse food, even if she intended this to lead to her death. Do you agree? Why or why not? How does this relate to issues of soft/hard paternalism?