or promotes his best interests. In addition the nature and cogency of the evidence for the harmfulness of the course of action must be set at a high level. To paraphrase a formulation of the burden of proof for criminal proceedings—better 10 men ruin themselves than one man be unjustly deprived of liberty.

Finally I suggest a principle of the least restrictive alternative. If there is an alternative way of accomplishing the desired end without restricting liberty then although it may involve great expense, inconvenience, etc. the society must adopt it.

The Refutation of Medical Paternalism

ALAN GOLDMAN

Except in a few extraordinary cases, strong paternalism in medicine is unjustified, Goldman argues. Patients have a right of self-determination, a right of freedom to make their own choices. Decisions regarding their own futures should be left up to them because persons are the best judges of their own interests and because self-determination is valuable for its own sake regardless of its generally positive effects. This right implies "the right to be told the truth about one's condition, and the right to accept or refuse or withdraw from treatment on the basis of adequate information regarding alternatives, risks and uncertainties." The faulty premise in the argument for medical paternalism, says Goldman, is that health and prolonged life can be assumed to be the top priorities for patients (and so physicians may decide for patients accordingly). But very few people always prioritize these values in this way.

There are two ways to attack an argument in favor of paternalistic measures (while accepting our criteria for justified paternalism). One is to argue that honoring rather than overriding the right of the person will not in fact harm him. The other is to admit that the satisfaction of the person's right may harm in some way, but argue that the harm does not merit exception to the right, all things considered. The first is principally an empirical, the second a moral counterargument.

The latter is not a perfectly clear-cut distinction, either in general or in application to the question of paternalism. For one thing, the most inclusive notion of harm is relative to the values and preferences of the particular individual. (This point will be important in the argument to follow.) A person is harmed when a state of affairs below a certain level on his preference scale is realized rather than one higher up. Our notion of harm derives what objectivity it has from two sources, again one principally empirical and the other more purely moral. The first is the fact that certain states of affairs are such that the vast majority of us would wish to avoid them in almost all conceivable contexts: physical injury, hastened death, or depression itself for example. It is an empirical question whether these states of affairs result from certain courses of conduct, hence, when they are predicted results, principally an empirical question whether harm ensues. The second source of a concept of harm independent of individual differences in subjective preferences is ideal-regarding: when the development of an individual capable of freely and creatively formulating and acting to realize central life projects is blocked, that person is harmed, whether

From *The Moral Foundations of Professional Ethics* by Alan Goldman (Rowman & Littlefield, 1980). Reprinted with permission of the publisher. Notes omitted.

or not he realizes it, and whether or not any of his present desires are frustrated.

The first argument against paternalistic interference holds that allowing an individual free choice is not most likely to result in harm taken in its objective sense. The second argument is somewhat more complex. It admits likely harm in the objective sense—worsened health, depression, or even hastened death in the examples we are considering—but holds that even greater harm to the individual is likely to ensue from the interference, harm in the more inclusive sense that takes account of his whole range of value orderings and the independent value of his integrity as an individual. In this latter situation there is one sense in which the individual is likely to suffer harm no matter what others do, since a state of affairs will be realized that he would wish to avoid, other things being equal, a state of affairs well below the neutral level in his preference orderings. But from the point of view of others, they impose harm only by interfering, since only that action results in a state of affairs lower on his scale of preferences than would otherwise be realized. In this sense harm is a relative notion, first because it is relative to subjective value orderings, and second because it is imposed only when a situation *worse* than what would otherwise occur is caused. We appeal to this second more inclusive notion in the second type of argument against paternalism.

Empirical Arguments

Returning to the medical context, other philosophers have recently questioned the degree of truth in the empirical premise that patients are likely to be harmed when doctors fully inform them. Sissela Bok, for example, has noted that in general it appears to be false that patients do not really want bad news, cannot accept or understand it, or are harmed by it. Yet she does not deny that information can sometimes harm patients, can cause depression, prolong illness, or even hasten death; and she explicitly allows for concealment when this can be shown in terminal cases. Allen Buchanan questions the ability of the doctor to make a competent judgment on the probability of harm to the patient, a judgment that would require both psychiatric expertise and intimate knowledge of the patient himself. Doctors are not generally trained to judge long-term psychological reactions, and even if they were, they would require detailed psychological histories of patients in order to apply this expertise in particular cases. As medical practices tend to become more impersonal, certainly a trend in recent years, such intimate knowledge of patients, even on a nontheoretical level, will normally be lacking. Physicians would then have to rely upon loose generalizations, based on prior impressions of other patients and folklore from colleagues, in order to predict the effect of information on particular patients.

Buchanan appears to consider this point sufficient to refute the argument for paternalism, eschewing appeal to patients' rights. But unless we begin with a strong presumption of a right of the patient to the truth, I do not see why the difficulties for the doctor in judging the effect of information on the patient recommends a practice of disclosure. If the decision is to be based upon risk-benefit calculation (as it would be without consideration of rights), then, just as in other decisions regarding treatment, no matter how difficult to make, it seems that the doctor should act on his best estimate. The decision on what to say must be made by him one way or the other; and without a right-based presumption in favor of revealing the truth, its difficulty is no argument for one outcome rather than the other. In fact, the difficulty might count against revelation, since telling the truth is generally more irreversible than concealment or delay.

One could, it is true, attempt to make out a case for full disclosure on strict risk-benefit grounds, without appeal to rights. As we have seen in earlier chapters, utilitarians can go to great lengths to show that their calculations accord with the intuitive recognition of particular rights. In the case of lying or deceiving, they standardly appeal to certain systematic disutilities that might be projected, e.g. effects upon the agent's trustworthiness and upon the trust that other people are willing to accord him if his lies are discovered. In the doctor's case, he might fear losing patients or losing the faith of patients who continue to consult him, if he is caught in lies or deceptions. A utilitarian could argue further that, even in situations in which

these disutilities appear not to figure, this appearance tends to be misleading, and that potential liars should therefore resist the temptation on this ground. One problem with this argument, as pointed out in the chapter on political ethics, is that it is empirically falsified in many situations. It is not always so difficult to foretell the utilitarian effects of deception, at least no more difficult than is any other future-looking moral calculation. In the case of terminally ill patients, for example, by the time they realize that their doctors have been deceiving them, they will be in no condition to communicate this fact to other patients or potential patients, even if such communication were otherwise commonplace. Thus the doctor has little to fear in the way of losing patients or patients' faith from his policy of disclosure or concealment from the terminally ill. He can safely calculate risks and benefits with little regard for such systematic disutilities. Again we have little reason to prefer honoring a right, in this case a right to be told the truth, without appealing to the right itself. The only conclusion that I would draw from the empirical points taken in themselves is that doctors should perhaps be better trained in psychology in order to be better able to judge the effects of disclosure upon patients, not that they should make a practice of full disclosure and of allowing patients full control over decisions on treatment. These conclusions we must reach by a different rights-based route.

I shall then criticize the argument for paternalistic strong role differentiation on the more fundamental moral ground. To do so I shall restrict attention to cases in which there is a definite risk or probability of eventual harm (in the objective sense) to the patient's health from revealing the truth about his condition to him, or from informing him of all risks of alternative treatments and allowing him a fully informed decision. These cases are those in which the high probability of harm can be supported or demonstrated, but in which the patient asks to know the truth. Such cases are not decided by the points of Bok or Buchanan, and they are the crucial ones for the question of strong role differentiation. The issue is whether such projected harm is sufficient to justify concealment. If the patient's normal right to self-determination prevails, then the doctor, in having to honor this right, is acting within the same moral framework as the rest of us. If the doctor acquires the authority to decide for the patient, a normally competent adult, or to withhold the truth about his own condition from him, then he has special professional license to override otherwise obtaining rights, and his position is strongly differentiated.

Before presenting the case against strong role differentiation on this basis, I want to dispense quickly with a possible conceptual objection. One might claim that the justification of medical paternalism would not in itself satisfy the criteria for strong role differentiation as defined. Since paternalism is justified as well in other contexts, the exceptions to the rights in question need not be seen to derive from a special principle unique to medical ethics, but can be held simply to instantiate a generally recognized ground for restricting rights or freedoms. If serious harm to a person himself generally can be counted as overriding evidence that the projected action is contrary to his own true preferences or values, and if this generally justifies paternalistic interference or delegation of authority for decisions to others, if, for example, legislators assume authority to apply coercive sanctions to behavior on these grounds, then the authority to be paternalistic would not uniquely differentiate doctors.

The above may be true in so far as paternalism is sometimes justified in other than medical contexts, but that does not alter the import of the argument for medical paternalism to our perception of the doctor's role. If the argument were sound, the medical profession might still be the only one, or one of only a few, paternalistic in this way. This would differentiate medical ethics sufficiently. I argued earlier that legislators must in fact honor normal moral rights. While paternalistic legislation is sometimes justified, as in the requirement that motorcycle riders wear helmets, such legislation is so relatively small a part of the legislator's concerns, and the amount of coercion justified itself so relatively light, that this does not alter our perception of the legislator's general moral framework. If the paternalist argument were sound in relation to doctors, on the other hand, this would substantially alter the nature

of their practice and our perception of their authority over certain areas of our lives. We can therefore view the paternalist argument as expressing the underlying moral purposes that elevate the Hippocratic principle and augment the doctor's authority to ignore systematically rights that would obtain against all but those in the medical profession. The values expressed and elevated are viewed by doctors themselves as central to their role, which again distinguishes this argument from claims of justified paternalism in other contexts. Furthermore, viewing the argument in this way brings out the interesting relations between positions of doctors and those in other professions and social roles. It brings out that doctors tend to assume broader moral responsibility for decisions than laymen, while those in certain other professions tend to assume less. In any case, while I shall not in the end view the doctor's role as strongly differentiated, I do not want to rely upon this terminological point, but rather to refute the argument for overriding patients' rights to further the medical goal of optimal treatment.

The Moral Argument

In order to refute an argument, we of course need to refute only one of its premises. The argument for medical paternalism, stripped to its barest outline, was:

1. Disclosure of information to the patient will sometimes increase the likelihood of depression and physical deterioration, or result in choice of medically inoptimal treatment.
2. Disclosure of information is therefore sometimes likely to be detrimental to the patient's health, perhaps even to hasten his death.
3. Health and prolonged life can be assumed to have priority among preferences for patients who place themselves under physicians' care.
4. Worsening health or hastening death can therefore be assumed to be contrary to patients' own true value orderings.
5. Paternalism is therefore justified: doctors may sometimes override patients' prima facie rights to information about risks and treatments or about their own conditions in order to prevent harm to their health.

The Relativity of Values: Health and Life

The fundamentally faulty premise in the argument for paternalistic role differentiation for doctors is that which assumes that health or prolonged life must take absolute priority in the patient's value orderings. In order for paternalistic interference to be justified, a person must be acting irrationally or inconsistently with his own long-range preferences. The value ordering violated by the action to be prevented must either be known to be that of the person himself, as in the train example, or else be uncontroversially that of any rational person, as in the motorcycle helmet case. But can we assume that health and prolonged life have top priority in any rational ordering? *If* these values could be safely assumed to be always overriding for those who seek medical assistance, then medical expertise would become paramount in decisions regarding treatment, and decisions on disclosure would become assimilated to those within the treatment context. But in fact very few of us act according to such an assumed value ordering. In designing social policy we do not devote all funds or efforts toward minimizing loss of life, on the highways or in hospitals for example.

If our primary goal were always to minimize risk to health and life, we should spend our entire federal budget in health-related areas. Certainly such a suggestion would be ludicrous. We do not in fact grant to individuals rights to minimal risk in their activities or to absolutely optimal health care. From another perspective, if life itself, rather than life of a certain quality with autonomy and dignity, were of ultimate value, then even defensive wars could never be justified. But when the quality of life and the autonomy of an entire nation is threatened from without, defensive war in which many lives are risked and lost is a rational posture. To paraphrase Camus, anything worth living for is worth dying for. To realize or preserve those values that give meaning to life is worth the risk of life itself. Such fundamental values (and autonomy for individuals is certainly among them), necessary within a framework in which life of a certain quality becomes possible, appear to take precedence over the value of mere biological existence.

In personal life too we often engage in risky activities for far less exalted reasons, in fact just for the pleasure or convenience. We work too hard, smoke, exercise too little or too much, eat what we know is bad for us, and continue to do all these things even when informed of their possibly fatal effects. To doctors in their roles as doctors all this may appear irrational, although they no more act always to preserve their own health than do the rest of us. If certain risks to life and health are irrational, others are not. Once more the quality and significance of one's life may take precedence over maximal longevity. Many people when they are sick think of nothing above getting better; but this is not true of all. A person with a heart condition may decide that important unfinished work or projects must take priority over increased risk to his health; and his priority is not uncontroversially irrational. Since people's lives derive meaning and fulfillment from their projects and accomplishments, a person's risking a shortened life for one more fulfilled might well justify actions detrimental to his health. . . .

To doctors in their roles as professionals whose ultimate concern is the health or continued lives of patients, it is natural to elevate these values to ultimate prominence. The death of a patient, inevitable as it is in many cases, may appear as an ultimate defeat to the medical art, as something to be fought by any means, even after life has lost all value and meaning for the patient himself. The argument in the previous section for assuming this value ordering was that health, and certainly life, seem to be necessary conditions for the realization of all other goods or values. But this point, even if true, leaves open the question of whether health and life are of ultimate, or indeed any, intrinsic value, or whether they are valuable *merely* as means. It is plausible to maintain that life itself is not of intrinsic value, since surviving in an irreversible coma seems no better than death. It therefore again appears that it is the quality of life that counts, not simply being alive. Although almost any quality might be preferable to none, it is not irrational to trade off quantity for quality, as in any other good.

Even life with physical health and consciousness may not be of intrinsic value. Consciousness and health may not be sufficient in themselves to make the life worth living, since some states of consciousness are intrinsically good and others bad. Furthermore, if a person has nothing before him but pain and depression, then the instrumental worth of being alive may be reversed. And if prolonging one's life can be accomplished only at the expense of incapacitation or ignorance, perhaps preventing lifelong projects from being completed, then the instrumental value of longer life again seems overbalanced. It is certainly true that normally life itself is of utmost value as necessary for all else of value, and that living longer usually enables one to complete more projects and plans, to satisfy more desires and derive more enjoyments. But this cannot be assumed in the extreme circumstances of severe or terminal illness. Ignorance of how long one has left may block realization of such values, as may treatment with the best chance for cure, if it also risks incapacitation or immediate death.

Nor is avoidance of depression the most important consideration in such circumstances, as a shallow hedonism might assume. Hedonistic theories of value, which seek only to produce pleasure or avoid pain and depression, are easily disproven by our abhorrence at the prospect of a "brave new world," or our unwillingness, were it possible, to be plugged indefinitely into a "pleasure machine." The latter prospect is abhorrent not only from an ideal-regarding viewpoint, but, less obviously, for want-regarding reasons (for most persons) as well. Most people would in fact be unwilling to trade important freedoms and accomplishments for sensuous pleasures, or even for the illusion of greater freedoms and accomplishments. As many philosophers have pointed out, while satisfaction of wants may bring pleasurable sensations, wants are not primarily *for* pleasurable sensations, or even for happiness more broadly construed, per se. Conversely, the avoidance of negative feelings or depression is not uppermost among primary motives. Many people are willing to endure frustration, suffering, and even depression in pursuit of accomplishment, or in order to complete projects once begun. Thus information relevant to such matters, such as medical information about one's own condition or possible adverse effects of various treatments, may well be

worth having at the cost of psychological pain or depression.

The Value of Self-Determination

We have so far focused on the inability of the doctor to assume a particular value ordering for his patient in which health, the prolonging of life, or the avoidance of depression is uppermost. The likelihood of error in this regard makes it probable that the doctor will not know the true interests of his patient as well as the patient himself. He is therefore less likely than the patient himself to make choices in accord with that overall interest, and paternalistic assumption of authority to do so is therefore unjustified. There is in addition another decisive consideration mentioned earlier, namely the independent value of self-determination or freedom of choice. Personal autonomy over important decisions in one's life, the ability to attempt to realize one's own value ordering, is indeed so important that normally no amount of other goods, pleasures or avoidance of personal evils can take precedence. This is why it is wrong to contract oneself into slavery, and another reason why pleasure machines do not seem attractive. Regarding the latter, even if people were willing to forego other goods for a life of constant pleasure, the loss in variety of other values, and in the creativity that can generate new sources of value, would be morally regrettable. The value of self-determination explains also why there is such a strong burden of proof upon those who advocate paternalistic measures, why they must show that the person would otherwise act in a way inconsistent with his own value ordering, that is irrationally. A person's desires are not simply evidence of what is in his interest—they have extra weight.

Especially when decisions are important to the course of our lives, we are unwilling to relinquish them to others, even in exchange for a higher probability of happiness or less risk of suffering. Even if it could be proven, for example, that some scientific method of matching spouses greatly increased chances of compatibility and happiness, we would insist upon retaining our rights over marriage decisions. Given the present rate of success in marriages, it is probable that we could in fact find some better method of matching partners in terms of increasing that success rate. Yet we are willing to forego increased chances of success in order to make our own choices, choices that tend to make us miserable in the long run. The same might be true of career choices, choices of schools, and others central to the course of our lives. Our unwillingness to delegate these crucial decisions to experts or computers, who might stand a better chance of making them correctly (in terms of later satisfactions), is not to be explained simply in terms of our (sometimes mistaken) assumptions that we know best how to satisfy our own interests, or that we personally will choose correctly, even though most other people do not. If our retaining such authority for ourselves is not simply irrational, and I do not believe it is, this can only be because of the great independent value of self-determination. We value the exercise of free choice itself in personally important decisions, no matter what the effects of those decisions upon other satisfactions. The independent value of self-determination in decisions of great personal importance adds also to our reluctance to relinquish medical decisions with crucial effects on our lives to doctors, despite their medical expertise.

Autonomy or self-determination is independently valuable, as argued before, first of all because we value it in itself. But we may again add to this want-regarding or utilitarian reason a second ideal-regarding or perfectionist reason. What has value does so because it is valued by a rational and autonomous person. But autonomy itself is necessary to the development of such valuing individual persons or agents. It is therefore not to be sacrificed to other derivative values. To do so as a rule is to destroy the ground for the latter. Rights in general not only express and protect the central interests of individuals (the raison d'être usually emphasized in their exposition); they also express the dignity and inviolability of individuality itself. For this reason the most fundamental right is the right to control the course of one's life, to make decisions crucial to it, including decisions in life-or-death medical contexts. The other side of the independent value of self-determination from the point of view of the individual is the recognition of him by others, including doctors, as an individual with his own possibly unique set of values and priorities. His dignity demands a right to make personal decisions that express those values.