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Paternalism: The Conflict Between Autonomy And Beneficence In The Case Of The Temporarily Mentally Ill Patients.

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Sammanfattning Abstract
<p>The health care formulation of the principle of autonomy can be expressed as follows; 'you shall not treat a patient without the informed consent of the patient, or his or her lawful surrogate, except in narrowly defined emergencies'. The principle of beneficence refers to a moral obligation to act for the benefit of others. In health care, the good or benefit in question is the restoration of the health of the patient. In fulfilling this obligation of beneficence, the physician sometimes intentionally overrides the patient's preferences or actions for the purpose of benefiting the patient. This is called paternalism. It therefore amounts to a violation of the principle of autonomy and hence there arises a tension or conflict between autonomy and beneficence.</p> <p>The principle of autonomy claims to be pre-eminent to the principle of beneficence and vice versa. Both have their arguments as well as their limitations. However, there is the need for at least weak paternalism for the mentally ill patients because of their diminished autonomy. But in the case of the temporarily mentally ill patient whose autonomy is both restored and diminished following the periodic and intermittent occurrence of his or her mental illness, there is a need to go deeper to find justification for paternalistic intervention.</p> <p>Both act and rule utilitarianism will find justification for paternalism in this case because the consequence of the action will be greater good for both the patient and the society. Kantianism will give it support from the point of view that the intention is to restore the autonomy of the patient by not using him or her as a means but as an end in himself or herself. Beauchamp and Childress will equally throw their weight behind the justification since prima facie obligations could be overridden in a conflict situation and since restricting a short term autonomy to protect and advance long term autonomy will appeal to common morality.</p>

Nyckelord Keyword Paternalism, Autonomy, Beneficence, Temporarily mentally ill patients.

DEDICATION

THIS WORK IS DEDICATED TO ALL THE MENTALLY ILL PATIENTS WHOSE AUTONOMIES HAVE BEEN UNJUSTIFIABLY OVERRIDDEN IN THE NAME OF PATERNALISM AND TO THOSE WHOSE LIVES HAVE BEEN IRREPARABLY RUINED OWING TO THE UNJUSTIFIABLE RECOURSE TO THEIR RIGHTS TO AUTONOMY.

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ABSTRACT

The health care formulation of the principle of autonomy can be expressed as follows; ‘you shall not treat a patient without the informed consent of the patient, or his or her lawful surrogate, except in narrowly defined emergencies’. The principle of beneficence refers to a moral obligation to act for the benefit of others. In health care, the good or benefit in question is the restoration of the health of the patient. In fulfilling this obligation of beneficence, the physician sometimes intentionally overrides the patient’s preferences or actions for the purpose of benefiting the patient. This is called paternalism. It therefore amounts to a violation of the principle of autonomy and hence there arises a tension or conflict between autonomy and beneficence.

The principle of autonomy claims to be pre-eminent to the principle of beneficence and vice versa. Both have their arguments as well as their limitations. However, there is the need for at least weak paternalism for the mentally ill patients because of their diminished autonomy. But in the case of the temporarily mentally ill patient whose autonomy is both restored and diminished following the periodic and intermittent occurrence of his or her mental illness, there is a need to go deeper to find justification for paternalistic intervention.

Both act and rule utilitarianism will find justification for paternalism in this case because the consequence of the action will be greater good for both the patient and the society.

Kantianism will give it support from the point of view that the intention is to restore the autonomy of the patient by not using him or her as a means but as an end in himself or herself. Beauchamp and Childress will equally throw their weight behind the justification since prima facie obligations could be overridden in a conflict situation and since restricting a short term autonomy to protect and advance long term autonomy will appeal to common morality.

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CHAPTER ONE

GENERAL INTRODUCTION

1.1. BACKGROUND OF THE STUDY

Contemporary epoch has greatly witnessed an upsurge of physician-philosopher collaboration on a variety of issues within their respective disciplines. Consequently, there has been a complementary synthesis between ethics and the medical practice. This has resulted among other things in a body of ethico-medical principles otherwise known as the principles of medical ethics evolved and formulated for the purpose of maximizing the medical benefits that the patient is entitled to in medical practice and to protect and promote the medical profession. As a matter of fact, these principles have their origins and foundations on the various ethical theories that have been propounded over the centuries and decades. The principles now constitute standards that radically define the medical practice of contemporary epoch. Apart from this physician-philosopher collaboration, another factor that has given rise to the formulation of these principles is the fact that ethical values are embedded in the medical practice and in the medical tradition following from the Hippocratic Oath. In fact, medical ethical values and standards can easily be derived from common sense understanding of the ends and purposes of medicine. Making reference to two prominent principles that have been visibly embedded in the medical tradition of health care ethics, T .I. Beauchamp writes;

Throughout the centuries, the health care professional's obligation, rights and virtues as found in codes and learned writings on ethics have been conceived through professional commitment to shield patients from harm and provide medical care, expressed in ethical terms as the fundamental obligations of nonmaleficence and beneficence. Medical beneficence has long being viewed as the proper goal of medicine and professional dedication to this gaol has being viewed as essential to being human.¹

On the other two principles, Beauchamp states that in recent years, a new idea has emerged that the proper model of the physician's moral responsibility should be understood less in

¹ Beauchamp, T. L., in Gillon, R.,1994,p.4

terms of traditional ideals of medical benefit and more in terms of the rights of patients, including autonomy-based rights to truthfulness, confidentiality, privacy, disclosure and consent, as well as welfare rights rooted in claims of justice.²The principle of respect for autonomy is rooted in the liberal western tradition of the importance of individual freedom, both for political life and personal development. Hence, the apparent arrival of a new health care ethics emphasizing autonomy rights and justice-based rights may not be a complete surprise when we consider the recent and contemporary social history.

In fact, there is no way of avoiding the ethical dimension of human behaviour. In the light of this, the research scientist involved with human beings and the physician have to ask himself or herself whether it is right or good to be involved in a particular act. This is irrespective of culture or creed. Consequently healers in every culture have developed an ethical code which includes sensitivity to the needy ill, respect for their human dignity as well as guarding of their secrets and a commitment not to take advantage of their vulnerability and to do them harm.

These principles namely; justice, beneficence, non-maleficence and autonomy set both the limits and the scope of medical practice and define the responsibilities and obligations of both the physicians, the state and the society to the patients as well as the patient's responsibility to the physician and other health care givers. Specifically, these four principles were developed by T. L. Beauchamp and James F. Childress. It is their opinion that rules for health care ethics can be formulated by reference to these four principles otherwise known as the four-principle approach together with other moral considerations which may not be apparently deduced from these four principles. Some of the moral considerations or rules include rules of truth-telling, confidentiality, privacy etc.

Consequently, Beauchamp and Childress tenaciously defend these four principles. They do not think that the traditional ethical theories are enough for an analysis of the problems within biomedicine³. They believe that ethical theories are often too abstract for practical use. In the attempt to choose a model for moral justification in biomedical ethics, they considered two

² Ibid.,

³ Beauchamp, T .L., and Childress, J. F.,2001,p.12

models before settling for their own model. The models they considered are the top-down model and bottom-up model.

A top-down model holds that we reach justified moral judgements through a structure or normative precepts that cover the judgement. This model is inspired by disciplines such as mathematics, in which a claim follows logically (deductively) from credible set of premises. The idea is that justification occurs if and only if general principles and rules, together with the relevant facts of a situation, support an inference to the correct justified judgement(s).⁴The following is a very simple example of this deductive form that they presented;

1x. Every act in a patient's overall interest is obligatory for the patient's doctor.

2x. Act of resuscitation b is in this patient's over all best interest.

Therefore,

3x. Act of resuscitation b is obligatory for this patient's doctor.⁵

In this model therefore, a case is simply justified by applying a general rule to the clear case falling under the rule.

They criticized this model of suggesting an ordering in which theories and principles enjoy priority in ethics over traditional practices, institutional rules, and case judgements. While much in the moral life does conform roughly to this linear- dependence conception much does not. Particular moral judgements in their opinion almost always require that we specify and balance norms not merely that we bring a particular instance under a covering rule or principle.⁶Added to this problem of the top-down model is the point that also creates a potentially infinite regress of justification because each level of appeal to a covering precept requires further general level to justify it.

The second model that they considered is bottom-up model. In contrast to the bottom-down level, this model implies that moral justification proceeds inductively (bottom up). Inductivists hold that we use existing social agreements and practices, insight-producing novel cases, and

⁴ *ibid.*,p.384

⁵ *ibid.*,p.386

⁶ *ibid.*,p.387

comparative case analysis as the initial starting points from which to make decisions in particular cases.⁷ Pragmatism and particularism therefore, are among the features of this model. Criticizing this model, Beauchamp and Childress opine that common morality incorporates precepts that bind all persons in all places. Therefore, when cultural groups compromise, ignore, or abuse universal moral standards, their practices do not become immune from moral criticism merely because they regard their views as deriving from their own moral tradition.⁸

In lieu of the above models, they found a via-media in what they called an integrated model. It is their conviction that neither general principles nor paradigm cases have sufficient power to generate conclusions with the needed reliability. This integrated model is also variously referred to as the coherence theory and reflective equilibrium and in this work, I will use them interchangeably. John Rawls is very famous with the idea of the idea of reflective equilibrium. As Beauchamp and Childress observed, he views justification as reflective testing of our moral beliefs, moral principles, theoretical postulates, and other relevant moral beliefs in order to make them as coherent as possible.⁹ In the light of this theory therefore, our considered judgements are liable to revision. The goal of reflective equilibrium is to match, prune and adjust considered judgements in order to render them coherent with the premises of our most general moral commitments. Beauchamp and Childress describe how it works as follows;

*We start with paradigm judgements of moral rightness and wrongness, and then construct a more general and more specific account that is consistent with these paradigm judgements rendering them as coherent as possible.*¹⁰

We cannot nevertheless, assume a completely stable equilibrium. The pruning and adjusting occur continually in view of the perpetual goal of reflective equilibrium. To escape the problem of infinite regress, they suggest that we have to accept some judgements as justified without recourse to other judgements.¹¹

⁷ Beauchamp, T. L and Childress, J.F., *ibid.*, p.392

⁸ *ibid.*, p.397

⁹ *ibid.*, p.398

¹⁰ *ibid.*

¹¹ *ibid.*

But what is the source or sources of these so called considered judgments that are required for justification? To resolve this poser, Beauchamp and Childress appealed to what they call the common-morality theory.¹² This theory succinctly put implies that the bioethical principles can be drawn from a common sense cross-cultural morality. It is then the coherent theory that will bring coherence among the various formulations of the common morality.

As plausible as these principles are, they often apparently contradict each other. A typical example is the conflict that seemingly exists between the principle of autonomy and that of beneficence when the physician and other surrogates find themselves in the dilemma of deciding for the temporarily incompetent patient or even a permanently incompetent patient who had enjoyed his or her individual autonomy or is entitled to his or her autonomy as a human person. This is the act of paternalism which generally speaking is the attitude of a person or government that subordinates should be controlled in a fatherly way for their own good.

Paternalism elicits a conflict between the principle of autonomy and that of beneficence. On the face value, it appears that it undermines the exalted position of the principle of autonomy. This scenario has created a lot of tension and conflict between the principles that are supposed to be harmoniously complementary to one another. This tension has led some schools of thought to call for the nullification of the practice of paternalism. This school of thought really has reasons for justifying its position. Many on the other hand still insist on its retention and application with many justifying arguments to put forward their case.

1.2 STATEMENT OF THE PROBLEMS

Consider a hypothetical patient, Frank. Frank, who is chronically and severely mentally ill, has been violent and has difficulty caring for himself. The few members of his family who were willing to help him have given up because of his violence, repeated hospitalizations, repeated incarcerations or self-negligence.

... Our societal pendulum has swung too far to the patients' rights side. For instance, Frank has the right not to take his medications as soon as he is discharged from the hospital. He has the right to be discharged if he is able to demonstrate the capacity to remain calm and cooperate with hospital staff. Indeed, Frank can do this for short periods when taking his

¹² *ibid.*,p.401

*medications in a controlled environment. If the attending psychiatrist and hospital do not discharge him, Frank has the right to sue the physician and hospital for illegally holding him against his will. So Frank is discharged when he is "safe enough" to leave, and within days, he has stopped his medications. Sooner or later, his paranoid thoughts will overwhelm him, and he will begin to act on them. His violent or bizarre behaviour will be reported to authorities and he will be back in jail or, more appropriately, back in the hospital.*¹³

The case of this hypothetical Frank represents the prevailing situation in which there is a conflict between autonomy and beneficence owing to the attempts by the physicians and other health care workers who would like to carry out their professional obligations and at the same time preserve the autonomous rights of their patients. The case of Frank vividly is problematic because he is seen as having an undiminished autonomy when he is sane but at the same time it is this autonomy that will make him return to the state of insanity .In fact, the problem lies in the intermittent and temporary nature of his mental illness.

The dignity of the person commands us to respect individual persons.¹⁴Autonomy generically, is the credo of the contemporary man in most of the western countries. Expectedly it is occupying a central stage in modern health care. It however, implies that the patient has the capacity to act intentionally with understanding and without controlling influences that would militate against a free and voluntary act. Hence, respect for the dignity of individuals involves allowing them to make their own choices and develop their own life plans.¹⁵In as much as this is true, there is also no gainsaying the fact that a person of diminished autonomy is controlled by or dependent on others at least in some respect with people incapable of deliberating or acting on the basis of such deliberations.¹⁶Prisoners and the mentally retarded are within this group. As William Ruddick observed,

*Attempts to apply the principle of autonomy have raised the question of scope, e.g. can the mentally ill patient give informed consent at least for some procedures.*¹⁷

¹³ www.psychlaws.org/GeneralResources/article203.htm

¹⁴ Garrett, T. M., et al., 2001, p.29.

¹⁵ *ibid.*,

¹⁶ Beauchamp, T .L., and Childress, J. F,*ibid.*,p.60

¹⁷ Ruddick, W.,1998, p.268

This implies that the application of the principle of respect for autonomy is laden with problems and difficulties when some group of persons whose competence for informed consent is not guaranteed as in the case of the mentally ill patients that Ruddick has pointed out.

He also pointed out that one of the principal topics in medical ethics is involuntary hospitalization and treatment of the mentally disturbed people.¹⁸ This is the case with the situation in which the hypothetical patient mentioned above is. How far can the patient's right to autonomy go in this kind of case? Let us consider this other principle that is also very paramount in health care.

The principle of beneficence implies that the health care provider to be of benefit to the patient as well as take positive steps to remove harm from the patient. This is said to be the primary goal of medicine. Owing to this, health care providers and surrogates sometimes decide on behalf of some patients whom they consider incompetent for informed decision like the mentally ill patients. This is an act of paternalism, though in a very loosed senses. This act seems to undermine the principle of right for autonomy.

There is always a conflict between the obligation to do good and the obligation to respect the autonomy of the patient in the case of the temporarily incompetent patients like that of the hypothetical Frank described above. Does the impression that the physician has an inbuilt-institutional superiority undermine the autonomy of the temporarily mentally ill patient in his or her relationship with him or her?

With regards to the principles of autonomy and beneficence, which one is superior to the other? In other words, which of them will the health care workers, the patients and their relatives should consider first in health care?

In the case of the temporarily mentally ill patients, it is controversial and ethically problematic when the physician in the fulfilment of his professional obligation paternalistically decides for him or her due to his or her temporary incompetence.

¹⁸ *ibid.*,

In as much as it is still debatable as to the autonomy of the mentally ill patient who does not fulfil some of the fundamental criteria for autonomy if any, the case is more problematic in the case of a mentally ill patient whose case is just temporary and fluctuating. This is why paternalistic application and surrogacy have constituted problems vis-à-vis the principles of autonomy and beneficence.

How are we to address the problem for the involuntary confinement and hospitalization of the mentally ill patients? Who is responsible for the risks involved when the physician beneficently adopts paternalistic approach in his dealings with the mentally ill patient like our hypothetical Frank? How defensible will the physician's paternalistic attitude be? Who is to decide and what happens when the physician decides through paternalism because of his professional obligation codified in the Hippocratic injunction, '*strive to help, but above all, do no harm*'? These are some of the questions begging for ethical answers so that the good act of paternalism will not be relegated, so that the mentally ill patients will be protected together with other individuals and the society.

The term paternalism seems to include the way a father would act toward his child, but the morally interesting cases are those of actions directed toward autonomous or formerly autonomous persons against their will, but for their own good.¹⁹

Of all the threats to autonomy, paternalism is the most prevalent within health care. When G. Dworkin asserted in his essay titled '*The Theory and Practice of Autonomy*' that there must be a violation of autonomy for one to treat another paternalistically²⁰, he re-echoed the need to engage in the project of finding justification for paternalism if any. The case of our hypothetical Frank mentioned above is one of the pointers to this dilemma. Succinctly put, paternalism is bedevilled with an avalanche of moral problems begging for solutions.

This is however, not the case with those patients who are regarded as incompetent patients. These include children, the senile and the mentally ill.

1.3. PURPOSE OF THE STUDY

The work is intended generally to critically investigate the conflict between autonomy and beneficence as is generated by paternalism. It is aimed at establishing that there is no conflict

¹⁹ Gillon, R., ed., 1995,p.410

²⁰ Dworkin, G.,1988,p.123

as such and to establish the mutuality of the two principles when rightly and objectively applied. The work will systematically formulate a reconciliation of the two principles.

Particularly, it is aimed at carrying out an ethical construction that will help policy and lawmakers evolve ethico-legal solutions aimed at arresting the conflict and dispute that will arise or that have been arising from paternalism for the mentally ill patients in general but particularly for the temporarily mentally ill patients where substantial conflicts and dilemmas abound. Furthermore, it is intended to educate health care workers of their responsibilities and limitations and *modus operandi*.

1.4. SCOPE AND STRUCTURE OF THE WORK

The work will be confined to the case of the temporarily mental ill patients. It will surely draw from the general principles for this particular case and then narrowed down to this particular case of the temporarily mentally ill patients.

The work is divided into chapters with a total of five chapters. The first chapter is concerned with a general introduction of the entire essay. As can be seen already, it is here that the background of the entire study, the statement of the problem, purpose and scope of the study and the methodology to be adopted in the essay will all be highlighted. The second chapter is going to take care of the explication of the basic concepts that will constitute the essay. This is very important because of the age long belief that the explication of concepts makes for a healthy discussion. Concepts will also be delineated to avoid any ‘conceptual mix-up’. The third chapter will delve into the basic conflict that has aroused the need for this essay. It will discuss the conflict between autonomy and beneficence due to paternalism. This chapter will analytically compare the two principles. It will further highlight the dilemmas of the physician and other surrogates in the face of the seemingly inbuilt conflict between these two principles in the case of the temporarily mentally ill patients in particular and the mentally ill patients in general. I will also in this chapter make a case for the primacy of the principle of autonomy and also the primacy of the principle of beneficence.

In chapter four, I am going to concentrate on paternalism in mental health as such. I am going to kick-start this by carrying out a brief survey of what mental illness is all about. It is pertinent to state that this is not going to be an exhaustive and comprehensive survey. The much that I can survey in this regard is the much that is needed for the sake of the essay and

the much that the scope of the essay permits. This chapter will also undertake a survey of paternalistic acts in health care in general and in the mentally ill patients in particular.

Emphasis will however be in the case of the temporarily mentally ill patients. Finally, chapter five will critically evaluate the entire essay and make a constructive case for paternalism in mental health within the context of the temporary mental illness as the scope of the essay has already defined.

1.5. METHODOLOGY

The work is going to be an ethical analysis of the principles in the light of the problems obtainable in the issue being discussed. It will conclusively, involve an attempt or attempts at proffering possible solutions to the lingering conflict.

CHAPTER TWO

CONCEPTUAL ANALYSIS AND DELINEATIONS

2.1. AUTONOMY

The word/term autonomy is a derivative of two Greek words namely; *autos*, which means self, and ‘nomos’ which means rule, governance or law. Literally, the word means independent legislation. Maurice Block remarks that at one period it was the synonym of sovereignty, but in time the sense of the word was restricted.²¹

According to Adler’s philosophical dictionary (1995), the Greek etymology of the word autonomy tells us that it is being law unto oneself, not being governed by any superior on earth.²²

Historically, the term was first used to refer to the self rule or self governance of independent Hellenic city states. The original use of the word in ancient Greek political thought designated the independence of city states that create their own laws instead of having them imposed from without by any other political powers. Confirming this Hellenic origin of the concept of autonomy, Soren Holen asserts that;

*The first traces of the concept of autonomy can be found in early Greek political philosophy. An important distinction here is whether a city state possessed autarchy (self rule) or whether it was under the rule of some other city state.*²³

Autarchy was seen as important because it allowed the citizens of an autarchic city-state to promulgate laws which were especially suitable to their specific situation. Autonomy on the other hand was sometimes used as a synonym for autarchy, but then almost always with the reference to city-states and not to individual persons. Because most Greek and Roman moral

²¹ www.econlib.org/library/ypd/Books/lalor

²² www.thegreatideas.org/apd-auto

²³ Encyclopedia of Applied Ethics, vol.1,1998,p.68

philosophy was not concerned with individual acts as such but more with how to define the virtues, autonomy never became a prominent theme in early moral philosophy.

In the medieval period, discussion of autonomy were not prominent either and the concept lay dormant until the Enlightenment period, where it was revived and connected to the growing emphasis on individualism in philosophy and in society at large.²⁴

In fact the concept of autonomy became central in the influential moral philosophy of Immanuel Kant (1748-1832). In Kant's ethics, autonomy was considered the ability to know what morality requires of us, and functions not as freedom to pursue ends but as the power of the agent to act on objective and universally valid rules of conduct (i.e. the different formulations of the categorical imperative which the will imposes on itself through pure reason). Kant concentrates on the autonomy of the will. Individuals as rational agents in his opinion, exercise their autonomy by originating universal laws. This does not imply making any subjective principle we like into universal laws. To arrest this problem of subjectivism, he states that only those subjective principles that pass the test of the categorical imperative can become universal laws. The categorical imperative is essentially not considered by Kant as an external constraint that limits our autonomy, rather it incorporates a requirement of rationality that one be able to universalize proposed subjective principles without this involving any form of contradiction. This principle of autonomy is applicable to all rational beings in virtue of their rationality. Therefore in exercising one's autonomy by originating universal laws one must recognize that other individuals have autonomy as well. Kant expresses this point by saying that one must treat other rational individuals as ends in themselves and not treat them as means to other ends.

John Stuart Mill is also a central figure in the historical development of the concept in his famous essay 'On Liberty' which is a defence of liberty on utilitarian grounds. According to him;

*The only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant...over himself, over his own body or mind, the individual is Sovereign.*²⁵

²⁴ ibid

²⁵ Mills, J. S, in Himmelfarb., G.,(ed) ,1986, p.68

He believes that people should be free to do any self-regarding action they want to do. He advocates the sovereignty or self rule of the individual over those aspects of his life that do not harm others. Even if we think that some course of action might be harmful to some one, we are not justified in intervening to prevent them acting in this way unless their action will harm others. Mill justifies this principle by claiming that its adoption will lead to happiness, which is the only thing that possesses intrinsic value in Mill's system. Therefore the principle of autonomy does not have its own independent justification but rather is justified by appeal to the principle of utility. Consequently he writes;

*It is proper to state that I forego any advantage which could be derived to my argument from the idea of abstract right as a thing independent of utility. I regard utility as the ultimate appeal on all ethical questions.*²⁶

Mill argues for freedom from constraints over an individual's own actions when these do not harm others. This area of an individual's life should be subject to his autonomous control and comprises first, liberty of thought and feeling which includes freedom to express and publish our thoughts. Second, we ought to have liberty to decide how to live our lives in the sense of having autonomous control over our choice of life plans. Lastly, we should have liberty to combine with others for a common purpose.²⁷

In contemporary thought, autonomy is most often equated with self-determination and individuals are said to be autonomous when their actions are truly their own. It is pertinent to point out that autonomy is given a primary or central place in the prevailing modern liberalism of contemporary society. In this vein, the concept acquired a diversity of meanings like *self governance, liberty, rights, privacy, individual choice, freedom of the will, causing ones behaviour and being one's own person.*²⁸

This diversity of meanings made Beauchamp and Childress to declare that autonomy is not a univocal concept in either ordinary English or Contemporary philosophy. Nevertheless, the

²⁶ *Ibid.*, pp.69ff

²⁷ www.ceus4casemanagers.com/ET1007

²⁸ Beauchamp, T. L. and Childress, J.F., *ibid.*, 120

word succinctly means the condition of something that does not depend on anything else. It denotes the absence of external constraints plus a positive power of self determination.²⁹

Autonomy means that an individual has the right to make decisions and take independent actions without external control. It is in fact;

*the potential or actual ability of individuals and groups to govern them; an ideal of character derived from the conception of self government or the right to self-determination in matters that solely or mainly concern individuals or groups themselves.*³⁰

The concept plays an important role in applied ethics because it is usually assumed that we should show special regards for the autonomous choices of people. It is also the bases for the claim of rights and responsibilities by individuals. Beauchamp and Childress assert that there is an intimate connection between autonomy and decision-making in health care and research.

2.2. THE PRINCIPLE OF RESPECT FOR AUTONOMY

As is commonly understood today autonomy is the capacity for self determination. It is also independence from controlling influences. But being autonomous however, is not the same as being respected as an autonomous agent.³¹ Respect for autonomy is the moral obligation to respect the autonomy of others in so far as such respect is compatible with equal respect for the autonomy of all potentially affected. In Kantian ethics it is described as treating others as ends in themselves and not as means.

To respect an autonomous agent is to acknowledge that person's right to make choices and take actions based on that person's own values and belief system. On this account, respect involves not only refraining from interfering with others choices, but sometimes entails providing them with necessary conditions and opportunities for exercising autonomy³². It implies also the recognition of a person's capacity and perspective as well the person's right to hold views. Beauchamp and Childress offer a detailed description and articulation of

²⁹ International Encyclopedia of Ethics, 1995, p.69

³⁰ Häyry, H., 1998, p.449

³¹ Beauchamp, T. M., and Childress J.F., *ibid.*, p.125

³² www.ascensionhealth.org/ethics/public/key-principle/respect_autonomy.asp

the principle of respect for autonomy that will help us appreciate it more in the following words:

To respect an autonomous agent is, at a minimum, to acknowledge that person's right to hold views, to make choices based on personal values and beliefs. Such respect involves respectful action, not merely a respectful attitude. It also requires more than non-interference in others' personal affairs. It includes in some context, obligations to build up or maintain others' capacities for autonomous choice while helping to allay fears and other conditions that destroy or disrupt their autonomous actions. Respect on this account involves acknowledging decision making rights and enabling persons to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult or demean others' rights of autonomy.³³

In the words of Stefan Bremberg, respect for autonomy or self determination is

The obligation to respect the autonomy of others as long as it is compatible with equal respect for the autonomy of all potentially affected.³⁴

The principle implies that one should be free from coercion in deciding to act, and that others are obligated to protect confidentiality, respect privacy and tell the truth. This principle states that an ethical theory should allow people to reign over themselves and to be able to make decisions that apply to their lives. This means that people should have control over their lives as much as possible because they are the only people who completely understand their chosen type of lifestyle. Each man deserves respect because only he has had those exact life experiences and understands his emotions, motivations and body in such an intimate manner. This is a highly simplified understanding of the meaning of the principle of respect for autonomy.

³³ Beauchamp, T. L, and Childress, J. F.,*ibid.*,p.63

³⁴ Bremberg, S.,2004,p.11

But why should individuals' autonomy be respected or why are people entitled to their autonomy? Beauchamp and Childress wrote that

*Kant argued that respect for autonomy flows from the recognition that all persons have unconditional worth each having the capacity to determine his or her own destiny.*³⁵

The second³⁶ formulation of his categorical imperative which is a key interest to this work at this juncture says;

*Act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means.*³⁷

To violate a person's autonomy therefore, is to treat that person merely as a means, that is, according to others' goals without regard to that person's own goals. For John Finnis, the principle of autonomy is an acknowledgement of both the radical equality of all human beings, and the inalienable responsibility of all who can choose to make their choices open to integral human fulfilment³⁸; it is also based on the fact that a person has an unconditional value and capacity to determine his or her own destiny.

In the area of medical practice in particular, the principle of respect for autonomy requires the physician to obtain informed consent from the competent patient before he medically acts, to maintain confidentiality and to avoid deception.³⁹ In this, respect for patient's autonomy refers to the capability and right of patients to control the course of their medical treatment and participate in the treatment decision-making process. The patient's autonomy is exercised through the process of obtaining informed consent. The following are the some examples of respect for a patient's autonomy:

³⁵ Beauchamp, T. L and Childress, J.F., *ibid.*, pp.63-64

³⁶ The first formulation of Kant's categorical imperative says, "Act only in accordance with that maxim through which you can at the same time will that it become a universal law." The third formulation is a synthesis of the first two.

³⁷ www.en.wikipedia.org/wiki/Immanuel_Kant#Kant.27s_moral_philosophy

³⁸ Finnis, J., in Gillon, R., 1994, p.40

³⁹ *Ibid.*,

- discussing the treatment plans and goals with the patient so that the treatment is directly related to the patient's goal and not that of the physician
- truth telling
- respecting the privacy of the patient
- protecting the confidential information of the patient⁴⁰

The health care formulation of the principle of autonomy can be expressed as follows; you shall not treat a patient without the informed consent of the patient, or his or her lawful surrogate, except in narrowly defined emergencies. The principle clarifies the meaning of respect for the person and his or her freedom in the context of healthcare. It not only seeks to prevent medical tyranny and to preserve freedom, but also to encourage rational decision making by the patient, who in the final analysis must live with the consequences of medical treatment or lack of it.

2.3. INFORMED CONSENT

This is the necessary derivative of the principle of respect for autonomy. Due to the vagueness of the concept, it has received a variety of definitions and articulations. Many have attempted to exaggerate its meaning while some have reduced it. This is why Beauchamp and Childress observed that:

*Some commentators have attempted to reduce the idea of informed consent to shared decision-making between doctor and patient, so that informed consent and mutual decision-making are rendered synonymous*⁴¹

Their thesis as they (Beauchamp and Childress) also pointed out is not that informed consent has this meaning in ordinary language or law, but rather that it should have this meaning. They however made a critique of this reduction of informed consent to shared decision making. They argued that informed consent is obtained and will continue to be obtained in many contexts or research and emergency medicine in which shared decision making is a misleading model.⁴²

⁴⁰ www.tpta.org/Ethics03/respect_for_autonomy

⁴¹ Beauchamp, T. L. and Childress, J .F., *ibid.*,p.77

⁴² *ibid.*,

Conclusively, they are of the opinion that shared decision-making is a worthy ideal in medicine but it neither defines nor displaces informed consent.⁴³ It is in other words very relevant but not to the extent of displacing informed consent.

For Jacqueline Atkinson, '*consent is the giving of permission to someone to do something which that person would not have the right to do without such permission*'.⁴⁴ Consent means that the person is allowed to exercise his or her right to determine what treatment is acceptable under what conditions, for how long and what end.

For Beauchamp and Childress, '*an informed consent is an autonomous authorization by individuals of a medical intervention or involvement in research*'.⁴⁵ In this sense, a person must do more than express agreement or comply with a proposal. In this sense also, an informed consent occurs if and only if a patient or subject with substantial understanding and in substantial absence of control by others, intentionally authorizes a professional to do something.

In another sense furthermore, Beauchamp and Childress try to analyze the concept of informed consent in terms of the social rules of consent in institution that must obtain legally valid consent from patients or subjects before proceeding with therapeutic procedures or research. In their very words; *informed consent refers only to an institutionally or legally effective authorization, as determined by prevailing rules.*⁴⁶

The implication of these two different senses of the concept of informed consent is that a patient or subject can autonomously authorize an intervention and so give an informed consent without effectively authorizing that intervention.

Discarding the different senses of the meaning of informed consent, Beauchamp and Childress believe that the received approach to the definition of informed consent has been to specify elements of the concept, in particular by dividing the elements into an information component and a consent component. The information component refers to disclosure of

⁴³ *ibid.*,

⁴⁴ Atkinson, J., in Baker, J. P et al., 1991, p.116

⁴⁵ Beauchamp, T. L., and Childress, J.F, *ibid.*, p.77

⁴⁶ *ibid.*,

information and comprehension of what is disclosed whereas the consent component refers to a voluntary decision and agreement to undergo a recommended procedure.⁴⁷ This two-component definition of informed consent has given rise to a five-element definition. These five elements derived from the two components are as follows; competence, disclosure, understanding, voluntariness and consent. They are presented as the building blocks for a definition of informed consent. One gives an informed consent to an intervention if (and perhaps only if) one is competent to act, receives a thorough disclosure, comprehends the disclosure, acts voluntarily, and consents to the intervention. This five-element definition is vastly superior to the one element definition in terms of disclosure that courts and medical literature have often proposed.⁴⁸

2.4. BENEFICENCE

The principle of beneficence in its simplest form is that we ought to do good or if, expressed as an obligation, that there is an obligation to help others. According the Encyclopaedia of Ethics ,a more substantial version (of the principle of beneficence) is that human beings ought to be taught to be strongly benevolent and beneficent; where ‘benevolence’ signifies “a wish or disposition to help others” where ‘beneficence’ signifies actually producing good”; where by helping others is meant more than helping one’s children, family, friends, or country, or where the degree to which we ought to help as well as the question whether the relevant normative statement is the best expressed as a virtue, definite or indefinite duty, rule or co-operative project is left to the particular theory to specify.⁴⁹ Acting so as to benefit oneself is also, strictly speaking, beneficence, but given people’s natural self-interested tendency to benefit themselves, self-beneficence is of less ethical interest than beneficent to others.

From the African perspective as articulated by Peter Kasenene

Following from the vital force (the meaning of ‘to be’), everyone has a duty to do good to his or her neighbour, especially to friends, relatives and clansmen, in order to promote the vital force. Generosity, kindness hospitality,

⁴⁷ *ibid.*,p.79

⁴⁸ *ibid.*,

⁴⁹ Encyclopedia of Ethics,2nd ed.,vol.1,2001,p.128

*sharing and charity, all of which promote vital force, are basic values.*⁵⁰

In African ethics these beneficent qualities are not mere virtues but duties. Beneficence is essentially done to preserve and enhance vital force or to restore it when it has been disrupted.

As a matter of fact, the term ordinarily connotes acts of mercy, kindness and charity. Altruism, love and humanity are also sometimes considered forms of beneficence. Broadly, speaking beneficent action intended includes all forms of action intended to benefit other persons. Succinctly put,

*Beneficence refers to an action done for the benefit of others; benevolence refers to the character trait or virtue of being disposed to act for the benefit of others; and principle of beneficence refers to a moral obligation to act for the benefit of others.*⁵¹

The implication of the principle of beneficence is that while many acts of beneficence are not obligatory, the principle of beneficence asserts an obligation to help others further their important and legitimate interests.

The principle of beneficence is traditionally understood as the ‘first principle’ of morality. This is courtesy of the dictum “*do good and avoid evil*” which lends it a moral content. The principle is also regarded as a ‘middle principle’ in so far as it is partially dependent for its content on how one defines the concept of the good or goodness. As a middle principle, beneficence is not a specific moral rule and cannot by itself tell us what concrete actions constitute doing good and avoiding evil.⁵² Narrowing it down to health care, the principle of beneficence implies that health care providers are ethically and morally bound to act in the best interest of the patient.

Good is not a monolithic concept. It is one of the terms that cannot be easily and strictly defined. The history of the philosophical debate about the nature of ‘the good’ is too long and unsettled. Various schools of thought, philosophical movements and theories have their different conceptions of the good. For the utilitarian for instance, the morally good is but

⁵⁰ Kasenene, P., in Gillon, R., 1994, p.189

⁵¹ Beauchamp, T. L, and Childress, J .F.,.ibid.,p.166

⁵² www.ascensionhealth.org/ethics/public/ke

another term for useful. The good that this essay discusses is the patient's good. The good of the patient is a particular kind of good to a person in a particular existential circumstance. It is the circumstance of being ill and needing the help of others to be restored to health or to cope with the assault of illness.

*In a general way, the medical good the patient seeks is a restoration of health—a return of life that permits the pursuit of personal goals with minimum of pain, discomfort, or disability.*⁵³

This is the end that the physician promises to serve by his or her act of profession. In this way the physician becomes an instrument in the attainment of the good that the patient seeks.

2.5 OBLIGATORY AND IDEAL BENEFICENCE

There is always confusion on the distinction between obligatory and ideal beneficence. This has led to a series of disputes on the understanding of the meaning of the principle of beneficence. While some argue that it is more than a mere moral responsibility to be beneficent, others argue that refusal to do so does not make one morally deficient. Some go the extreme of extending it to a legal obligation to be beneficent. This scenario explains the need to clarify and specify beneficence with the aim of locating and identifying the limits of one's obligation to be beneficent as well as the points at which beneficence is obligatory. It is very important to point out that the difference between obligatory and ideal beneficence is quite unclear and full of ambiguities.

Beauchamp and Childress tried to make this distinction through an analysis of the New Testament parable of the Good Samaritan. They are of the view that the Good Samaritan's act is more an ideal beneficent than an obligatory beneficence. This is because his act seems to exceed more than ordinary morality. Both the actions and motive of the Samaritan is beneficent and the parable suggests that positive beneficence is more ideal than obligatory.⁵⁴

Ideal beneficence requires extreme generosity. It goes beyond the common morality that does not require severe sacrifice and extreme altruism in the moral life (e.g., giving both of one's

⁵³ Pellegrino, E. D., and Thomasma, D. C., 1988, p. 77

⁵⁴ Beauchamp, T. L. and Childress, J. F., *ibid.*, p. 167

kidneys for transplantation). Nonetheless, the principle of positive beneficence does support an array of more specific moral rules of obligation.⁵⁵ Examples of these rules of beneficence as enumerated by Beauchamp and Childress include the following;

1. Protect and defend the rights of others.
2. Prevent harm from occurring to others.
3. Remove conditions that will cause harm to others.
4. Help persons with disabilities.
5. Rescue persons in danger⁵⁶.

2.6. GENERAL AND SPECIFIC BENEFICENCE

According to Beauchamp and Childress, *'specific beneficence is directed at specific parties, such as children, friends and patients; whereas general beneficence is directed beyond these special relationships to all persons.'*⁵⁷ The description of general beneficence is shrouded in controversy. Some people argue that we are obligated to act beneficently to all regardless of special relationships, conditions and circumstances or shared and historical affiliation or otherwise. For W. D. Ross, the *'obligation of general beneficence rests on the mere fact that there are other things in world whose conditions we can make better.'*⁵⁸ Such an unqualified form of general beneficence obligates us to benefit persons whom we do not know and with whose views we are not sympathetic.

For Beauchamp and Childress,

The thesis that we have the same impartial obligation to persons we do not know as we have to our own families is both overly romantic and impractical. It is also perilous because this unrealistic and alien standard may divert attention from our obligations to those whom we are close or

⁵⁵ Ibid.,

⁵⁶ Ibid., p.167

⁵⁷ Ibid., p.169

⁵⁸ Ross, W. D., 1930, p.21

indebted, and to whom our responsibilities are clear rather than cloudy. ⁵⁹

Their argument is that the more we generalize obligations of beneficence, the less likely we will be able to meet our primary responsibilities, which we may find difficult to meet. *For this reason, in part, we believe that the common reality does recognize significant limits to the demands of obligatory beneficence.* ⁶⁰

2.7. BENEFICENCE AND NONMALEFICENCE

Having dwelt on the meaning of the principle of beneficence, let us consider the meaning of the principle of nonmaleficence immediately before we go ahead in this sub-section. The principle of nonmaleficence asserts an obligation not to inflict harm on others. In medical ethics, it has been closely associated with the maxim '*Primum non nocere*': "*Above all (or First) do no harm*" ⁶¹ Unlike the principle of beneficence which has its origins in the Hippocratic oath, the origins of the principle of nonmaleficence is still obscure and unclear. Nevertheless, the Hippocratic Oath clearly expresses an obligation of nonmaleficence and an obligation of beneficence in these words: "*I will use my treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them*" ⁶²

There is the general impression that nonmaleficence and beneficence are to be considered together in ethical discussions and applications. This has led some philosophers to combine nonmaleficence with beneficence in a single principle; William Frankena for instance divides the principle of beneficence into four general obligations as follows;

1. One ought not to inflict evil or harm
2. One ought to prevent evil or harm
3. One ought to remove evil or harm
4. One ought to do or promote good

Beauchamp and Childress identified first of these obligations as the obligation of nonmaleficence.

⁵⁹ Beauchamp, T. L and Childress, J. F., *ibid.*,

⁶⁰ *Ibid.*,

⁶¹ *Ibid.*,p113

⁶²*Ibid.*,

It is however very pertinent to distinguish between these two principles. As rightly observed by Beauchamp and Childress, conflating nonmaleficence and beneficence into a single principle obscures relevant distinction. For instance, obligation not to harm others (e.g., those prohibiting theft, disablement and killing) is distinct from obligations to help others (e.g., those prescribing the provision of benefits, protection of interests, and protection of welfare)

The principle of beneficence potentially demands more than principles of nonmaleficence because we must take positive steps to help others and contribute to their welfare, not merely refrain from harmful acts. This is clear when we look at the most general form of the principle of beneficence which says no more than ‘do good’ while the principle of nonmaleficence tells us to ‘avoid evil’. Obligation not to harm others are sometimes more stringent than obligations to help them, but obligations of beneficence are also sometimes more stringent than obligations of nonmaleficence.

Beauchamp and Childress distinguish these two principles by putting the prevention and removal of evil or harm, as well as taking nonmaleficence to mean ‘not inflicting evil or harm.’⁶³ For Raanan Gillon, our *prima facie* duty to nonmaleficence is general in that it encompasses all other people, although he is quick to add that it does not follow from this that avoiding doing harm takes priority over beneficence.⁶⁴

2.8. PATERNALISM

In political life and medicine, the age long model of making choices for other people without their consent allegedly for their own best interest came to be called at the end of the 19th century paternalism. It has its conceptual origins in the Latin word, ‘*pater*’ which means father and refers to the patriarchal family model where the father makes all choices, especially when it comes to affairs of his children. The paternalistic attitude has been widely discredited in the political ideologies of the affluent and liberal West, but it can still be detected in many areas of legislation and social policy and most notably in medicine and health care⁶⁵. There are so many definitions of the concept of paternalism. Let us consider some of them.

⁶³ Hoose, B., Theology and the Four Principles: A Roman Catholic View 11, in Gillon, R., ed., Principles of Health Care Ethics, *ibid.*, p.46

⁶⁴ *ibid.*,

⁶⁵ Häyry, H., *ibid.*,

Paternalism is an attitude of a government or a person that subordinates should be controlled in a fatherly way for their own good. According to the Merriam-Webster online dictionary, paternalism is a system under which an authority undertakes to supply needs or regulate conduct of those under its control in matters affecting them as individuals as well as in their relations to authority and to each other.⁶⁶ In the words of Simon Clarke;

*I define paternalism in the following way. X behaves paternalistically towards y: (1) only if x aims to close an option that would otherwise be open to y, or x chooses for y in the event that y is unable to choose for himself; and (2) to the extent that x does so in order to promote y's good.*⁶⁷

For P. Hershey, an action, initiated by a human individual or group with regard to another human individual or group, is paternalistic if and only if, (1) the action is primarily intended by the initiator to benefit the recipient, and (2) the recipient's consent or dissent is not a relevant consideration for the initiator.⁶⁸ Furthermore, practices and actions are paternalistic when those in positions of authority refuse to act according to the peoples wishes, or they restrict people's freedom, or in other way attempt to influence their behaviour, allegedly in the recipient's best interest. It is also referred to as a policy that prevents others from doing harm to themselves or a belief in such policies.

According to Beauchamp and Childress,

*Paternalism is the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden.*⁶⁹

In essence, paternalism involves some form of interference with or refusal to conform to another person's preferences regarding his or her own good. It typically involves force or coercion on the one hand, or deception, lying, manipulation of information or nondisclosure

⁶⁶ www.m-w.com

⁶⁷ Clarke, S., 2002,p.81

⁶⁸ www.ncbi.nlm.nih.gov/entrez/query

⁶⁹ Beauchamp, T. L, and Childress, J.F.,ibid.,p.178,

of information on the other hand. Many of the definitions of paternalism agree that all paternalistic acts restrict autonomy.

A look at these definitions shows that they are very wide. I purposely overlook this because the intention here is to give a general view of the meaning of the concept of paternalism. In the course of the work, paternalism as is related to the health care will be clearly and concisely analyzed.

Under this general scope also, I am going to briefly explore the different types of paternalism as follows:

Individual paternalism is when the motive of the paternalist is to benefit an individual.

Social paternalism: When the focus is on a group or a class of individuals.

Sometimes, **pure** or **impure** paternalism are used instead of these two types of paternalism stated above.

Active paternalism: may occur when the paternalist acts in order to promote benefit despite a preference of non-intervention.

Passive paternalism: may exist when refraining to execute a patient's preference.

Soft paternalism: is a type of benevolent control over people's affairs. It consists in caring action that does not constitute violations of recipient's autonomy. Examples of such actions are truthfulness and non-sensational health education, warning labels on dangerous products, improvement in the social security system. Soft paternalism does not normally need any separate legitimisation.

Hard paternalism: By contrast to soft paternalism, hard paternalism violates people's self-determination; at least according to the strictest interpretation of what constitutes a violation. Hard paternalism can further be divided into weak and strong paternalism. The distinction between weak and strong paternalism was introduced by Joel Feinberg. This is what I am going to consider in the following sub-section.

Weak paternalism: Weak paternalism consists of a caring control that at first glance seems to violate the recipient's autonomy but that in the last analysis, does not. It is applied to children, those with severe mental defect, the senile, those with moderate mental defects. In this case, an agent intervenes on grounds of beneficence or non-maleficence only to prevent substantially non-voluntary conduct, that is, to protect persons against their own substantially non-autonomous actions. Substantially, non-voluntary and non-autonomous actions include

cases of consent or refusal that is not adequately informed, severe, depression that precludes rational deliberation and addiction that prevents free choice and action.⁷⁰

Strong Paternalism: On the contrary, strong paternalism involves the interventions intended to benefit a person, despite the fact that the person's risky choices and actions are informed, voluntary and autonomous. A strong paternalist refuses to acquiesce in a person's autonomous wishes, choices and actions when there is a need to protect that person. He will restrict the information available to the person or override the person's informed and voluntary decisions. These choices need not to be fully informed or voluntary, but for the interventions to qualify as strong paternalism, the choices must be substantially autonomous.⁷¹

⁷⁰ Ibid., p.180

⁷¹ Ibid., p.181

CHAPTER THREE

THE CONFLICT BETWEEN AUTONOMY AND BENEFICENCE.

3.1. A COMPARATIVE ANALYSIS OF THE TWO PRINCIPLES

I have already developed a good number of definitions and descriptions of these two principles namely the principle of autonomy and the principle of beneficence. In this sub-heading therefore, I only intend to briefly and succinctly compare the two principles analytically though.

I have *ab initio* stated that the health care formulation of the principle of autonomy can be expressed as follows; “*you shall not treat a patient without the informed consent of the patient or his or her lawful surrogate, except in narrowly defined emergencies*”.⁷² The principle draws line for the exercise of the physician’s professional obligation and leaves the duty of decision making to the patient. This seeks to prevent medical tyranny and to preserve freedom, but also to encourage rational decision making by the patient who in the last analysis must live with the consequences of the medical treatment or lack of it.

Beauchamp and Childress’ analysis of autonomous actions is in terms of normal choosers who act intentionally, with understanding and without controlling influences.⁷³

With regard to intentionality, there are a lot of controversies on the meaning of an intentional action. Views sway from seeing it based on such conditions as volition, deliberateness, willing, reasoning and planning. One of the few widely accepted and shared views is that intentional actions require an agent’s plan-a blueprint, action.⁷⁴ For an action therefore, to be autonomous it must correspond to the agent’s conception of how it was planned to be performed. This work is not on intention as such and so I need not go into the intricacies of the concept. I hope that the brief analysis of intentional act suffices for the essay. For Beauchamp and Childress nevertheless, the first of these conditions for an autonomous action i.e., intentionality, is not a matter of degree⁷⁵. In other words, acts are either intentional or unintentional.

⁷² Garrett, T. M., et al., 2001,p.30

⁷³ Beauchamp, T. L., and Childress, J. F.,*ibid.*,p.58

⁷⁴ Goldman, A. I., 1970,p.49

⁷⁵ Beauchamp, T. L and Childress J. F., *ibid.*..

On the other hand, the conditions for understanding and absence of controlling influences can both be satisfied to a greater degree or lesser extent. For an action to be autonomous, it only requires a substantial degree of understanding and freedom from constraint and not a full understanding or a complete absence of influence. The reason for this assertion is because to limit adequate decision making by patients to the ideal of fully or completely autonomous decision making strips these acts of any meaningful place in the practical world where people's actions are rarely, if ever fully autonomous in this regard. Practical actions are usually substantially autonomous but not far from fully autonomous.

In medical decision making, the principle of autonomy imposes on the physician the obligation of respect for the patient's self determination. There is in fact, the principle of informed consent which flows from the concept to autonomy. According to this principle, not only is a patient entitled to decide what may be done to his body, the patient is entitled to receive an adequate amount of information to help him make that decision. Applying the five conditions that I have outlined and briefly explained earlier to the context of health care and medical decision making, we arrive at the principle of autonomy in health care. This principle expresses the concept;

*That professionals have a duty to treat the patient according to the patient's desires, within the bounds of accepted treatment, and to protect the patient's confidentiality*⁷⁶

Under this principle, the physician's primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given to the patient's needs, desires and abilities and safeguarding the patient's privacy.

According to J. Davenport, 'in order to exercise the right of autonomy, a patient must first possess the capacity to make decisions.'⁷⁷ A patient who is able to make medical decisions is considered to possess capacity. On the other hand, a patient who is not mentally or psychologically able to make medical decisions is considered to lack capacity.

⁷⁶ www.ada.org/prof/prac/law/code/principle

⁷⁷ www.xnet.kp.org/permanentejournal/sum97pj/principles

There are usually three aspects to be evaluated when assessing a patient's capacity. They are the following:

1. Patients must show that they understand the given information about diagnosis and treatment and that they appreciate the significance of the disease and its consequences.
2. Patients should be able to deliberate in accordance with their own values.
3. Patients should demonstrate an ability to communicate consistent choices regarding their decisions.

Naturally, informed consent is closely joined to capacity. For there to be "good" informed consent, a patient must have the capacity to decide. In the words of B. N. Whitstone, informed consent refers to *"the active involvement of a patient in understanding and agreeing to medical treatment."*⁷⁸ This underlies what I have already mentioned.

From a legal standpoint, informed consent means that physicians should disclose to patients all information 'material' to making a decision whether to undergo or forgo a proposed treatment or diagnostic procedure. Practically speaking, it means that whenever possible, the patient has been told about and understands all of the risks and potential benefits of a treatment.

Morality requires not only that we treat persons autonomously and that we refrain from harming them, but also that we contribute to their welfare including their health.⁷⁹ This brings me to the principle of beneficence.

As a principle, beneficence asserts the duty to help others further their important and legitimate interests. In the light of this principle is the firm concept through out the histories of ethics, medicine and public health that the failure to benefit others when in the position to do so - and not simply the failure to avoid harm - violates social or professional duties. It will be pertinent to point out that while the principle of beneficence refers to a moral obligation to act for the benefit of others, beneficence ordinarily and generally refers to an action done to benefit others whereas benevolence refers to the character trait or virtue of being disposed to act for the benefit of others⁸⁰. Indeed, very similar are these terms but a closer look at them reveals their subtle and serious differences. Many acts of beneficence are not obligatory but a

⁷⁸ www.tchin.org/resource_room/c_art_18.htm

⁷⁹ Beauchamp, T. L., and Childress, J. F., *ibid.*, p.165

⁸⁰ *ibid.*, p.166

principle of beneficence establishes an obligation to help others further their important and legitimate interests.

According to Beauchamp and Childress, it is not only demanded that human beings treat others as autonomous beings (the principle of respect for autonomy) it is also demanded that human beings further the good of others. The actions that further the good of others belong to this principle of beneficence. As I mentioned in the early part of this essay, it is usually difficult to find a sharp distinction between not harming others (nonmaleficence) and furthering their good (beneficence). However, the principle of beneficence demands more of the agent than the principle of nonmaleficence does as I have stated before.

There is however, a limit to the beneficence that the individual is obligated. Beauchamp and Childress believe that there are five demands that must be fulfilled for one to be obligated to further the good of other. They write;

*X has a determinate obligation of beneficence toward Y if and only if each of the following conditions is satisfied and X is aware of the relevant facts: (1) Y is at risk of significant loss or damage; (2) X's action is needed (singly or in concert with others) to prevent this loss; (3) X's action (singly or in concert with others) has a high probability of preventing it; (4) X's action would not present significant risks, cost, or burdens to X; and (5) the benefit that Y can be expected to gain outweighs any harms, costs or burdens that X is likely to incur.*⁸¹

This is also the view of K. E. Logstrup who writes that the radical character of the demand should not be mistaken for limitlessness⁸². One therefore has only the responsibility for the part of the other's life one holds in his or her hands. One must also know that as Beauchamp and Childress write that 'X' only has an obligation of furthering the good of the other person if X's action would not present significant risks, costs, or burdens to 'X'. The conditions identified above also indicate when for instance, X's general duty of beneficence becomes a

⁸¹ Beauchamp, T. L., and Childress, J.F., p.171

⁸² Logstrup, K. E., 1998, p.204

specific duty of beneficence toward Y. In fact, we also have a duty of being very prudent in discharging the duty of beneficence.

In health care in particular, the principle of beneficence;

*Expresses the concept that professionals (health care professionals) have a duty to act for benefit of others. Under this principle, physician's primary obligation is service to the patient*⁸³

For centuries, beneficence was actualized through the process of the patient presenting himself to the physician for examination and inquiry and then following the advice of the physician.⁸⁴This is a foundational model of medical practice finding its root in Hippocrates.

Comparatively, the two principles find a common feature in the fact that they play very prominent and significant roles in the physician-patient relationship. The principle of autonomy as we have seen emphasizes the obligation of the health care professional to treat the patient according to his or her desires and personal values. It imposes on the physician the obligation of respect for the patient's right to self determination. This is a shift from the prior traditional model of medicine that placed the responsibility for treatment decisions mainly in the hands of physicians. It was then generally assumed that since most people lacked medical training, they would be unable to understand all of the benefits and risks of proposed treatment and to make choices about them. This was the era when the other principle namely the principle of beneficence held sway. While the principle of autonomy generally speaking, holds that the individual patient has the right to determine what he or she deserves and desires in medical decision making. The principle of beneficence on the other hand opines that the obligation of the health care professional is basically to act for the benefit of the patient by virtue of his or her professional knowledge and experience in the medical profession which is higher than that of the patient. This is the genesis of the act of paternalism which the subsequent chapter will do justice to. Moreover, a subsequent sub-section will discuss in detail the claim for primacy of each of the principles over the other.

⁸³ www.ada.org/prof/prac/law/code

⁸⁴ www.xnet.kp.org/permanentejournal/sum97pj/principles

3.2. THE DILEMMA OF THE PHYSICIAN AND OTHER SURROGATES.

I will like to begin by stating what the characteristics of an ethical dilemma are. The following are the four characteristics of an ethical dilemma. In fact, they must be present for an ethical dilemma to exist.

1. A choice must be made: This means that there must be a decision at that particular period for treatment to continue or to stop as the case may be.
2. There must be significant consequences for taking either course of action: Any action taken will definitely have some consequences arising from its choice.
3. Each of the courses of action can be supported by one or more ethical principles. This implies that among the actions that constitute the viable options for decision, there are ethical principles to validate or justify their morality and hence the choice of them.
4. The ethical principles supporting the unchosen course of action will be compromised⁸⁵: In this case, it means that for any course of action to be taken or chosen, the ethical principles supporting the one not chosen must have been compromised or sacrificed for the one chosen.

In the light of these features, I will like to consider Frank. Frank has the right not to take his medications as soon as he is discharged from the hospital. He has the right to be discharged if he is able to demonstrate the capacity to remain calm and cooperates with hospital staff. He has the right to sue the physician and hospital if they hold him against his will. Yet his paranoid thoughts normally overwhelm him because he will stop his medications after his discharge from the hospital.

This is a case where the physician and other health care workers find themselves in a dilemma. This is as a result of the demands of the principle of autonomy which demands the right of the patient be respected and the demand of the principle of beneficence which requires them to act for Frank's benefit.

Following from this principle of autonomy, the physician or hospital must discharge Frank whenever he is 'safe enough'⁸⁶ to leave the hospital. Failure to do this, Frank will sue them

⁸⁵www.nyu.edu/gsus/dept/philo/courses/bioethics/papers

for illegally holding him against his will. From all these, we can see why the physician is duty-bound to allow Frank who is normal and courtesy of the medications that he is taking in the controlled hospital environment to leave the hospital and even whether to continue to take his medications when he leaves for his house. Any attempt by the physician and other health care workers to go contrary to this will amount to infringing on the right of Frank. This also applies to Frank's relatives who have been going through a lot of problems and difficulties in helping him. According to the story, they have already given up. They cannot do for Frank what he does not approve, else they will infringe on his rights.

The existential and most humanly likely course of action for the health care professional and even Frank's relatives to do will not be to allow Frank always leave the hospital whenever he is in the state of the so-called normalcy. There are other options that will of course not be in compliance with what Frank will ordinarily want. This is where the dilemma lies of course.

In fact, the summary of the dilemma here is the professional obligations of the physician cum hospital and the preservation of the autonomous rights of the patient – Frank. This is because despite the fact that physician is aware that Frank's paranoid will overwhelm him due to his discontinuation of his medications when he leaves the hospital, they apparently risk being sued for violating Frank's right if they hold him against his will in the hospital when it was also apparent that he is normal. A very wide and logical application of the principle of autonomy will stress that since the respect for freedom and privacy is ultimately rooted in the dignity of the individual person, then the principle of autonomy also calls for respecting even those persons who are not at a given moment capable of free choice. Many are even of the view that persons do not lose their dignity because they are unconscious or in coma or out of contact with reality. Though such people present special practical difficulties, they must be respected. In the same vein, specialized knowledge and even license to practice does not authorize professionals to control any aspect of another's life or to limit the freedom of others. On the other hand, the obligation imposed by the principle of beneficence requires of the health care professionals to act for the benefit of Frank and by extension the society that may not be safe on account of the return of Frank's paranoid.

Taking a look at the features of ethical dilemma mentioned earlier, one can see why and how the case of Frank qualifies as an ethical dilemma. With regard to the first feature, a choice

⁸⁶ This is the period that Frank's mental health is restored due to the medications that he is taking. It implies that he has regained his competence and capacity for decision making.

must be made. The health care professionals must decide on what to do with Frank. The relatives of Frank are also bound to make a decision. There is the absolute need for a choice to be made. On the second feature, it is very evident that any course of action taken in the case of Frank will result in some very significant consequences. If it is decided that Frank should be allowed to roam the streets and he stops his medications as he normally does which will definitely usher in a return of his paranoid, the consequences will be untold bizarre actions that will not only affect him but will also make the society unsafe for others. If he is hospitalized against his will when it is clinically certified that he is normal, it will result in gross violation of his right. On the third feature, it is clear that if the health care workers and Frank's relatives decide to keep him in the hospital against his will for the purpose of benefiting him and the society, this is supported by the ethical principle of beneficence. On the other hand, if they decide to let him go according to his will having fulfilled the requirements for informed decision and consent, this is supported by the principle of respect for autonomy and informed consent. Finally, any course of action taken will lead to compromising the ethical principle of the unchosen course of action. In other words, if it is decided that Frank's will be done, then the ethical principle of beneficence has been compromised whereas if he is held back in the hospital against his will then the ethical principle autonomy has been compromised.

3.3. THE PRIMACY OF THE AUTONOMY PRINCIPLE

In their book, 'For the Patient's Good: The Restoration of Beneficence in Health Care', Edmund Pellegrino and David Thomasma quoted Gloria Chaines who bitterly decried the so called disregard for the patient's right to autonomy in the following words;

They have us cornered in the medical-market, their arrogance unwarranted, their lack of sensitivity insufferable, and I don't like it a bit ... asking for a plausible explanation is still scorned as presumptuous. Many doctors talk to patients as though they are slightly retarded, deliberately creating a condition of dependence.⁸⁷

⁸⁷ Pellegrino, E. D., and Thomasma, D. C., 1998,p.4

Many agree that the importance of respect of an individual's autonomy has led to a shift in the issues that dominated bioethical discussion: whereas bioethical texts and journals used to be occupied largely with assessing the moral pros and cons of procedures, an increasingly large portion of bioethical literature now focuses on determining means to ensure competency, protection of confidentiality and privacy, informed consent and voluntariness. In discussion of cases, a bioethicist will often argue in a way that suggests that once it is ensured that that the patient's choice is autonomous, the work of the bioethicist is done.

A bioethicist concerned that a patient make a good moral choice would be attempting to explain the principles which have led the bioethicist to judge a choice to be moral and finding just ways to persuade the patient to accept these principles and then to make moral choice. In fact, Janet Smith writes that,

*Less and less of bioethical literature argues the morality of procedures and practices; more and more is directed towards finding means to ensure that choices are autonomous*⁸⁸.

The argument here is that emphasis is basically on ensuring that choices are autonomous. It is however not an attempt at saying that there is a complete neglect of the morality of procedures and practices, the point being made is that it of less emphasis compared with the type of attention that autonomous choices have received. J. Smith also makes a sweeping statement in this regard when she says that '*The autonomous choice has supplanted the good moral choice as the Primary concern of bioethics*'⁸⁹

The afore mentioned opinion of Gloria Chaines accurately expresses the perceptions of many bioethicists, lawyers, patients etc on the way the physicians ignore the right of the patients as well as their desires for understanding and participation in medical decisions that affect them. Hence, the principle of autonomy should be pre-eminent above any other principle to correct this perceived anomaly. It is for this group of people that the argument for the primacy of the principle of autonomy holds.

⁸⁸ www.aodonline.org/aodonline-sqlimages/SHMS/Faculty

⁸⁹ Ibid.,

One of the arguments for the primacy of the principle of autonomy is the right of every individual to her personal values and furtherance of the individual's personal goals without any undue interference. Justice L. D. Brandeis calls it the right to be left alone. This school of thought views the 2,500 years old Hippocratic model of the physician (where the physician is regarded as the benign, authoritarian, paternalistic decision maker, taking the full responsibility for the welfare of his or her patient) as unacceptable. Pertinent to point out here is that nowhere in the Hippocratic corpus is there any provision for the patient's view of things. The relationship between the physician and the patient is even described in one place as being between "one who orders and one who obeys". This is absolutely unacceptable and utterly contradicts the credo of the contemporary man where the patient or his or her proxy is the ultimate arbiter of the patient's own good. It is against the autonomy model of clinical decision making which is firmly grounded in the dignity of the human person. Furthermore, it is not in consonance with the doctrines of individual and political rights and freedom that undergird modern democracy. To go against this is can even be viewed as going contrary to the universal declaration on human rights. The preamble of the declaration states as follows;

*Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world*⁹⁰

It will therefore amount to tyranny and dictatorship if the patient's right to autonomy is in any way compromised in clinical decision making.

Pellegrino and Thomasma trace this explosion of this autonomy model of physician-patient relationship to the expansion of political democracy to every sphere of civic life, fostering in each of us the desire to participate in the decisions that affect our lives as individuals. This 'democratization' according to them carries with it a certain distrust of all authority, expertise, privilege, and prerogative of the kind traditionally wielded by physicians, lawyers and other professionals⁹¹.

Also contributive to this explosion according to them is the general improvement in the education of the public and the dissemination by the media of information about both the

⁹⁰ Universal Declaration of Human Rights 10th December, 1948.

⁹¹ Pellegrino, E .D.,and Thomasma, D. C.,Ibid., p.12

advances of medicine and the ethical dilemmas those advances produce⁹².As a result of this, the public appreciates that the decisions doctors make in the use of medical knowledge make a vast difference in our lives, and that those decisions increasingly involve value choices. Finally, they state that;

*The increasingly divergent moral pluralism in our society impels us to seek to protect our personal values against usurpation by others.*⁹³

This is very noticeable in the way people these days react to medical issues. Controversies and dilemmas surround many medical decisions. The Terri Schiavo case is still very fresh in our minds⁹⁴.

These factors and others have converged to undermine the traditional model of benign, paternalistic physician who assumes full responsibility and authority to determine the patient's best interest and to act so as to advance those interests - if need be, without the patient's participation.

One of the foundations of the argument for the primacy of the autonomy principle is what Klaus Demmer calls the 'undestroyable dignity of the human person'⁹⁵. This he claims is at the root of autonomy. There are so many reasons for this assertion however. An example is the Christian perspective. Humans according to Edmund Pellegrino must be free because each has his or her worth...each must be free to follow his or her conscience in moral choices-medical or otherwise⁹⁶.

This autonomy however is not absolute from the Christian perspective. This is because the Christian is obliged to use his/her God-given freedom wisely and well. "*Autonomy is a necessary means to ding the right and the good to fulfilling the stewardship of our own*

⁹² Ibid.

⁹³ Ibid.

⁹⁴ Terry Schiavo from the US suffered a brain damage in 1990.She was living at the mercy of a tube that supplied a nutrient solution to her body. Doctors ruled that she was in a persistent vegetative state, with no real consciousness or chance of recovery. Her husband, Michael Schiavo consistently won legal battles by arguing that his wife would not have wanted to live in her condition, thereby calling for the disconnection of the tube. This was against the view of Terri Schaivo's parents and family who described the eventual disconnection of the tube on March 18th, 2005, as 'judicial homicide'.

⁹⁵ Demmer, K., 1989,P.108

⁹⁶ Ibid., p.123

health".⁹⁷ This means refraining from self-destruction by suicide or deleterious life styles, or neglecting a needed and appropriate medical care. Still defending the pre-eminence of the principle of autonomy, Edmund Pellegrino forcefully asserts that

*.... If a patient refuses to acknowledge these duties, the physician cannot impose them on him or her. Strong paternalism is uncharitable because freedoms to choose to shape one's own life is intrinsic to being human. To ignore it is to violate the very humanity of the patient....*⁹⁸

The argument here is that proposing the primacy of the principle of autonomy will definitely help in not overriding the dignity and humanity of the patient.

3.4. THE PRIMACY OF THE PRINCIPLE OF BENEFICENCE

I have in chapter two discussed the meaning and the practical cum theoretical controversies surrounding the determination of what patient's good is. Here I intend to put forward the arguments for the primacy of the principle of beneficence in health care. Pellegrino and Thomasma contend that beneficence remains the central moral principle in the ethics of medicine and that it entails more than the negative principle of '*primum non nocere*', and that it entails positive enhancement of all the components packed into the complex notion of the patient's good.⁹⁹ This is a sweeping remark that sets the tone for their argument. It also addresses the fact that the argument is for the general meaning of the patient's good in the midst of the complex notions of what the good of the patient is.

It is worthy of note that the theory of acting for the good of the patient and on virtue was formulated originally by Socrates, Plato, and Aristotle and was reinforced by the Roman Stoics and was modified by Saint Thomas Aquinas.¹⁰⁰ This theory prevailed in Western culture until Enlightenment when it came under attack by the French philosophers and British empiricists.

⁹⁷ Ibid.,

⁹⁸ Ibid.,

⁹⁹ Pellegrino, E. D., and Thomasma, D. C., 1998, p. vii.

¹⁰⁰ Ibid., p.3

Acting for the good of the patient is the most ancient and universally acknowledged principle in medical ethics. In the words of Pellegrino and Thomasma;

It grounds ethical theories and shapes the way their principles are applied in particular cases. It is the ultimate court of appeal for the morality of medical acts.¹⁰¹

This statement negates or refutes the primacy of the principle of autonomy in health care in all its ramifications. Pellegrino and Thomasma outlined some limitations of the principle of autonomy which implies that it is not the pre-eminent principle in health care. The limitations are as follows;

Contextual Limitations: Here they argue that the autonomy principle may not apply in some contexts of medical treatment. They gave an example as when treating the aged and senile that is referred from nursing homes for urinary tract infections¹⁰². In such cases according to them, physicians may have an obligation to disregard the patient's wishes until they are convinced that the patient is competent. This is however an example of weak paternalism. Some contexts that warrant the physicians to disregard the patient's wishes include when the patients are senile, confused, depressed or incapacitated in their abilities to make autonomous judgements.

Existential Limitations: The effect of illness and disease on personal autonomy limit self-determination to variable degrees they argue. In their opinion this is evident in the report by physicians that patients really want them (the physicians) to make the decisions as reported by A. Soffer in his article titled, "Searching Questions and Inappropriate Answers"¹⁰³

This existential limitation is manifested in the way sickness affects the individual. In fact, to be sick existentially speaking, is to be subject to pathophysiological effects of illness, pain and fear and to the professional and institutional environment in which decisions occur. Self direction is practically marred by the way disease may disrupt the unity of the self, ego and body. Life plans are threatened by the finitude of human life revealed in

¹⁰¹ Ibid., p.73

¹⁰² Ibid., p.17

¹⁰³ *ibid.*

illness.¹⁰⁴ Deliberation and application are consequently impeded by the distractions and realities of pain and fear.

Conceptual Limitations: Their contention here is that the concept of autonomy in health care as a model is limited from the conceptual perspective. The term or concept of autonomy does not encompass the doctor-patient relationship in all its ramifications. What happens between the physician and the patient has many formulations according to them. In the words of Pellegrino and Thomasma it can be seen as safeguarding the person, respecting persons, healing or restoring a lost wholeness, putting the patient's needs first, making a right and good medical decision or acting in the best interest of the patient¹⁰⁵. Each of these formulations ascribes a somewhat different moral tone to the physician's obligations with respect to the patient's autonomy. This shows how limited the concept of autonomy is.

I have put forward these limitations of the principle of autonomy in discussing the primacy of the principle of beneficence because it is an indirect way of exalting the principle of beneficence against the so called and already discussed primacy of the autonomy principle.

Still defending the primacy of the principle of beneficence, Pellegrino and Thomasma categorically state that '*medicine as a human activity is of necessity a form of beneficence*'¹⁰⁶. This statement is almost another way of identifying medicine as beneficence. Their reason for such an opinion is because they see medicine as a response to the need and plea of a sick person for help, without which the patient might die or suffer unnecessary pain or disability.

In the same vein, they also believe that the primacy of beneficence is also founded on their opinion that the obligation to help the sick is a general one involving humans, even those who are not professed healers. This is grounded on the claim that comes from the vulnerability and suffering of a fellow human.

Furthermore, beneficence is argued to be the primary requirement of medicine because the patient's problems and needs are regarded as the physician's primary concern, taking

¹⁰⁴ *ibid.*,

¹⁰⁵ *ibid.*, p.18

¹⁰⁶ *ibid.*, p.32

precedence, except in the rarest circumstances, over all other concerns. Also, the physician cannot be fulfilling his or her promise of helping if he or she intentionally harms the patient for any reason, hence the primacy of beneficence in health care. One can even argue that the choice to foster autonomy is based on what benefits the patients and therefore his or her good. What I am saying here is that the clamour for the primacy of the principle of autonomy implicitly is for the primacy of the principle of beneficence since it is for the good of the patient.

CHAPTER FOUR

PATERNALISM IN MENTAL HEALTH

4. I. MENTAL ILLNESS: A BRIEF EXPOSITION

Mental illness is not an easy term to define. Nevertheless, generally speaking,

*Mental illness refers to clinically significant patterns of behavioural or emotional functioning that are associated with some level of Distress, suffering (pain, death), or impairment in one or more areas of functioning (e.g., or school, work, social and family interactions). At the basis of this impairment is a behavioural, psychological dysfunction, or a combination of these.*¹⁰⁷

Mental illness is a term that refers to all the different types of mental disorders, including disorders of thought, mood or behaviour¹⁰⁸. These disorders cause distress and result in reduced ability to function psychologically, socially, occupationally or interpersonally. People who have a mental illness might have trouble handling such things as daily activities, family responsibilities, relationships, or work and school responsibilities. They can have trouble with one area or all of them, to a greater or lesser degree.

Mental illness is an illness just like physical illness. But instead of affecting a person's body, it affects a person's feelings and the organ that controls them, the brain. A physical illness might make it difficult to walk; a mental illness can make it difficult to maintain relationships with people or cope with life's daily activities.¹⁰⁹

In African traditional medicine, mental ill-health is defined as a situation whereby the victim is prone to interpreting issues haphazardly as registered in his tortured consciousness.¹¹⁰ In fact, in extreme cases of neurosis, the entire system of the patient is unstable and may be unable to

¹⁰⁷ www.mentalhealth.com/book/p43-yout.html#Head_3

¹⁰⁸ www.cnn.com/health/library.

¹⁰⁹ www.mhaofnyc.org/6aboutmi.html,

¹¹⁰ www.biol.tsukuba.ac.jp

differentiate between realities and imaginations. The person may not heed to impending dangers and may be unable to recognize people previously known to him or her.

Just as there are many different kinds of physical illnesses, there are many different kinds of mental illnesses. Many are of the view that there are more than 200 of them. I will however like to mention the following that are strictly relevant for this essay;

Dementia: These are various mental impairment conditions. Dementia is characterized by significant loss of intellectual abilities such as memory capacity severe enough to interfere with social or occupational functioning. Below are the types of dementia;

1. Alzheimer's disease (AD): this affects the mental abilities including memory, language and cognition. It is in fact, a progressive, neurodegenerative disease characterized by memory loss, language deterioration, impaired visuospatial skills, poor judgment and indifferent attitude.¹¹¹ It is the most common cause of dementia.
2. Multi-Infarct dementia (MID): This is a common cause of dementia in the elderly and it occurs when blood clot block small blood vessels in the brain and destroy brain tissue.
3. Dementia with Lewy Bodies: This is a neurodegenerative disorder associated with abnormal structures found in certain areas of the brain.
4. Binswanger's disease: This is a rare form of dementia characterized by cerebrovascular lesions in the deep white-matter of the brain, loss of memory and cognition and mood changes.
5. Pick's disease; a form of dementia characterized by a slowly progressive deterioration of social skills and changes in personality, along with impairment of intellect, memory and language.

Behavioural disorders: Disorders affecting behaviour and emotional wellbeing. The following are types of behavioural disorder;

1. Attention Deficit-Hyperactivity Disorder (ADHD): This is a behaviour disorder that can manifest as hyperactivity, difficulty in concentration, inattention or a combination

¹¹¹ www.wrongdiagnosis.com/a/alzheimers_disease/intro.htm

of all these. This type of disorder was previously called the Attention Deficit Disorder (ADD).

2. Conduct Disorder; behavioural disorder with antisocial behaviours.
3. Oppositional Disorder; behavioural disorder with defiance and aggression.

Psychotic Disorders; these are mainly those disorders that involve symptoms such as delusions and paranoia. The following are the major examples of psychotic disorder.

1. Schizophrenia: Psychiatric disorder with delusional beliefs and hallucinations.
2. Brief Psychotic Disorder: Episodes of brief psychosis.
3. Delusional Disorder: Persistent delusional beliefs.

Personality Disorder: These are psychological disorders affecting the personality .Examples are as follows;

1. Paranoid Personality Disorder: Excessive paranoid beliefs.
2. Schizoaffective Disorder: A disorder with features like a mixture of schizophrenia and certain mood disorders.
3. Borderline Personality Disorder: This is a serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image, and behaviour.

As I have earlier pointed out, there are other types of mental illness but these few suffice for the work. My primary concern and point of interest in these types of mental illness listed above is that they can fit into the temporary or intermittent nature of the type that the hypothetical Frank suffers from. It is pertinent to remember that the story of the hypothetical Frank does not state the type of mental illness that he suffers from. The fact is that whenever he stops his medication outside of the hospital environment, he will return to his state of insanity. It could therefore, be any of the above listed types of mental illness that he suffers from.

The bottom-line remains that the patient is intermittently mentally healthy and mentally unhealthy. The patient succinctly put, fluctuates between periods of sanity and periods of insanity within which he or she regains or loses his or her right to autonomy as the case may be. However, there are also situations where somebody can chronically suffer from any of the above listed types of mental illness. Such a situation does not generate or elicit

much tension as does the situation of intermittent and periodic mental illness vis-à-vis paternalism. This will be extensively discussed in the next chapter.

4.2. MEDICAL PATERNALISM IN GENERAL

I have tried in chapter two to explain the meaning of the concept paternalism. However, it will not be out place to state again that in its broadest sense,

*Paternalism refers to acting in what is determined to be someone else's best interests, either without seeking the individual's input or ignoring his or her stated preferences.*¹¹²

In common usage and following from this definition, the word carries a negative meaning implying that an adult is being treated like a child. Indeed the root of the word is 'pater' which is the Latin word for 'father'.

With this idea of what paternalism generally or broadly is, one can then easily locate and identify paternalism in medical practice and health care. Medical paternalism is expressed in a 'doctor knows best' situation in which the patient was either not well-informed or asked for input in medical decision making about his or her own care and/or simply ignored.

In medical paternalism, the health care professional has a conception of benefits, harms and their balance that differs from that of the patient. According to Beauchamp and Childress, the concept of paternalism as recorded by the Oxford English Dictionary is the principle and practice of paternal administration; a government as by a father, the claim or attempt to supply the needs or to regulate the life of a nation or community in the same way as a father does those of his children.¹¹³ This is of course an explication of the general concept of paternalism but it is the most logical way to trace their description of the meaning of medical paternalism. Here Beauchamp and Childress articulate the meaning of paternalism as it was used and understood from the beginning prior to its particular application to particular areas like medicine and health care. They did not fail to point out that contrary to Oxford English Dictionary's dating of the term from the 1880s, the term is much older and appears very early

¹¹² www.sclhs.org/mission_vision/ethics/paternalism

¹¹³ Beauchamp, T. L., and Childress, J. F., *ibid.*, p.178

in human thought.¹¹⁴This is very correct recalling my earlier assertion that it is an age long model of making choices for other people without their consent allegedly for their own best interest.¹¹⁵

Describing medical paternalism, Beauchamp and Childress state that;

When the analogy with the father is used to illuminate the role of professional or the state in health care, it presupposes two features of the paternal role: that the father is benevolent, i.e., that he has interest of his children's welfare rather than letting them make decisions¹¹⁶.

The above statement means that medical paternalism following the analogy occurs when the physician or the state as the case may be, benevolently acts for and only for the interest of the patient without letting the patient apply his or her right to autonomy by making the decisions himself or herself. Medical paternalism involves overriding a patient's wishes or actions in order to benefit or to prevent harm to that patient. It is the intentional overriding of one person's known preference or actions by another person and in this case the physician and health care workers where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person (patient) whose will is overridden. Medical paternalism usually restricts the patient's liberty and is often coercive.

The act of medical paternalism has throughout the history of medical practice been drawing its validity, basis and justification from the principles of nonmaleficence and beneficence. I have already explicated and delineated these two principles. Nevertheless, suffice it to reiterate that beneficence stands for the proposition that it is the physician's duty to do good for his or her patient. This is certainly a foundational principle of medical practice finding its roots in Hippocratic Oath. For centuries, beneficence was actualized through the process of the patient presenting himself to the physician for examination and inquiry and then following the advice of the physician. Nonmaleficence on the other hand stands for the Hippocratic duty to 'do no harm' it is often joined with the principle of beneficence.

¹¹⁴ Ibid.,

¹¹⁵ Supra

¹¹⁶ Beauchamp, T. L., and Childress, J. F., *ibid.*,

For a deeper appreciation of the meaning of medical paternalism, I bring in the distinction that Joel Feinberg made between strong and hard paternalism as is recorded by Beauchamp and Childress. In weak paternalism, an agent intervenes on grounds of beneficence or nonmaleficence only to prevent substantially nonvoluntary conduct.¹¹⁷ This means that the individual is protected against his or her own substantially non-autonomous actions. Substantially nonvoluntary or non-autonomous actions include cases of consent that is not adequately informed, severe depression that precludes rational deliberation, and severe addiction that prevents free choice and action. Weak paternalism requires that some such form of compromised ability be present.

This explains why so many people are of the view that weak paternalism is not a problematic paternalism as such. The health care provider in weak paternalism overrules or overrides the wishes of an incompetent or a doubtfully competent patient thereby restricting what qualifies an act to be regarded as paternalistic. This is because the patient's consent is missing. This restriction or limitation has led many to also refer to weak paternalism as restricted or limited paternalism. According to Thomas Garrett et al., weak paternalism is also sometimes called cooperative paternalism when one of its purposes is to restore the person's competence so that the patient may give informed consent.¹¹⁸ Due to these nuances, I will like to regard weak paternalism as paternalism in a loose sense as against paternalism in the strict sense.

On the contrary, strong paternalism involves interventions intended to benefit a person despite the fact that the person's risky choices and actions are informed, voluntary and autonomous.¹¹⁹ A strong paternalist therefore, refuses in this case to acquiesce in a person's autonomous wishes, choices and actions in order to protect that person. It involves the usurpation, that is, the coercive seizure, of the patients' right to make decisions. Strong paternalism is also called extended paternalism and in summary attempts to over rule or override the wishes of a competent person. Beauchamp and Childress observe that these wishes or choices need to be fully informed or voluntary, but that for the interventions to qualify as strong paternalism, the choices must be substantially autonomous.¹²⁰ This implies that unlike in

¹¹⁷ Ibid., p.181

¹¹⁸ Garrett, T. M., *ibid.*, p.40

¹¹⁹ Beauchamp, T. L., and Childress, J. F., *ibid.*,

¹²⁰ *Ibid.*,

weak paternalism, strong paternalism does not depend on a conception of compromised ability, dysfunctional incompetence, or encumbrance in deciding, willing, or acting.

4.3. MEDICAL PATERNALISM FOR THE MENTALLY ILL PATIENTS

I am going to consider here the application of practice of paternalism for the mentally ill patients or in mental health as the case may be.

In his article titled, '*Can paternalism be justified in mental health care*', Breeze Jayne defined paternalism as;

*An action which restricts a person's liberty justified exclusively by consideration for that person's own good or welfare carried out either against his present will or his prior commitment.*¹²¹

As in many other definitions of paternalism that I have put forward in this work, the term implies that it is an attempt to assess and address the needs of an individual or group in the same way that a father does with his children. This can of course, involve using coercion to achieve the good that is not recognized as such by the recipient.

Indeed contemporary society has witnessed a substantial move towards empowering patients through the promotion of choice and shared decision-making in health care. This as a matter of fact is predominant in the Western world. Logically and realistically, this appears to reflect an anti-paternalistic stance. This is not truly the case in the case of the mentally ill patients. In the UK for instance, mental health professionals were given the legislative power to ensure the ongoing monitoring and supervision of discharged patients deemed most at risk to self or others, or of defaulting of treatment.¹²² This is an absolute paternalistic approach which distinguishes the mental health care from others. According to Dr George Szumkler and Dr Frank Holloway of the Institute of Psychiatry, King's College, London;

Mental health legislation ignores the question of 'capacity' for decision-making and a consideration of whether

¹²¹ Jayne, S., pp.260ff

¹²² Patients in The community act, DOH 1996.

treatment is in the patient's 'best interest' (as viewed from the patient's perspective)¹²³

This means that the patient's autonomy fails to receive or be accorded the respect accorded to non-mentally ill patients. The thesis here is that there is paternalistic involuntary treatment of all the mentally ill patients no matter the cause of their impaired ability or the type of their impairment or disorder.¹²⁴

In the United States the legal system permits what is called involuntary commitment. Every state has a law for it. In the state of Maine for instance, Alicia Curtis reports that;

This law means that if a person has a mental illness, and if they are in imminent danger of harming themselves or someone else, they can be put into a psychiatric hospital against their will.¹²⁵

Though this may not be exactly the same with the situation in the UK due to the presence of the clause 'imminent danger of harming themselves or someone else', they still highlight the distinctive nature of medical paternalism for the mentally ill patients as against general paternalism in health care. The practice in the two countries under review is also similar because in the UK mental health legislation also allows the detention of mental health patients in the hospital for the sake of protecting them and others.¹²⁶ This is similar to the practice in the US as I have earlier mentioned. This act of compulsory commitment or detention brings into focus the convergence of social paternalism and medical paternalism in mental health care. This is because of the social demand or the state role in getting the mentally ill patient into detention for the purpose of protecting him or her against himself or herself and for protecting the people. Social paternalism is when the focus is on a group or class of individuals or in the society as is the case here.

To show the extraordinariness of mental health care and by implication paternalism in mental health care, the Swedish Health and Medical Service Act has supplementary provisions for the

¹²³ www.iop.kcl.ac.uk/iopweb/departments/home

¹²⁴ Supra (see list of types of mental illness)

¹²⁵ www.psychrights.org/state/maine/involuntary_commitment

¹²⁶ www.iop.kcl.ac.uk

mentally ill patients found in the Compulsory Mental Care Act (LPT) and the Forensic Mental Care Act (LRV). While the later contains provisions on the treatment of people who have committed crimes and are regarded as suffering from a serious mental disturbance, the former which is of interest to this work regulates the care of people suffering from serious mental disturbances and where it is considered that the necessary care cannot be provided on a voluntary basis. This may be the case when a person refuses care and as result of the patient's mental disturbance threatens his or her personal safety of others. Here again we see an interplay of medical paternalism and social paternalism.

There is a significant difference in terms of causation of neuroses between Western and African traditional medicine. Mental health care in African traditional medicine though efficacious tends towards spiritualism and divination which in most times is difficult to provide good epistemic explanations for to the uninitiated. Hence, the management of neurosis by African traditional healers should be expected to be radically different from what obtains in western therapies and procedures. African traditional healers make use of divination to unearth the mental and psychological problems of their patients. In fact, psychotherapy is an integral part of African traditional medicine. Very little consideration is given to the autonomy of the mentally ill patient in this context. Many however, are coming into agreement with the Western view and understanding of mental illness and its management.

4.4. MEDICAL PATERNALISM FOR THE TEMPORARILY MENTALLY ILL PATIENTS.

The temporarily mentally ill patient is the crux of this essay. It is within this context that paternalism very clearly and glaringly comes out as a conflict between the principle of autonomy and the principle of beneficence.

The temporarily mentally ill patients constitute a special type of mentally ill patients. This is because in health care context, autonomy entails that competent individuals should be able to decide which medically indicated, effective procedures are appropriate for them. In other words, competence is a necessary criterion for a patient's autonomy to be respected. The absence of competence which is the case for the mentally ill patient makes paternalism not a conflict as such between autonomy and beneficence as is the case in the mentally ill patient.

The temporarily mentally ill patient's appreciation and awareness of their condition do fluctuate during the course of their illness. They do have the competence and capacity for informed decision making during the period of their normalcy.

The temporarily mentally ill patients are those mentally ill patients whose mentally healthy and mentally unhealthy conditions fluctuate periodically. They are those mentally ill patients that are clinically certified healthy from the mental health perspective but after some time they return to the state of mental illness. This is the case with our hypothetical Frank.

Medical paternalism in this case is very problematic and complex. In fact it is here that it vividly manifests itself as a conflict between autonomy and beneficence as the title of the essay suggests.

Those who suffer from temporary mental illness do pass for normal on their good days. Their illness comes in episodes and cycles as the case may be. Within those periods that they are normal, it will amount to a violation of their right for self determination to paternalistically interfere with their decisions regarding their mental health generally. They can within this period decide - in the light of the present day emphasis on the patient's right - whether to remain hospitalized or not, they are to decide whether to continue with their medications or not, in fact, one can even say that they are entitled to their decision on whether to remain mentally ill or not. Paternalism is completely ruled out ordinarily speaking, for the temporarily or intermittently mentally ill patient when he or she is considered to have improved enough to be discharged to an out patient setting. The patient has the right within this period not to be given reasonable outpatient treatment against his or her will. This is very true even if the patient has broken the law or violated another person's safety in the past as a consequence of his or her illness. All this is possible courtesy of their appeal to the principle of autonomy.

I am not trying to justify or glorify this trend but I am pointing out an ethical dilemma that the health care worker and the society at large face in the case of the temporarily mentally ill patients. Decrying this hopeless situation, Milian Nestor laments that; "*we need involuntary outpatient laws...before the rights of the mentally ill render them hopelessly mentally ill*"¹²⁷

¹²⁷ <http://www.psychlaws.org/GeneralResources/article203.htm>

This makes us to understand that there are little or no legislations on how to practice medical paternalism for the temporarily mentally ill patients because it is only in such a situation that the question of autonomy comes into play since the autonomy of the mentally ill patient is eroded or diminished owing to his or her state of insanity. This statement also is not oblivious of the fact that legislations vary across jurisdictions and countries such that in the real sense the statement that there are little or no legislations could be criticised but the statement is useful for the purpose of the work having searched for materials to state otherwise without any success so far. Therefore, the reaction that the statement is due to generate is one of the latent purposes of this essay. It is as a matter of fact a presentation of the general portrait of medical paternalism in the United States. In essence, medical paternalism for the temporarily mentally ill patients is problematic. A more detailed and exhaustive discussion on this, that is, medical paternalism for the temporarily mentally ill patients will be done in the next chapter.

CHAPTER FIVE

CRITICAL EVALUATION AND CONCLUSION

Paternalism accordingly and expectedly has attracted to itself both proponents and opponents. Many have vigorously defended and demanded it for health care while others have aggressively refuted and refused it for health care and mental health in particular. In this section of the work, I will both defend and refute paternalism and then finally reconcile the two by defending the mutual relationship between autonomy and beneficence.

5.1. ANTIPATERNALISM

Following the Hippocratic tradition, the act of paternalism remained unchallenged for centuries. Ludwig Edelstein while tracing the origin of paternalism vis-à-vis its link to the Hippocratic Oath argued that the Hippocratic ethic in general is a manifestation of Pythagoreanism¹²⁸. In the Hippocratic tradition, the physician and not the patient is the authority on what constitutes the patient's interests. This is possible following the Pythagorean bent of the entire Hippocratic ethics Edelstein has observed. This is one of the reasons why many criticize paternalism.

J. S. Mill believed that paternalistic behaviour can never be justified. He argues as follows;

But neither one person, nor any number of persons, is warranted in saying to another human creature of ripe years, that he shall not do with his life for his own benefit what he chooses to do with it. He is the person most interested in his well-being: ... with respect to his own feelings and circumstances, the most ordinary man or woman has means of knowledge immeasurably surpassing those that can be possessed by any one else. The interference of society to overrule his judgment and purposes in what only regards himself must be grounded on general presumptions; which may be altogether wrong, and even if right, are as likely as

¹²⁸ Edelstein, L., 1967, p.3

Pythagoreanism was the Greek philosophical-scientific school of thought that believed that knowledge was too potent and dangerous to be in the hands of ordinary people.

*not to be misapplied to individual cases, by persons no better acquainted with the circumstances of such cases than those are who look at them merely from without*¹²⁹.

Here Mill is claiming that a person knows his or her interest best and therefore, nobody should under any condition decide for the person what is the best for him or her.

He also argued in favour of anti paternalism by maintaining that coercive interference tends to stunt a person's capacities and is at the same time degrading. He therefore writes;

*To be prevented from doing what one is inclined to, or from acting according to one's own judgment of what is desirable, is not only always irksome, but always tends, pro tanto, to starve the development of some portion of the bodily or mental faculties, either sensitive or active; and unless the conscience of the individual goes freely with the legal restraint, it partakes, either in a great or in a small degree, of the degradation of slavery*¹³⁰

The thesis here is that in order to develop oneself in any direction one must exercise intellectual and physical powers and capacities. Even the risk of the person harming himself should not prevent this freedom or autonomy because it is the part of the price of allowing individuals freedom to choose for themselves.

Kantian views are frequently absolutistic in their objections to paternalism. In Kantian views, we must always respect the rational agency of other persons. Consequently, to deny an adult the right to make his or her own decisions, however mistaken from some standpoint he or she may be is to treat the person as simply means to his or her own good, rather than as ends in themselves. The Kantian Categorical Imperative would not justify Paternalism, in this sense, as a matter of fact. For Kant you can not treat a person as a means to an end even to their own ends. No one knows what the future consequences will be.

¹²⁹ <http://www.victorianweb.org/philosophy/mill/ten/ch7b.html>

¹³⁰ Robson, J. M., 1965, p.938

In a way anti-paternalism is already incorporated into Kantian theories by their prohibition against lying and force¹³¹ - the main instruments of paternalistic interference. Since these instrumentalities are already denied even to prevent individuals from harming others, they will certainly be forbidden to prevent them from harming themselves

J. S. Mill also articulated his famous ‘*harm principle*’ in justifying anti-paternalism. In this principle Mill holds that paternalism can only be justified to prevent harm to other people and not to prevent self-harm. More precisely, coercion can only be justified to prevent harm to unconsenting others, not to prevent harm to which the actors competently consent. He writes;

*The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.... The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute.*¹³²

Furthermore, he believes that the strongest argument against paternalism is the utilitarian argument that no one else is likely to know better than a given individual what is best for that individual to choose. He rather believes that there is a positive value in the exercise of autonomous choice, so that it is better for a person to make choice in his own behalf than for someone else to impose that same choice on him.

This disposition goes a long way in justifying the refusal and rejection of paternalism by the likes of Gloria Chaines as I mentioned in chapter three. Chaines complained that patients have been cornered in the medical market by the physicians with unwarranted arrogance and

¹³¹ The Kantian approach to lying supports a strong prohibition against any kind of lying, since lying cannot become a universal law for all rational beings (if everyone lied, no one would believe what anyone said, which would make lying impossible, since a lie depends upon someone believing you) and it treats the person who is being lied to as a means to an end. According to Kant, the duty to avoid lying holds absolutely, in every situation. The same can be said of cheating and stealing. Cheating involves breaking the rules; if everyone broke the rules all the time, then there would be no rules and thus no cheating. Stealing involves taking someone else's property; if everyone stole all the time, there would be no such thing as private property and thus no such thing as stealing. Furthermore, both cheating and stealing involve treating people purely as a means to an end. In cheating, that end is a higher grade or a victory; in stealing it is the acquisition of something someone else owns. In both cases, as with lying, the person whom you are dealing with is given no opportunity to consent to your actions, and is thus being used merely as a means to an end.

¹³² <http://faculty.washington.edu/himma/bls308/lect4.htm>

insensitivity. She further complained that doctors talk to patients as though they are slightly retarded thereby deliberately creating a condition of dependence.¹³³

The scenario decried by Gloria Chaines here is a direct undermining of the personal autonomy of the patients by the physicians. Patients like anyone else, are self-determining, self governing people who are able to make up their own minds on appropriate treatment for themselves, provided doctors supply enough information. In fact, the scenario under discussion disregards the informed consent of the patient and this accounts for the unacceptability of paternalism to some.

In his book: *'Moral Dilemmas of Modern Medicine'*, M. Lockwood defined paternalism as; *"Behaving towards someone in a way that does not respect his or her autonomy, for that person's supposed good"*.¹³⁴

It is this characteristic feature of not respecting the patient's autonomy that laid the foundation for the attack on the validity and moral justifiability of paternalism. According to the principle of autonomy, an action tends to be morally right in so far as it respects the autonomy of another. Following this view, it is not right to produce benefit or good for another via paternalism even if one is able to determine what actually is good that the other deserves and desires.

The case of Karen Quinlan¹³⁵ readily comes to mind at this juncture. It is the most celebrated court case to establish that physicians no longer have the right to do what they think will benefit the patient. The autonomy of the patient generates a right of non-interference that remains even if the physician correctly believes that he or she could benefit the patient by violating the patient's autonomy. In this sense therefore, paternalism is unacceptable, indefensible and undesirable.

¹³³ Supra, p.33

¹³⁴ Lockwood, M.,1985,p.18

¹³⁵ Karen Ann Quinlan was the first modern icon of the right-to-die debate. The 21-year-old Quinlan collapsed at a party after swallowing alcohol and the tranquilizer Valium on 14 April 1975. Doctors saved her life, but she suffered brain damage and lapsed into a "persistent vegetative state." Her family waged a much-publicized legal battle for the right to remove her life support machinery. They succeeded, but in a final twist, Quinlan kept breathing after the respirator was unplugged. She remained in a coma for almost 10 years in a New Jersey nursing home until her 1985 death.

This unacceptability, indefensibility and undesirability of paternalism is founded on the fact that paternalists advance people's interests at the expense of their liberty. In this, paternalists suppose that they make wiser decisions than the people for whom they act. Sometimes this is based on presumptions about their own wisdom or the foolishness of the people, and therefore can be dismissed as presumptuous.

According to Jacqueline Atkinson, "*Autonomy is important insofar as it distinguishes humans from most animals, from 'brutes'; to deny an individual's autonomy is to treat that person as less than human*".

The argument here therefore, is that any infringement of another's autonomy in the name of paternalism amounts to reducing that person to the level of animals. This is an unacceptable *infra-dig* to man according to the opponents of paternalism.

Towing the same line, Beauchamp and Childress remark that;

*Antipaternalists oppose (strong) paternalistic intervention because it violates individual rights and unduly restricts free choice.*¹³⁶

Strong paternalistic interventions in their view display disrespect towards the autonomous agent. It implies a subordination of the patient as morally unequal with the physician who treats him or her as less than an independent determiner of his or her own good. Existentially, if others impose their conception of the good on us, they deny us the respect they owe us, even if they in fact provide us with a benefit and have a better conception of our needs more than we do. Rightful authority resides in the individual. This is the argument of the antipaternalists who also maintain that one cannot truly heal, i.e. help a person to become whole again, if one neglects, ignores, countermands, or destroys a patient's autonomy.¹³⁷

Beauchamp and Childress also state that;

¹³⁶ Beauchamp, T. L., and Childress, J.F., *ibid.*, p.182

¹³⁷ Pellegrino E. D. and Thomasma, D. C., *ibid.*, p.206

*Paternalistic standards are too broad and therefore would authorize and institutionalize too much intervention if made the basis of policy.*¹³⁸

The point being made here is not just that paternalism is not justifiable but that it should not be adopted as a standard or a model in health care owing to the adverse moral consequences that it will bring. If adopted as a standard or basis of policy, there will then be justification for any arbitrary imposition of any decision by the physician and other health care workers on the patient. There will also be a justification for treating an adult like a child.

Finally, the increasing moral pluralism in our contemporary society impels us to seek to protect our personal values against usurpation by others. It is therefore *ad rem* to jettison paternalism in all its ramifications.

5.2.JUSTIFYING PATERNALISM

Despite the avalanche of reasons given by the antipaternalists for rebutting paternalism, there is also a plethora of reasons for justifying paternalism in health care.

First and foremost, it is an indubitable fact that patients basically and primarily come to the physician to be healed or at least, restored to function and be relieved of suffering as much as possible. Stephen Wear argues that,

*given this overriding agenda, the primacy of which both parties agreed upon, anything that enhances healing was appropriate, anything that diminishes it was to be avoided.*¹³⁹

This is the very existential situation that the patient and the physician find themselves in the encounter. A sick man wants his health restored and he looks upon the physician to do that for him. Following from what Stephen Wear stated above, it is logical to defend paternalism if it is the only way that can enhance healing. Patients go to the physician in severe pain or distress, some at the risk of death or permanent damage, and their principal reason for seeking

¹³⁸ Ibid.

¹³⁹ Wear, S., *ibid.*, p.26

medical attention is to have their pain or condition relieved - any way it works. This is the existential demand of the sick man.

One of the reasons why the antipaternalists reject and refuse paternalism is because it tends to reduce the patient to a level of dependency and subordination to the physician, against this backdrop, Elliot Shinebourne and Andrew Bush remark that "within every adult remains something of the child they once were"¹⁴⁰. They also quoted the statement of C.C. Jung that

*In every adult there lurks a child- an eternal child, something that is always becoming, is never completed, and calls for increasing care, attention and education.*¹⁴¹

This is evident during the period of illness. In times of illness or despair elements of the child remaining in our conscious or unconscious mind are more activated than at other times.

Medicine and physicians exist because humans become ill. Illness is a subjective state, one in which a human being detects some change, acute or chronic, in his mode of existence based on anxiety about the functions of the body or mind. For Pellegrino and Thomasma, it is ;

*The perception of an altered state of existence, one in which the patient interpretes some symptom or sign as an indication that he is no longer "healthy" according to his own definition of that fluid and multi-interpretable word.*¹⁴²

A person who arrives at the conclusion that he or she is ill becomes a patient - one who bears some disability, some deficiency or concern, one who is no longer "whole", one who perceives special limits of his or her accustomed activity.

The patient's autonomy which the antipaternalists vigorously vouch for, does not give sufficient attention to the impact of disease on the patient's capacities for autonomy itself.

¹⁴⁰ Shinebourne, E. A., et.al., 1994, p.399

¹⁴¹ Ibid.

¹⁴² Pellegrino E. D. and Thomasma, D .C., ibid.

It is a truism that medicine should restore autonomy but one cannot assume that autonomy is fully restorable or preservable in cases of serious illness. Even the briefest experience of illness shows that ill persons often can become so anxious, gully, angry, fearful or hostile that they can make judgement that they would not make in calmer times.¹⁴³ In fact, patients during the period of illness become preoccupied with their diseases and their bodies and may even see their bodies as objects that failed them. They are even forced to reassess their values and goals. These features of illness alter personal wholeness to a profound degree. In the words of Pellegrino and Thmomasma;

*When a person becomes ill, he is therefore in an exceptionally vulnerable state, one which severely compromises his customary human freedoms to use his body for transbodily purposes, to make his own decisions, to act for himself, and to accept or reject services of another. The state of being ill is therefore one of wounded humanity, of a person compromised in his fundamental capacity to deal with his vulnerability.*¹⁴⁴

This component of our personality, however mature, autonomous and self reliant we are, may require care which may come in the form of paternalism. The point being made here is that in the same way as a child is in part dependent on the care, protection from harm and expertise of his parents, so is a sick patient in part dependnet on the care, protection from harm and expertise of his doctor.

The term paternalism as I have hitherto pointed out is a derivative of the Latin word '*pater*' which means father. Hence from its etymology, it means acting like a father would to his children. On the positive side, it would be an absolute duty to safeguard the welfare and health of his child, to act always in the best interest of the child, to use his knowledge, skill and understanding to secure those interests, to take responsibility for decisons made and to be available to the best of his ability at all times when the child needed him.

This fatherly attitude to the child implies not respecting the autonomy of the child *per se*. But paternalists will argue that it is not aimed at villoating or infringing on the right of the child or

¹⁴³ Pellegrino, E. D., and Thomasma, D. C., *ibid.*,

¹⁴⁴ Pellegrino, E. D., and Thomasma, D. C., *ibid.*, p.208

the patient with reference to paternalism in health care. They will argue that it is aimed at protecting and safeguarding that autonomy or the potential for autonomy as much as possible. Corroborating this position, E.A. Shinebourne and A. Bush state that;

*Paternalism does not have to imply disrespect for autonomy. It can, but can also be used to protect someone whose autonomy or personal freedom has been eroded by illness until such time as he can regain control of his destiny.*¹⁴⁵

This is why paternalists argue that paternalism rather than disregard or disrespect the individual's right to autonomy, it protects and safeguards it in the real sense. Put in another way, paternalism sometimes aims at protecting and advancing the individual's (long-run) autonomy by the so called restriction of the individual's (short-run) autonomy. This is obviously consequentialistic, that is, more harm than good is produced. So one might prevent people from taking mind-destroying drugs on the grounds that allowing them to do so destroys their autonomy and preventing them from doing so preserves it.

D.L. Jackson and S. Younger caution against what they see as the superficial preoccupation of contemporary medicine with the principle of autonomy. They consider that acting in the patient's best interest is paramount in health care and warn against physicians acting upon decisions made by patients who might be inappropriately described as autonomous¹⁴⁶. The type of people being referred to here include children and people with mental health problems.

It is not as if paternalists are oblivious of the need to preserve the rights of the patients, of course they are not. This is why they have itemized the conditions under which paternalism can be justified. As Beauchamp and Childress put it;

Some influential supporters of paternalistic intervention hold that a paternalistic action can be justified only if (1) the harms prevented from occurring or the benefits provided to the person outweigh the loss of independence and the sense of invasion the intervention causes, (2) the person's condition seriously limits his

¹⁴⁵ Ibid., p.401

¹⁴⁶ Jackson, D. L and Younger S., 1979, pp.260-265

*or her ability to make an autonomous choice,(3) the intervention is universally justified under relevantly similar circumstances, and (4) the beneficiary of the paternalistic actions has consented,will consent, or would, if rational, consent to those actions on his or her behalf.*¹⁴⁷

This would have been a plausible argument for supporting paternalism but for the last lines where reference is made to consent .This appeal to consent has received the support of many prominent theorists.They appeal to consent be it rational,subsequent,hypothetical etc to justify paternalistic actions.For G. Dworkin (quoted by Beauchamp and Childress), “*the basic notion of consent is important and seems to me the only way to try to delimit an area of justified paternalism*”¹⁴⁸. In the words of Rosemary Carter, “*consent plays the central role in justifying paternalism, and indeed ... no other concepts are relevant.*”¹⁴⁹ Donald VanDeVeer similarly justifies paternalistic interventions for persons “*acting in a seriously encumbered manner where it is highly probable that they would give valid consent to the intervention if the opportunity were available.*”¹⁵⁰

Beauchamp and Childress observed that for the those who support consent based-based theory,paternalism is a ‘social insurance policy’ to which fully rational persons would subscribe in order to protect themselves.¹⁵¹Those who use consent as a justification for paternalism thus conclude that we should consent to a limited authorization for others to control our actions in particular situations through paternalistic policies and practices.

In my opinion, the appeal to consent as a form of justification for paternalism is contradictory to the very meaning of paternalism as such.In fact,an appeal to consent obscures more than clarifies the issues concerning the justification of paternalism.Children for instance are not controlled by their parents because they (the parents) believe that they will give their consent.Even if the parents hope for subsequent consent and approval by the children,the justification for their intervention and control rests on the welfare of the children and not on

¹⁴⁷ Beauchamp, T .L., and Childress,J.F.,*ibid.*,p.183

¹⁴⁸ *Ibid.*,p.184

¹⁴⁹ *Ibid.*

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.*

their autonomous choices. The bottom line of the intervention by parents is their belief that their children will have better lives whether they know it or not.

Notwithstanding the shortcoming of this argument, it still retains its attraction which lies in its attempt in harmonizing the principle of beneficence and the respect for autonomy so that paternalistic interventions respect autonomy rather than override it which is one of the reasons why anti paternalists shun paternalism.

I mentioned and explained in chapter two that informed consent is a necessary derivative of the principle of respect for autonomy which is the anchor on which anti paternalists hinge their arguments against paternalism. Succinctly put, "*an informed consent is an autonomous authorization by individuals of medical intervention.*"¹⁵² Informed consent broadly speaking implies a shared decision-making between doctor and patient. In other words, if the patient understands what the physician proposes to do, and thus informed, consents to its being done, then the medical intervention is not imposed on the patient in violation of the patient's autonomy, rather that medical intervention is properly viewed as a service provided to that patient at that patient's request.

Nevertheless, informed consent has two parts; informing and consenting. The physician does the informing while the patient or his proxy does the consenting. Real life experiences show that it is not always guaranteed that a wonderfully well articulated, clearly and accurately presented lectures result in getting all the students well informed and thoroughly educated. It just takes an examination or test on the same lecture to prove that not all was able to grasp the contents of the lecture. Informed consent can therefore go wrong in the informing because informing, like any other sort of teaching, is often harder to accomplish than one expects. Human physiology is largely a mystery to most people even at the level of gross anatomy. It is not just unusual interpretations or unexpected ignorance that can impede understanding in a clinical setting. Heightened anxiety associated with illness, the effects of medication, the regression that is commonly exhibited by patients and many other factors can interfere. Supporting this view Samuel Gorovitz remarks;

¹⁵² Ibid., p.143

*Recent empirical studies have shown that the cognitive capacities of patients are often diminished by the circumstances of their illness and hospitalization. Other studies have shown that patients often retain little of the information that is provided to them – a fact that practicing physicians have long known.*¹⁵³

Added to this is the fact that some medical procedures are so complicated or even controversial that a lay man can hardly be expected to have the necessary background information to understand what is really at issue in a decision about treatment. The complicated nature of some medical procedures sometimes gives the medical community a great deal of trouble deciding the best course of treatment that should be carried out. The point that I want to drive home here is that informed consent itself is in most cases very difficult to achieve. Some physicians according to Gorovitz believe that it is even impossible to achieve because patients are never actually well informed, and cannot be¹⁵⁴. Such physicians ask this question according to him;

*Are we to interrupt their illness ... in order to send them through medical school so that they can understand as we do what their problems and options are?*¹⁵⁵

It is absolutely impossible to interrupt someone's illness in order to send him to medical school. The point being made is that it is impossible for the patient to fully comprehend the complex procedure of medical treatment.

Paternalists do not argue that the patient has not the right to personal decisions irrespective of all that I have mentioned above. The arguments above do not imply that physicians may just act as they think best despite the wishes of the patients. The fact that the patient's knowledge will always be imperfect, and will often be inferior to the physician's does not alter the fact that the patient has dominion over his or her own body. Also the fact that knowledge is imperfect does not imply that it is inadequate for the particular purpose at hand. In the same

¹⁵³ Gorovitz, S., 1982, p.40

¹⁵⁴ Ibid.

¹⁵⁵ Ibid., p.41

vein, the fact that the patient may, will or does make the wrong decision about treatment does not entail that the patient lacks the right to make that decision. The point being made here is to show how difficult and for some impossible it is to arrive at a really informed consent which warrants paternalistic intervention.

Proponents of paternalism can also argue their case from the historical evolution of the nature of medicine itself and the ways in which obligations of physicians derive from what the physician is conceived to be.

In early Greek times, as reflected in many of the Hippocratic books, medicine is seen primarily as a *tekne*; a craft such as carpentry, for example.¹⁵⁶ A craft man has certain obligations to his craft: such as preserving it against fakes, practicing it competently, teaching it, and advancing its knowledge.

Historically, medicine was not referred to as a “profession” until the first century A.D., when Scribonus Largus, a physician in the time of Claudius, wrote his treatise *On Remedies*¹⁵⁷. Here medicine is classified as a profession, a vocation, in which the nature of medicine is to heal. This raised certain expectations on the part of the patient and imposed certain obligations on the physician. In the opinion of Pellegrino and Thomasma, commiseration and humaneness are the doctor’s unique professional virtues, as truth is for the judge following this classification by Scribonus Largus.¹⁵⁸ This idea of profession as a special calling is more demanding and implies a nobility of dedication.

In line with these antecedent views of the nature of medicine, modern medicine though not exactly the same with the previous views, tended to promulgate the image of a special calling with certain prerogatives of authority and paternalism, thereby combining technical and moral authority. This view of medicine as a gentlemanly profession required the physician to be courteous, kind yet firm, taking his patient’s concerns into account and acting on his or her behalf. This is the historical evolution of the Hippocratic model of the physician-patient relationship as is articulated in the nature of medicine. In this articulation, one observes that the physician, at first a craftsman and later a more elite personage, had great concern for his corporate and personal reputation. By virtue of his greater knowledge and skill, the physician

¹⁵⁶ Pellegrino E. D. and Thomasma, D.C., *ibid.*, p.196

¹⁵⁷ *Ibid.*

¹⁵⁸ *Ibid.*

was presumed to act as a benevolent authority in medical and moral matters. He took upon himself the cares of the patient, decided what was best and whom he should treat. It is therefore the primary obligation of the physician to promote health. It is in fact, an inborn role of the physician. The physician should strive for the patient's best interest. It is most important to prevent, or at least mitigate, serious complications of diseases. If the physician finds an intervention necessary in order to promote health, he or she would fight for it, although the patient is reluctant or even refuses.

Robert Veatch and Carol Mason state that Percival's ethics (which is the first most important Anglo-American discourse from within the the health profession) illustrates its general support of professional authority by counselling physicians to unite tenderness with steadiness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect and confidence. In their exact words;

*The more specific notion that physicians know what is best for their patients and should promote that perception is illustrated by Percival's reluctance to disclose bad news to the patient, and his prohibition on quack medicines.*¹⁵⁹

In the same context of not attempting to undermine the autonomy of the patient, Beauchamp and Childress list the following conditions as necessary for paternalistic intervention to be appropriate and justified;

1. A patient is at risk of a significant, preventable harm
2. The paternalistic action will probably prevent the harm
3. The projected benefits to the patient of the paternalistic action outweigh its risks to the patient
4. The least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted.¹⁶⁰

These conditions in my restricted view are self explanatory and do not need further commentary.

¹⁵⁹ Veatch, R. M., in Gillon, R., 1994, p.400

¹⁶⁰ Beauchamp, T. L and Childress, J.F., *ibid.*, p.186

5.3.A CASE FOR PATERNALISM IN MENTAL HEALTH

An individual can only be deemed to be autonomous insofar as he or she is mentally competent. There are also other circumstances that can lead to the erosion of autonomy. If this is the case, there is nothing to argue about or to prove to justify paternalism for the mentally ill patients. Following from my earlier discourse on paternalism, if paternalism ever exists in mental health, then it is paternalism in the weak sense. This is the form of paternalism where an agent intervenes on grounds of beneficence or nonmaleficence only to prevent nonvoluntary conduct – that is, to protect persons against their own substantially nonvoluntary or nonautonomous actions. Substantially nonvoluntary or nonautonomous actions as Beauchamp and Childress wrote include cases of consent or refusal that is not adequately informed, severe depression that precludes rational deliberation, and addiction that prevents free choice and action.¹⁶¹ In weak paternalism therefore, a person's ability must be compromised in some way. Downplaying the need for justification of weak paternalism, Beauchamp and Childress also write that;

*If a paternalistic intervention does not override autonomy because no substantial autonomy is present, it is far easier to justify the intervention than it would be if a comparable preference or action were autonomous.*¹⁶²

In essence, that we should protect persons from harm caused to them by conditions beyond their control is not a controversial premise. This is almost a given because substantially autonomous actions are not at stake. To this end, Joel Feinberg who actually introduced the distinction between strong and weak paternalism argued '*that it may be severely misleading to think of weak paternalism as a kind of real paternalism*'¹⁶³

The mentally ill patient is an incompetent patient and that is why paternalistic intervention in this case is regarded as weak paternalism, that is also why it is not a problem to be justified nor is it controversial.

¹⁶¹ Ibid., p.181

¹⁶² Ibid.

¹⁶³ Ibid.

Looking at the position of the two major champions of individual autonomy as I have pointed out hitherto, namely Immanuel Kant (in his categorical imperative) and John Stuart Mill in his utilitarianism, we discover their own agreement to the fact that there are limitations to the autonomy of the individual, or put in another way, the fact that there are circumstances when individual autonomy is eroded. An essential element of ideal autonomy is rationality. While Mill and Kant had different explanations for why autonomy is important, both of them thought rationality was important for the autonomy of others being binding upon us. Mill thought that a full set of liberties should only be fully extended to

*. . . human beings in the maturity of their faculties. We are not speaking of children, or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury*¹⁶⁴

As The Belmont Report¹⁶⁵, puts it, “the principle of respect for persons derives from the Kantian conviction that individuals should be treated as autonomous agents and that persons with diminished autonomy are entitled to protection. The mentally ill patients and minors constitute the incapacitated or those with diminished autonomy. According to Philip Darbyshire;

*It had been widely accepted that left to their own devices, people with mental handicap would be unable to ensure and safeguard their own health and welfare. For this reason, people with mental handicap had to be ‘looked after’ and protected from themselves.*¹⁶⁶

Paternalistic control for him has been a cornerstone of the care of people with a mental handicap for many years.¹⁶⁷ Such protection as he mentioned, ensured that they were denied almost any measure of personal autonomy or control over their own lives.

¹⁶⁴ <http://jme.bmjournals.com/cgi/content>

¹⁶⁵ The Belmont Report (1979) is the major ethical statement guiding human research in the United States.

¹⁶⁶ Darbyshire, P., p.88

¹⁶⁷ *Ibid.*

In essence, the principle of respect for autonomy does not mean that the principle of beneficence or concern for the well being of others, can simply be ignored. This is because it is not every patient has the decision making capacity. Decision-making capacity refers to an individual's actual ability to make reasoned choices. Basically, determining decision-making capacity requires an evaluation of three criteria;

1. How well does the patient understand his or her illness and its implications?

2. How well does the patient evaluate information? That is, how well integrated are the current choices with the values the patient expressed in the past? Are they rational, can the patient explain reasons for them, and do they reflect an ability to weigh risks and benefits of various options?

3. Can the patient effectively communicate his or her wishes?

A person with mental handicap is largely seen as incapable of exercising any degree of autonomy or choice.

Nevertheless, the case is different when it comes to patients that are temporarily or intermitently mentally ill. It is within this area that there is real conflict in the practice of paternalism. Types of mental illness that qualify for this category include the ones that I have already mentioned in the last chapter, they include, dementia (under which we have alzheimer's disease, multi-infarct dementia, dementia with lewy bodies, bismanger's disease and pick's disease), behavioural disorder comprising attention deficit-hyperactivity disorder, conduct disorder and oppositional disorder, psychotic disorders like schizophrenia, brief psychotic disorder and delusional disorder and finally, personality disorder which includes paranoid personality disorder, schizoaffective disorder and borderline personality disorder. The common feature that these array of mental illnesses possess that qualifies them for consideration here is that they affect the mentally ill patient intermittently or temporarily. The patient who suffers from them fluctuates between periods of sanity and periods of insanity. It is pertinent to point out that there are also situations where they chronically attack the patient. In such cases or situations, paternalistic intervention is less problematic. It is otherwise in such cases where a patient suffers from any of these illness but gets well once momentarily only to get back to his or her former mentally ill health condition. The conflict arises when the patient whom during this period of sanity is competent and capable of informed consent at least in principle takes a decision that runs contrary to what the physician and other health care workers in the discharge of their professional

obligations think is the best for the patient. A discussion about this has been amply done in chapter three.

It is not an easy task to make a case for paternalism in the case of the temporarily mentally ill patients whose autonomy is seemingly restored during their periods of normalcy. Many legislations are bereft of statutes providing for adequate involuntary outpatient and inpatient treatment for such cases.

Our hypothetical Frank still represents this group of patients in the context of this work. The following is the list of Frank's rights according to the hypothetical story;

1. He has the right not to take his medications as soon as he is discharged from the hospital
2. He has the right to be discharged if he is able to demonstrate the capacity to remain calm and cooperate with hospital staff.
3. If the attending psychiatrist and hospital do not discharge him, he has the right to sue the physician and hospital for illegally holding him against his will despite the fact that his paranoid thoughts will overwhelm him and he will begin to act on them.

The negative summary of these is that Frank has the right to continue to be psychotic. He has a right not to be given reasonable outpatient treatment against his will. These are all courtesy of Frank's appeal to the principle of autonomy and its consequences.

Nevertheless, I have in chapter three discussed the limitations of the principle of autonomy. Succinctly put, they are contextual, existential and conceptual.¹⁶⁸ Frank's appeal to the principle of autonomy suffers from these limitations.

Contextually, the conviction that Frank will abandon his medications as soon as he leaves the hospital which will definitely usher in a return of his paranoid thoughts marks this context out and sets the limitation of the appeal to the principle of autonomy. It would have been more complicated if it is doubtful if he will abandon his medications and if his paranoid thoughts will return. In this context therefore, it is very clear that indiscriminate appeal to Frank's

¹⁶⁸ *Supra*, p.38

right to autonomy will do him no good. The physician will also be failing in his professional obligation to the patient if he or she goes ahead to do Frank's bidding.

Existentially, the effects of the incessant mental incapacitations and hospitalizations of Frank cannot be ignored. It will be dangerous to rule out that his self-direction, life plan and ego must have been adversely affected and practically marred by this reality. In other words, the fact that Frank's world view and personality must have been distorted and bastardized by his mental ill health characterized by his getting in and out of the hospital must be taken into consideration. Existentially, he is a sick man and a peculiar one. He deserves therefore, a peculiar medical attention which paternalism can supply. I have previously discussed the existential effects of sickness. Owing to this inevitable negative effects of illness, there is no gainsaying the fact that Frank's capacity for informed consent has become grossly if not completely diminished.

Recapitulating what I have already written in chapter three on conceptual limitations of the principle of autonomy as put forward by Pellegrino and Thomasma in expressing their opinion that autonomy does not encompass the doctor-patient relationship in all its ramifications. For them it can be seen as safeguarding the person, respecting the person, healing or restoring a lost wholeness, making a good and right medical decision or acting in the best interest of the patient.¹⁶⁹ Conceptually therefore, Frank's appeal to the principle of autonomy is limited because the physician and other health care providers at his service maybe acting for his best interest, maybe safeguarding his person etc.

Lawrence P. Ulrich maintains that the principle of autonomy is not absolute and that it functions contextually and that its exercise frequently depends upon other values, priorities, and social conditions which are part of the patient's health care setting.¹⁷⁰ In the light of this statement, Frank must not always appeal to his right for autonomy because it is not absolute. Other values have to be put into consideration as well as other priorities and his social setting. The obligation to help the sick is in the actual fact, a general obligation and it is not an overstatement to describe Frank as sick even during the period of his normalcy. Helping him cannot in this case be possible without a paternalistic approach with its inherent consequences like infringing on his right to autonomy. It is also a fact that by respecting a patient's

¹⁶⁹ *Ibid.*, p.39

¹⁷⁰ <http://academic.udayton.edu/LawrenceUlrich/315prinsme.htm>

autonomy, the physician can better serve his or her patient. However, Beauchamp and Childress believe that respecting a patient's autonomy involves more than non-interference in the patient's personal affairs to actual obligation to build up or maintain the patient's capacities for autonomous choice.¹⁷¹ Frank's capacity for autonomous choice cannot be built or maintained by allowing him do his bidding as is contained in the story. The physician and the health care workers owe him the responsibility of helping him build up this his capacity and maintaining it by paternalistically choosing what they think is best for him.

Among the plethora of moral theories, I would to employ a consequence-based theory and an obligation-based theory as well the method of Beauchamp and Childress to consolidate and conclude the case that I am making for paternalism in this work.

Consequentialism is a label affixed to theories holding that actions are right or wrong according to the balance of their good and bad consequences.¹⁷² The right action therefore, in any circumstance, is the one that provides the best over all result, as is determined from an impersonal perspective that gives equal weight to the interest of each affected party. The most prominent consequence-based theory is utilitarianism¹⁷³ and it accepts one and only one basic principle of ethics: the principle of utility.

*The principle asserts that we ought always to produce a maximal balance of positive value over disvalue (or the least possible disvalue, if only undesirable results can be achieved).*¹⁷⁴

The classical origins of this theory are found in the writings of Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873).

Although utilitarians share the conviction that we should morally assess human actions in terms of their production of maximal value, it is on record also that they lack a consensus of opinion on what constitutes the values that should be maximized. Bentham and Mill are for instance hedonistic utilitarians because they conceive utility entirely in terms of happiness or

¹⁷¹ Beauchamp, T. L., and Childress, J.F., *ibid.*, p.63

¹⁷² *Ibid.*, p.340

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid.*

pleasure. However, many recent utilitarian philosophers have argued that values other than happiness have intrinsic worth. Some list friendship, knowledge, health and beauty, whereas others list personal autonomy, achievement and success, understanding and enjoyment.¹⁷⁵

Even when their lists differ, these utilitarians concur that the greatest goods is in terms of the total intrinsic value produced by an action¹⁷⁶. In this sense, the utilitarians will evaluate the case of Frank in terms of the consequences of the paternalistic action of the physician and the health care workers. The intended goal of the physician and his allies is to realize the greatest good by balancing the interest of all affected. By not heeding absolutely to the demands of Frank, the physician and the health care workers intend to achieve the greatest good for Frank and for the society.

Both rule and act utilitarianism will approve of paternalism in Frank's case. This is because rule utilitarianism in its attachment to the rules of morality believes that we should support rules if and only if these rules would produce the most favourable consequences.¹⁷⁷ Act utilitarianism will on the other hand while simply considering the consequences that will occur from the paternalistic action will give kudos to it since it is intended to protect not only Frank but also the society.

On the other hand, deontological theory is a theory that some features of actions other than or in addition to consequences make actions right or wrong¹⁷⁸. This type of theory is now increasingly called Kantianism because the ethical thought of Immanuel Kant has most deeply shaped its formulations¹⁷⁹. I therefore crave the indulgence of the reader to call it Kantianism.

One of Kant's most important claims is that moral worth of an individual's action depends exclusively on the moral acceptability of the rule of obligation. (See the earlier discussion on the categorical imperative in chapter two). For Kant, one must act not only in accordance

¹⁷⁵ Ibid.

¹⁷⁶ Ibid.

¹⁷⁷ Ibid.

¹⁷⁸ Ibid, pp.348 ff

¹⁷⁹ Ibid.

with but for the sake of obligation.¹⁸⁰ That is, to have moral worth, a person's motive for acting must come from recognition that he or she intends what is morally required.

In the light of Kant's categorical imperative, the physician and the health care workers can defend their paternalistic approach to Frank by saying that it is because they want to treat Frank as an end in himself and not as a means toward achieving the so called patient's autonomy. The intrinsic worth of Frank lies more in his being taken care of so that we will recover and his health restored than in his being allowed to do things that are bizarre and that will not only jeopardize his humanity but that of others in the society where he lives. Frank's life, security and future cannot be justifiably sacrificed on the altar of protecting his right to autonomy; it should rather be the other way round. If Frank destroys himself, there will not be any room to talk about his autonomy again. His autonomy presupposes his humanity and his autonomy can only be protected and safeguarded if he is saved from the harm that he will do to himself and by extension to others.

But how will the champions of principlism, namely Beauchamp and Childress address this issue? They made it clear in their latest work that they unite the common morality with the coherence theory model of justification¹⁸¹. I have already discussed in chapter one, though in brief, their adoption of this theory against the other two models. It is their belief that this strategy allows them to rely on the authority of the principles in the common morality, while incorporating tools to refine and correct unclarities and to allow for additional specification of the principles.¹⁸² Defending their tenacious recourse to the principles they said that;

*The general norms and schemes of justification found in philosophical ethical theories are invariably more contestable than the norms in common morality. We cannot reasonably expect that a contested moral theory will be better for practical decision-making and policy development than the morality that serves our common heritage.*¹⁸³

¹⁸⁰ Ibid., p.350

¹⁸¹ Ibid.,p.403

¹⁸² Ibid.

¹⁸³ Ibid.

It is also obvious that even proponents of the same type of general theory typically disagree about its commitments and how to apply it. The principles that Beauchamp and Childress maintain are drawn from this common morality and it is their contention that they receive more social consensus because of the central social role that common morality plays and also the fact that these principles appear in some form in all major theories. But what happens when the principles conflict with each other as is apparent in the case of paternalism for the temporarily mentally ill patients ably represented by the hypothetical Frank? Because they do not believe in the use of hierarchy of rules or principles and following from their adoption of the coherence theory or integrated method, they will reply that;

*The latitude to balance prima facie principles in case of conflict leaves room for compromise, mediation, and negotiation; and the need to specify them allows for moral growth and progress.*¹⁸⁴

This statement dissipates the fear and the allegation that the principles are rigid and tyrannical. There are situations when moral agents act correctly in overriding a prima facie obligation. The principles are linked in our moral thinking and actions and neither of them enjoys any pride of place. It will therefore not be out of place to suggest that Beauchamp and Childress will subscribe to overriding of Frank's right of autonomy since doing so will amount to simply restricting his short-term right in order to protect, advance and safeguard his long-term autonomy. Common morality will readily approve of this and since the principles are negotiable, and 'compromisable' the conflict will be settled. Sound moral reasoning for Beauchamp and Childress can occur at any level of generality and can motivate revisions of ethical belief either upward or downward.¹⁸⁵ This is possible due to their adoption of the coherence theory. They believe that even the rule about putting the patient's interest first is not categorical for all possible cases. For them it is an acceptable starting premise as a considered judgment and no more. We are left with a range of options about how we should and should not specify this rule and balance it against other norms.

¹⁸⁴ Ibid., p405

¹⁸⁵ Ibid., 403

CONCLUDING REMARKS

The conflict generated by beneficence and autonomy is an inescapable dimension of medical practice. This conflict finds its roots in paternalism. I have in this work tried within the limits of my inevitably restricted capacity and scope to ethically analyze this conflict and some possible ways of resolving the conflict.

In doing this I tried to carry out analytic conceptual explication. The concept and principle of autonomy were explicated together with their necessary consequence namely, informed consent. This was also done to the concept and principle of beneficence. Their different types were equally x-rayed. Beneficence was further contradistinguished from nonmaleficence. The concept of paternalism and its various types were not spared in this explication.

The subsequent chapter discussed the various arguments for and against the primacy of each of the two principles over the other. This was however, preceded by a comparative analysis of the two principles and an exposition of the dilemma that the physician, other health care workers and other surrogates face as a result of the conflict that exists between these two principles. Next was an analysis of what mental illness was. This ushered in a further analysis of medical paternalism in general and medical paternalism for the mentally ill patients in particular. A hypothetical patient named Frank was used in the work to represent the mentally ill patients whose mental illness is intermittent and temporary. The principles as a matter of fact are applied to specific cases and this is one of them.

Finally, the reasons for rejecting paternalism by the antipaternalists were discussed followed by efforts at justifying paternalism, as paternalists will argue. A case was then made for paternalism in mental health care that was further tailored down to the case of the temporarily mentally ill patients. The argument that was put forward is that the physician and other health care workers override the autonomous right of the patient to achieve the greatest good.

A consequence based ethical theory, namely utilitarianism was adopted to strengthen the case for paternalism for the temporarily mentally ill patients. An obligation based theory was equally employed particularly, Kantianism. Following the categorical imperative, it was argued that the physician and the health care workers can justify their paternalistic

intervention by saying that what was aimed at was treating the patient as an end in himself and not as means toward achieving the so called autonomy.

The presumed view of the champions of principlism was also sought to address this issue. I call it presumed because they did not address such a case particularly in their works. Finding, a cover in their contention that the principles are neither rigid nor hierarchically arranged as well as their appeal to common morality as the foundation of the principles, an argument was put forward in support of paternalism for the temporarily mentally ill patients. Since they hold that a prima facie obligation can be overridden in a conflict situation, their presumed justification of the paternalism was stated.

It will be stating the obvious to say that this work is bound to be awash with deficiencies, inconsistencies and an avalanche of shortcomings. I have not said everything should be said on this matter and I cannot. Neither have I consulted every material that should be consulted nor have I given the best and most appropriate interpretation of the ones consulted. Proponents of the same theory do not always agree as a matter of fact. My limitations are therefore, existential and realistic. That this work will provoke a lot of reactions is a given and honestly speaking is one of the latent goals that I intend to achieve.

Nevertheless, no matter how paltry the comments made in this work are, they may elicit a second look at paternalism for those who refuse and reject it for the temporarily mentally ill patients as is illustrated in the body of this work. It is not ruled out that many do not know their reason(s) for refusing and rejecting it. They may find their reason(s) in this work and may also find the reason to reconsider their positions in this work. Those who appreciate it but do not know why can do the same while those who appreciate it with reasonable reasons may find this work very pithy while others may not. To those who do not subscribe to paternalism for any reason I will like them to ponder on this statement; *'It may not be desirable, or even possible, to exclude paternalism from medicine'*¹⁸⁶ in general and from the temporarily mentally ill patients in particular.

¹⁸⁶ Elliot, .S. A.,ibid.,p.398

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