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THE CONFLICT BETWEEN AUTONOMY AND BENEFICENCE IN MEDICAL ETHICS:
PROPOSAL FOR A RESOLUTION*

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I INTRODUCTION

Three radical changes have occurred in the ancient edifice of medical ethics in the last two decades. Each promises to transform the nature of the physician-patient relationship with repercussions in the domains of law, society, and ethics. Each merits the most careful scrutiny by the profession and the public, because how we resolve the moral dilemmas they produce will determine not only our relationships with the medical profession, but what kind of society we are, or wish to be.

The three changes we consider most crucial are these: 1) the shift in the locus of decision-making from the physician to the patient — a shift philosophically from the primacy of beneficence to the primacy of autonomy in physician-patient relationships; 2) an unprecedented expansion of medical technological capability, thus expanding enormously the range and complexity of clinical and policy decisions in health care; 3) the entry of economic considerations as primary forces in individual and policy decisions regarding health and medical care, thereby creating a conflict between the canons of economics and the canons of traditional medical ethics.

In this essay we will confine ourselves only to the first of this triad of changes — the shift from beneficence to autonomy in medical ethics. We recognize the interdependence of the whole triad of changes, and that to dissect them from each other is difficult and somewhat misleading. Yet the scope of this essay forbids a full examination of the interdependence of autonomy, technological possibility, and economics in the evolution of contemporary medical ethics. We are preparing a more thorough examination of

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these relationships in a forthcoming book. (E.D. Pellegrino and D.C. Thomasma, For the Patient’s Good (unpublished manuscript)).

This essay falls into two parts: first, we will examine the limitations of both the autonomy and paternalist models of the physician-patient relationship and second, we will outline a model of beneficence that promotes the good of the patient yet de-absolutizes autonomy and avoids the pitfalls of traditional paternalism.

II THE AUTONOMY MODEL AND ITS LIMITATIONS

A. Socio-historical Critique of Autonomy

The autonomy “model” of clinical decision-making is firmly grounded in the dignity of human persons and the claim they have on each other to privacy, self-direction, the establishment of their own values and life-plans based on information and reasoning, and the freedom to act on the results of their cogitations. The historical origin of the principle of autonomy, as it is interpreted by many ethicists today, is of recent date. It is found mainly in the philosophical treatises of the French and English Enlightenments and the emergence of the doctrines of individual and political rights to freedom that undergird modern democracy.

The notions of individual rights and autonomy have been gathering strength in American public life since the founding of our country. They, however, lagged behind in the medical relationship. Only in the last several decades have they become powerful enough to challenge the traditional paternalism that dominated the relations of doctors and patients for 2,500 years — at least since the time of Hippocrates.¹ For our purposes, we need not trace this history in detail. It suffices to take note of the major forces that have nurtured the exponential growth of autonomy in the last two decades.

First, is 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” carries with it a certain distrust of all authority, expertise, privilege and prerogative — of the kind tradition­ally wielded by physicians, lawyers and other professionals.

To this we must add the general improvement in the education of the public and the dissemination by the media of information about both the advances of medicine as well as the ethical and legal dilemmas those advances produce. As a result, the public appreciates that it makes a vast dif­

ference in our lives what decisions doctors make in the use of medical knowledge, and that those decisions increasingly involve value choices.

Lastly, the increasingly divergent moral pluralism in our society impels us to seek to protect our personal values against usurpation by others. This is recognized as a genuine danger in medical decisions which can involve our deepest convictions about life and death, abortion, euthanasia, genetic manipulation, and the like.

These factors have converged to undermine the traditional model of the benign, paternalistic physician, who assumes full responsibility and authority to determine the patient’s best interests and to act so as to advance those interests — if need be, without the patient’s participation. This is the conception of “beneficence” still dominant in the minds of many physicians and patients; it still shapes the ethos and ethics of medicine. It is the conception, too, that is the focus of criticism by the proponents of autonomy who equate beneficence almost entirely with medical paternalism.

It is true that, here and there, in the history of medicine there were suggestions of patient participation in clinical decisions. Plato, for example, distinguished the physician of the free man from the physician of the slave by the fact that the former educated and consulted with his patient, while the latter did not. It is true too, as Katz points out, that in more recent times, some like Samuel de Sorbire tentatively suggested that patients ought to be part of the doctor’s decisions. Moreover, a closer reading of Percival’s Ethics serves to qualify the standard account of the Eighteenth Century physician as merely a condescending gentleman — authoritarian. The same is true of some aspects of Worthington Hooker’s Treatise on Physicians and Patients — an American work on medical morals that deserves to be better known.

But exceptions like these aside, paternalism was the dominant, and indeed the accepted, model of the clinical relationship for most of medicine’s history. Paternalism was not as ethically dubious in times past as it would be today. For one thing, the educational gap between physician and patient was wider than it is now. Further, participatory democracy even in Greek times was not a reality for most people. Finally, almost all medical treat-

2. Neither in the oath, the other deontological books, nor the whole body of the Hippocratic corpus is there evidence of an obligation to obtain patient consent or participation. Indeed, most of the direct references were to the contrary. See Pellegrino, Toward A Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness, 4 J. MED. & PHIL. 32 (1979).


5. W. HOOKER, PHYSICIAN AND PATIENT (1849).
ments were non-specific, as much depended upon faith in the physician as on any genuine therapeutic potency. Indeed, most therapeutic efforts were either useless or dangerous. Ordinary patients were not aware, however, of the therapeutic poverty of most prescriptions.

"Aesculapian Power" was a major ingredient of cure. It rested on faith in the quasi-hieratic power and authority of the physician as a person. Indeed, the physician himself was part and parcel of the cure as Lain Entralgo points out.6 Only in very recent times have these conditions changed so radically that the more objectionable features of medical paternalism have begun to be felt. Medicine's capacities to alter individual and social life are unprecedented. An educated public grasps this fact and no image grants the physician unrestricted discretion in the use of his powers.

Eliot Freidson has detailed the negative effects of the professionalization of contemporary medicine.7 His study is very cogent but it undervalues some of the more positive aspects of professionalization. Anything so powerful as modern medicine requires a formal professionalization process to assure that high levels of competence, conduct and accountability are maintained. This aspect of professionalization must not be lost in the current antipathy to paternalism.

In fact, the dangers of paternalism lie less in professionalization than in the irresponsible uses of power and the attributions of superiority that arise from the social ascendancy of medicine. As John Stuart Mill remarked, "Whenever there is an ascendant class, a large portion of the morality emanates from its class interests and its feelings of superiority."8 This too is the basis for Illich's mordant criticism but he weakens his case by the polemics of social revolution with which he heavily flavors his charges against medicine.9

Thus, the revulsion many competent adults feel about medical paternalism may more properly derive from anger about physicians' pretensions as a superior class than from any inherent property of professionalism itself. Women have often complained that gynecologists "pooh-pooh" their complaints (e.g., the premenstrual syndrome debate) on the grounds of sexist power struggles. Patients are forced to wait for the doctor in the waiting rooms, suggesting that their time, their values, their lives are not as important as the doctor's. Cartoons abound in which the public fears that doctors

are too busy managing their money to care about patients. These are examples more of the role of power and class than of any inherent properties of professionalization. They are often at the bottom of the declining status of the physician recorded in serial American Medical Association ("AMA") surveys on the public image of the doctor.10

The patient autonomy movement is an understandable counter-reaction to such class domination. Nonetheless, autonomy should not be viewed as an absolute model for the doctor-patient relationship itself because it is insufficient to claim, as the move to patient autonomy often does, that medical paternalism is a direct outgrowth of professionalization. Nor is paternalism a prima facie medical or social evil as Berlant supposes.11 Modern medicine incorporates moments of patient choice as well as moments of necessary, beneficial paternalism. The former occur when the diagnosis and options are clear and well documented. The latter occur when not enough is known about a disease and its prognosis, when no therapeutic modality has a clear edge, or when an existing therapy has marginal or dubious benefit. In these cases, physicians may be forced to recommend, even urge a course of action based on an intuitive assessment of the data. The important thing here is that the physician make clear the uncertainties with which he must contend. This preserves autonomy and so it is not paternalistic but it is beneficent.

Some philosophers who defend the absoluteness of patient autonomy on moral grounds neglect the fact that "decision-making" among humans is an inter-personal transaction. They thus downgrade the bilaterality of the patient-physician relationship. Doctor and patient are existentially bound to each other in a way that makes moral atomism and absolute decisional autonomy unrealistic and undesirable goals for both parties. Moreover, the philosophical atomism on which such a notion is based is of dubious viability in a complex, interrelated, technologically-driven society like our own.12

The patient autonomy model does not give sufficient attention to the impact of disease on the patient's capacities for autonomy. We agree with Eric Cassell that medicine should restore patient autonomy,13 but one cannot assume that autonomy is fully restorable or preservable in cases of serious illness. Patricia Bradley formulates a telling objection to the position of Robert Veatch, one of the most prominent ethicists arguing for the patient autonomy model. According to Bradley,

Veatch argues that the relationship between doctor and patient is an equal one, ignoring . . . the fact of illness which places the patient in a potentially vulnerable relationship with his physician. Based as it is on a wrong assumption, this model must be rejected when applied to the traditional doctor-patient relationship.  

Even the briefest experience with illness shows that ill persons often can become so anxious, guilty, angry, fearful, or hostile that they make judgments they would not make in calmer times. Patients become preoccupied with their diseases and their bodies. The patient may see his body as an object that failed him. Patients are forced to reassess their values and goals. These primary characteristics of illness alter personal wholeness to a profound degree. They change some of our assumptions about the operation of personal autonomy in the one who is ill.  

Healing as a moral component of the physician-patient relationship is not given sufficient weight in the autonomy model. The physician's task goes beyond the prevention of harm. It includes restoration or improvement of biological function. If health is in any degree a value of the body as a biological organism, then the physician has some obligation to work toward this good, which is intrinsic to medicine. This is the case even when the patient, in the presence of life-threatening illness, may deny or reject health. On this view both the physician and patient are obliged to work towards restoration of the good of the body, which is health. We have structured elsewhere the hierarchical relationship of this good and the good of self-determination when they are in conflict in, and between, patient and doctor.  

Distinguished ethicists like James Childress recognize the realities of these conflicts between autonomy and paternalism. They prefer to err, if they must, on the side of autonomy of what we consider erroneous meta-ethical grounds, namely that rights take precedence over goods. The central point or differences in our own position is that there are better arguments in particular instances for the ascendancy of goods over rights.  

It is, of course, increasingly true that patients with chronic, unremitting, disabling disorders, like degenerative disorders of the nervous system, incurable neoplasms, or intractable pain, may wish to assert their right to an au-

15. Cassell, Disease, as an 'It': Concepts of Disease Revealed by Presentation of Symptoms, 10 SOC. SCI. IN MED. 143 (1976).
17. Pellegrino, Moral Choice, the Good of the Patient, and the Patient's Good, in ETHICS AND CRITICAL CASE MEDICINE 117 (J. Moskop & L. Kopelman eds. 1985).
tonomous decision to discontinue treatment or to die. But, most often, life and health are still primary values most patients will assert over their moral and legal rights of autonomous refusal of medical care. The average patient also usually assumes that his health is still the physician's primary value as a physician. There is a real danger of harm to the patient if doctor and patient misunderstand each other on this point.

Patient autonomy models often have their origins in the civil and human rights movement, rather than in an ontology of relations specific to medicine and healing. Few would disavow the positive gains effected by the political struggle for human rights. But it does not follow that the adversarial presumptions of the rights movement are transferable, without modification, to the debate about the locus of medical decision-making. The image of doctors as adversaries, sinister in their conspiracy against patients, is a colorful but overplayed metaphor. It stimulates scrutiny of the abuses of power that can, and all too often do, characterize medical decisions. Nonetheless, there are still physicians of character motivated by an ethic of compassion and commitment that transcends post-enlightenment rights-based ethical theories.\textsuperscript{18}

B. Limitations of Autonomy, Philosophical Critique

Our objections to autonomy as an absolute principle in medical decision-making, or as a replacement to beneficence, when they are seemingly in conflict, needs a little more formal analysis than the foregoing. We find autonomy wanting in three dimensions — the contextual, the existential, and the conceptual.

1. Context Limitation

The autonomy model may not apply in some contexts of medical treatment. For example, paternalism may be appropriate when treating the aged and senile referred from nursing homes for urinary tract infections.\textsuperscript{19} In such cases, physicians may have an obligation to disregard the patient's wishes until they are convinced that the patient is competent. This is an example of "weak" paternalism, different in moral quality from "strong" paternalism in which the objections of a competent patient are overruled, or deception is practiced to manipulate a decision.

Physicians may, therefore, act over the objections of patients, to preserve

\begin{itemize}
\item[\textsuperscript{18}] Thomasma, \textit{The Basis of Medicine and Religion: Respect for Persons}, 47 \textsc{Linacre Q.} 142 (1980).
\item[\textsuperscript{19}] Thomasma, \textit{Professional and Ethical Obligations Toward the Aged}, 48 \textsc{Linacre Q.} 73 (1981).
\end{itemize}
life or prevent serious harm, when patients are senile, confused, depressed or otherwise incapacitated in their ability to make autonomous judgments. The same holds for emergency room treatment. Here the uncertain prognosis, the urgency for unambiguous decision, and the probability that the patient would want to be treated were he fully competent, would militate against unrestrained adherence to the patient's expressed wishes. The same may apply to hasty requests not to be resuscitated when clinical outcomes are still in doubt. On the other hand, when the clinical context is clearer, less urgent, and the patient's competence certain, autonomy can and should be given primacy.

Weak paternalism may be appropriate when treating children where competence is difficult to judge, or genuinely in doubt. We may presume that, were they autonomous, children would choose to be treated — provided there is sufficient benefit to be gained from treatment. This is true too with therapeutic research in children. The context — the calculus of benefits and burdens of experimental procedure — will determine the moral licitness of the research. This would not be the case with non-therapeutic research where a child would be exposed to risk, without the chance of benefit. One cannot under any doctrine of paternalism — weak or strong — presume or impose altruism on the part of another.

The clinical context may change day by day, hour by hour, even in the same patient and with it, the moral defensibility of any act of paternalism.20 Senile patients may wax and wane in competence. Acutely and desperately ill patients with severe trauma and burns may vacillate in their desire to live. While the decision to treat may be very difficult, the presumption to treat is often morally defensible if there is appreciable probability of a successful outcome. What constitutes "success" under such circumstances may be debatable, but overly hasty decisions not to treat out of deference to the principle of autonomy may be more damaging to the patient's ultimate best interests than some degree of paternalism.

This "variability of context" is, therefore, an important moral limitation on autonomy. It demands careful assessment in each case, while remaining sensitive to the moral obligation to respect patient autonomy. Engelhardt also takes note of this variability and concludes that it is the product of rational disagreements about the risk-benefit calculus.21 On this view the variability rests on the relativity of subjective values of the interpreting parties and not in the objective difference in contexts as we have argued.

Irrespective of its origins, context variability raises questions about any model of patient autonomy. It also underscores the need for some ranking of goods in medicine if we are to choose one ethical model over others, or one moral choice over others. Any mode of clinical decision-making, by virtue of the fact that it is clinical, must take into account the particularities and uniqueness of each human being's experience of illness.

2. Existential Limitations: The Fact of Illness

The effects of illness and disease on personal autonomy limit self-determination to variable degrees. That is why so many physicians report that patients really want them to make the decisions. On this view, autonomy ought not, therefore, be taken as a starting point or absolute ordering principle in medicine. Rather, it should be seen as part of the goal of treatment, one of the goods of the patient, to be promoted but not to the total exclusion of all other goods.

If we take the impact of illness and disease seriously, we must modify the autonomy model. That model has four features: self-direction, establishing a life plan, deliberating about applying a life plan (reasoning and information), and acting on the basis of such deliberations.

Becoming "sick" can modify each of these features. To "be" sick is to be subject to the patho-physiological effects of illness, pain, fear, and to the special professional and institutional environment in which decisions occur. Self-direction is marred by the way disease may disrupt the unity of the self, ego, and the body. Life plans are threatened by the finitude of human life revealed in illness. Deliberation and application are impeded by the distractions of pain and fear, or by the process of institutionalization. The extent to which the operations of autonomy can be impeded by being, and becoming, a patient is impressive.

Of course the autonomy of most patients is only mildly incapacitated by disease. We must not, therefore, use the autonomy limitation as an excuse for all sorts of paternalism. On the whole, patients' choices can, and should, be accepted. On the other hand, people who are incapacitated by disease or trauma should not be abandoned to their autonomy, but merely given the "facts" and asked to make a decision. This is a form of moral abandonment. The proponents of autonomy as the prime moral obligation should give more attention to the available data about the psychosocial impact of disease on personal and moral status. A Medline search in 1985 produced eighty-six articles directly related to the impact of disease on autonomy and life adjust-

ments. These data strongly suggest that: a) autonomy is limited by illness and disease, and that, b) any model of doctor-patient relationship must take this limitation into account. Neither of these points is sufficiently appreciated in the current ethical debates about autonomy.

One might argue that we are merely talking about varying degrees of competence, and that the problem is one of determining competence. On this view the autonomy model would remain intact since incompetent patients could be treated paternalistically without violating the principles of autonomy. Such an interpretation would, however, offend those for whom autonomy has become an absolute principle of medical ethics.

3. Conceptual Limitation as a Model

The autonomy model, as a model, is also limited. It has been constructed in dialectical opposition to the paternalistic model. But neither paternalism nor autonomy correctly describes the full range of ethical norms governing the doctor and patient. What occurs between doctor and patient has many formulations. It can be seen as restoring autonomy, 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 interests of the patient. Each formulation ascribes a somewhat different moral tone to the physician's obligations with respect to the patient's autonomy.

What occurs between doctor and patient in non-therapeutic research is not encompassed in any of these terms. The goal here is not primarily the benefit of the experimental subject but the discovery of knowledge. Moreover, the subject's autonomy is not affected by illness. In non-therapeutic research then, respect for autonomy is mandatory as a moral principle. The duty of beneficence towards the patient would be at the lowest level of sensitivity - i.e., non-maleficence. In therapeutic research, however, the good of the patient is involved, and the questions about autonomy and paternalism would be the same as the ones we have already raised.

25. Thomasma, supra note 18.
26. Address by Edward Pellegrino, University of Illinois Medical Center Commencement Ceremony (June 6, 1980).
29. Ingelfinger, Arrogance, 303 NEW ENG. J. MED. 1507 (1980).
C. Social-Ethical Limitations of Autonomy

Beyond its limitations in one-to-one medical decisions, autonomy as a dominant ethical principle in medical ethics has serious limitations in social ethics, as well. These are: 1) the movement it fosters from substantive to procedural ethics; 2) the move from concern for the common to individual good; and 3) the erosion of the concept of democracy itself. Only brief mention into these limitations is possible here.

1. From Substance to Procedure in Ethics

One very strong impetus for the trend toward autonomy is the obvious moral pluralism of our society and the possibility that physicians and others in authority may override personal belief systems. One way to guard against this kind of moral trespass is to accept the irreconcilability of moral conflict, and turn the focus on the process of decision-making. Emphasis is then placed on respect for the autonomy of the parties to a clinical decision. Most of the recommendations of the multi-volume reports of the President's Commission for the Study of Biomedical and Behavioral Research place their emphasis on procedure — informed consent, anticipatory declarations of several kinds, the proper use of proxy and surrogate decision makers and the establishment of ethics committees. Many of the cases that have come to the courts have turned on the question of who shall decide, under what conditions, and by what criteria. Formalization of the decision-making process is reflected also in the recommendations of the Department of Health and Human Services pertaining to the care of terminally ill, handicapped and physically impaired infants. Tristram Engelhardt has argued particularly vigorously that the function of ethics itself in a morally pluralistic society that wishes to remain peaceable must be analysis and clarification. A particular set of values he contends cannot be propounded for the whole community; freedom is to be protected at all costs. Ethics therefore must not concern itself with moral content or normative prescriptions.

This neat dissection of analytical from normative ethics is illusory. Analytical ethics does in fact make a normative assertion, namely that autonomy is the first principle, and it overrides all others. Engelhardt's rigorous extrapolation of the logic of autonomy to its conclusions is the strongest argument against a purely procedural ethic. Pragmatically attractive as it may
be in such a morally pluralistic and democratic society as ours, procedure
cannot be self-justifying. To assert freedom as ultimate means that the
search for the good life, and a good life, and the good society must be aban-
doned. We are forced to retreat into private morality for the most meaning-
ful questions humans ask. But this retreat brings its own serious problems
with it.

2. Moral Atomism

The retreat to private morality eventually leads to a kind of moral atom-
ism in which each individual's moral beliefs and actions — unless they dis-
turb the peaceable community — are unassailable. Moral debate is not only
frustrating but futile, since each person is his own arbiter of the right and the
good. The traditional notion of ethics as reasoned public discourse in search
of the common good is discarded. The sense of community identity that
derives from some consensus on things that ought to be done, and what
ought never to be done is lost.

The overall result is a defection from what John Courtney Murray called
the "affairs of the commonwealth." These affairs end up in courts, decided
by legal adversarial procedure and judicial opinion which must inevitably
mix moral issues without the accompanying moral debate requisite to ethi-
cally sound judgment.

For example, is the decision to withhold elective treatment from a
Down's Syndrome child the private decision of its parents based on their
evaluation of quality of life, or their personal and social burden of raising a
retarded child? Moral privatism of this sort challenges government intru-
sion, and dilutes the state's "interests." Can the obligation of government to
protect the rights of the weak, the vulnerable, and the comatose, be abro-
gated on the plea of moral privacy and autonomy? The Baby Doe case in
Bloomington, Indiana and the Baby Jane Doe case in Stony Brook, Long
Island are cases in point.

It is impossible to escape the burden of doing ethics since most people still
want to know whether what is procedurally acceptable is also right and
good. Freedom to make one's own choices must be protected, but the flight
into metaethics will not eradicate the equal need for society to engage in the
pursuit of some common moral goals beyond autonomy.


34. Angell, The Baby Doe Rules, 314 NEW ENG. J. MED. 642-44 (1986). See also Child
Abuse and Neglect Prevention and Treatment Program, supra note 31.
3. **Erosion of the Idea of Democracy**

Perhaps the most serious consequence of the absolutization of autonomy is the limit it places on the idea of democracy itself. Democracy is reduced to a procedure for settling otherwise irreconcilable differences among citizens, but without commitment to any common set of values except freedom of private judgment. Certainly one measure of a democratic society is the degree of freedom it affords for divergent and contrary opinion. But those freedoms must serve some common community purpose as well.

Is not one of the traditional aims of our democracy to advance the cause of community rather than its atomization? This is our inheritance from the classical and Judaen-Christian traditions. How far may this inheritance be squandered without corroding the idea of democracy itself? How logical is the separation between public and private morals? Is the purpose of government only to restrain unbridled self-interest or to promote the common good? The incommensurability of some of today's conflicting moral claims makes consensus unlikely. But without moral consensus private values become more selfish, more crude, and more intensely combative. Power becomes the make of morals if the common moral perspective is lost and democracy itself is weakened. Is there some other choice than Rousseau or Khomeni?

The socio-political and socio-ethical consequences of the move toward autonomy are yet to be comprehended fully. Medical ethics — as the arena of some of the sharpest ethical debates in contemporary society — is the paradigm that brings these questions to our immediate attention. Their significance transcends medical ethics. And how we resolve them will determine what kind of society we shall have.

### III LIMITATIONS OF THE PATERNALISM MODEL

Just as formidable objections to the patient autonomy model can be raised, so too can objections be raised to medical paternalism. The foremost objection is that a physician often cannot heal a person just by curing a disease, especially if the physician systematically ignores or disregards the patient's view. Cassell's argument that restoring function, or curing, should be a secondary aim of medicine, and that medicine's primary aim is to restore autonomy, has much to recommend it.\(^35\) It is a little extreme, however, and in its way absolutizes autonomy as Childress has pointed out.\(^36\)

Healing does involve restoring autonomy. For this reason, Culver and

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\(^36\) *Id.*
Gert are correct to insist that strong paternalism always demands justification because it violates a moral rule. But Culver and Gert do not deal directly with the moral content of medicine itself. Strong paternalism is objectionable not only because it violates moral rules, but because it violates the architectonic aim of medicine, which is to heal the one who is ill. To violate a person's autonomy is not to heal, but to wound his humanity.

Strong paternalism is objectionable because it violates the humanity of the patient. The obligation is owed rational beings to be free to decide about the conduct of their own lives. Indeed, such decisions are peculiarly human. To infringe on such a fundamental right clearly demands special justification. Medical paternalism fails because it overrides an essential element in deontological ethics, at the core of medicine, i.e., respect for persons. To violate the patient's autonomy is to deprive him of one essential component of his own good, and thus to violate medicine's promise to act for the good of the patient.

Many physicians hold that the patient's rights to autonomy should not get in the way of their medical needs, i.e., medical "indications" should dominate clinical decisions. But as we shall argue the case, the hierarchy of patient goods may not always place medical needs in the highest place. Lack of respect for such a hierarchy of values is a major cause of patient complaints about physician paternalism.

Like the autonomy model, medical paternalism can fail to distinguish contexts and their role in medical and ethical decision-making. As a consequence, medical paternalism tends to universalize a stance valid in one context but not necessarily in another. Generalization of one experience, like "saving" one patient through paternalism, into a universal moral posture, is not valid.

Perhaps the biggest failure of medical paternalism is its assumption that medical values or medical good is the highest good, and that it has an absolute quality which overrides other values. Or, even less justifiably, a particular physician's preferences for one treatment among several may become an absolute. Some surgeons prefer radical mastectomy while others prefer limited resection and radiation for cancer of the breast. Some cardiologists prefer medical over surgical management in certain types of angina pectoris. Alternative procedures may lead to similar outcomes but with different risks and quality of life. Selection of one procedure over others depends as much on the patient's and the physician's values as on the scientific data. The patient, for reasons of great importance to him, may reject even the scientifically preferred therapy for one of lesser effectiveness.

37. See Pellegrino, supra note 17.
Medical paternalism asserts that the physician unequivocally knows better than the patient what is "good" for him. It also subsumes all the patient's good under only one good — medical good — a point we shall develop in more detail later. Other dimensions of the good of the patient must also be considered. One of these is surely the preservation of the fundamental human good of making one's own decisions about the kind of life one wants to lead, or the risks one wants to take.

In what ways, then, is the paternalism model inadequate? We suggest three criticisms, parallel to the three we levelled at the autonomy model.

A. Context Limitation

Paternalism may apply in a certain limited context, such as making decisions over the objection of a minor about what might be best for that child, but it cannot function as a universal or general principle of medicine since it assumes something fundamentally flawed: not only that professionals know what is best for all patients, but also that they may override the patient's wishes in the pursuit of what is medically indicated. Paternalism has enjoyed such a long season because physicians can readily offer examples in which their expertise saved some patient from a truly disastrous decision. An internist of our acquaintance, for example, cites a "memorable" time when he convinced a rabbi to have a colostomy following colonic resection for cancer. The convincing took three days of vigorous debate and discussion. In telling this tale, the physician appealed to the metaphysical assumption that it is better to live than to die, to live with an impairment than to die without one. In the main, persons do accept this assumption, but not always, and not everywhere. To what extent he may, or may not, have unjustifiably exhausted the rabbi's will to autonomy is impossible to say. Given the rabbi's Talmudic training, the dialectic must have been intense and the physician's "victory" not an easy one.

B. Existential Limitation

Not only is the context a limiting factor, but the concept of paternalism itself is limited. It is not just a matter of the fallacy of expertise. The expert does not always know more about what is "best" for the non-expert. Difficulties of prognosis and the harms/benefit calculus are obvious limitations. There is also no way to define clearly what is absolutely best for the patient in medical terms alone. That definition is always related to the values the patient professes, those the institution and society assume, and those the culture holds to be important. Lacking any unequivocal definition of "benefit,"
the physician cannot presume to define the whole of the patient's good without essential input from the patient.

Some patients reject the benefits of medical interventions simply for their own reasons. Mr. Bartling, in a hospital intensive care unit in California, wished to be removed from the respirator even though he understood this would lead to his death. The Supreme Court of California upheld his legal right to his request. Some hospitals or other institutions may limit the medical benefits to be given patients. For example, Catholic hospitals rule out abortions. Nursing homes may have policies which "interpret" benefit to patients to include limitations on cardio-pulmonary resuscitation.

Society defines what benefits shall be given its citizens in general, and even which medical benefits may be offered. In England, there are limitations on the use of dialysis after a certain age. Respirators are removed after ten days if certain patients do not respond by that time. Finally, social values are in a constant state of definition and re-definition. At the moment our social values tend to accept the medical intervention model of beneficence. Other cultures, or subcultures within our own, may accept or reject this model.

All of these considerations put limits on paternalism. They mitigate the absoluteness of benefit from medical benefits that paternalism requires.

C. Conceptual Limitation as a Model

Paternalism as a model of patient-physician relationship is itself flawed. At the root of this limitation is the fact that authentic healing cannot take place in a paternalistic model, since paternalism overrides patient choices. Personal choice is essential to the processes of reintegration essential to healing. Undeniably, "cures" can often take place in a paternalistic relationship — for example, treating pneumococcal pneumonia in an elderly patient with a stroke. This is "effective," and medically indicated, but not necessarily beneficial treatment, if the patient is dying of metastatic malignancy.

The paternalistic model also fosters a certain detachment deleterious to patient "care" and it separates cures from care. The physician tends to apply the medically indicated course of action as if that patient were, indeed, the corpus upon which one practiced the medical craft. A "cure" might ensue. But the patient's most cherished value, his life plan, the kind of life he might wish to have, his relationships to others might be so violated as to vitiate the medical good. Wounding outweighs healing under such circumstances.

IV Beneficence in Trust: A Model for Medical Decisions

If both autonomy and paternalism have deficiencies, what model of medi-
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A. The Principle of Beneficence: Degrees of Sensitivity to Good of Others

Since the model we wish to propound is grounded in the principle of beneficence, we must first outline our understanding of this essential first principle of medicine and healing. Beneficence, like the good of the patient which it presumably serves, is not a univocal or simple notion. There are levels of beneficence, as Frankena points out. Just how and at what level one interprets beneficence will determine the moral obligations one feels one owes patients, and also the degree of altruism one feels obliged to practice.

The most minimal level is the level of non-maleficence, i.e., the duty not to do direct harm to another. This is the level contained in the Hippocratic prescription in the Epidemics — “at least do no harm.” This level of beneficence is expected in any civilized society. It is enjoined even in the most extreme libertarian moral philosophies.

A further step in beneficence is the duty to prevent harm to others, i.e., to remove or limit the possibilities of harm. Here we move from passive non-maleficence to a more active intervention on behalf of others. At once, even at this minimal level, the possibility of paternalism begins to appear. For example, we might readily agree that there is a duty to remove an obstacle on a railroad track that would result in derailment and harm to other people. But this action might conceivably deprive some passenger who at that moment wishes to die and would prefer to do so in a railway accident, of the privilege of doing so. Most people would discount such an unlikely prospect and agree that there was a positive moral obligation to remove the object in the interest of the majority of passengers who certainly do not want to die this way.

But what about protecting people against accidents by enforcing laws to “buckle up,” or wear helmets, or wear goggles at work. This view of beneficence requires a more direct limitation of autonomy. While libertarians might resist this degree of paternalism, society seems to be giving certain measures like these sanction on the thesis of harm to others by the economic costs and disability incurred by society which suffer the injured to go untreated — even if they elect to ignore safety requirements.

One, however, can go further — and out of the principle of preventing

harm, make the growing of tobacco, or the preparation of distilled liquors illegal. Here the intervention, while indirect so far as the one injured goes, is nonetheless significant for smokers and tobacco growers. Freedom and autonomy conflict in this case with beneficence in a way our society does not at this point countenance. Conceivably it might sanction such measures at some time in the future. To do so is to raise the interpretation of beneficence to a higher degree than simple non-maleficence.

Even further along the scale is to interpret the duty of beneficence as binding even at some risk of discomfort or pain to the benefactor. Law does not require anyone to risk life, limb or even inconvenience to save the life of another. But in medical encounters, traditionally some degree of effacement of personal self-interest has always been understood as a duty. One needs only to think of the expectation that physicians will treat patients with contagious diseases (AIDS is a current case in point) and the scorn heaped on physicians who desert their posts in time of disaster, or epidemic. Camus' Rieux is an exemplary physician precisely because he did not desert the people of Oran even though he might have claimed the privilege since his wife was ill elsewhere in a sanatorium.

This level of beneficence is implicit in that "higher degree of self-effacement" — which Harvey Cushing termed the "common devotion" of the medical profession. It is admittedly a degree of beneficence above that expected by law, or the mores of other activities like business, relationships with neighbors, or professional colleagues. It is a level, we would submit, that is essential to medicine as a moral enterprise. Without some degree of self-effacement, medicine ceases to be a profession, in any traditional sense of that term, and becomes only a trade or craft.

On the other hand, the degree of self-effacement expected is not of the heroic or sacrificial kind. It does not require the dedication of a Mother Teresa, Albert Schweitzer, or St. Francis. In them, we move beyond duty — at least in secular terms — to supererogation, to obligations one may feel out of religious or other altruistic motives. We enter here the realm of "agapeistic" ethics — one grounded in love and charity for others.39

We would argue that beneficence in medical transactions should include some degree of effacement of the physician's self-interest in the interests of his patient. Just how much effacement is required cannot be defined in any absolute way. Many physicians today think this degree of beneficence is questionable and even objectionable. Physicians are asserting their "rights" to recreation, family life, social activity, time off, freedom to choose to treat only those who pay, the right to strike, and to work for investor-owned insti---

tutions. These may not be overtly unethical practices, but they are often at the moral margin where self-effacement would dictate some limit on the physician’s personal interests or privileges.

For the purposes of the model we wish to advance we will argue that the fact of illness, what it does to the sick person, and the kind of special relationship it entails with the physician dictate a degree of beneficence that goes beyond passive non-maleficence. It includes, in our view, some obligation to act in the patient’s interests even at some cost to the comfort, power, prestige or fiscal benefit of the physician.

With this interpretation of beneficence let us turn to the model which we feel most closely exemplifies the duties physicians owe patients.

**B. Major Features of the Beneficence Model**

Given the shortcomings we have pointed out with both the patient autonomy and medical paternalism models, is there an alternative that does not reduce to one or the other? We suggest there is, though we appreciate that the complexity of the physician-patient relationship can never be adequately described in a single model. One purpose in sketching the beneficence model is to circumvent the substantial problems with the models we have already mentioned. We do not claim that the physician-patient relationship is fully defined by this model either.

There are six major features of the beneficence model:

1) **The Aim of Medicine is Beneficent**

Medicine as a human activity is of necessity a form of beneficence. It is 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. The obligation to help the sick is a general one involving humans, even those who are not professed healers. It is grounded in the claim that comes from the vulnerability and suffering of a fellow human. One is impelled, even by the lesser degrees of beneficence, not to harm, and even, to ease suffering.

When one is a professed healer one possesses knowledge and skill society has permitted one to acquire precisely because it can benefit others. One also promises to help and to act on behalf of the good of the patient when one offers oneself to another as a healer. Further, without the special knowledge the healer has acquired others would suffer so that, in a sense, all the sick have some claim on all healers.40

Beneficence is a prime requirement for medicine and it has three specific

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obligations. First, the patient's problems and needs are the physician's primary concern, taking precedence, except in the rarest circumstances, over all other concerns. Second, harm must be avoided because the physician cannot fulfill the promise of helping if he intentionally harms the patient for any reason. Third, both autonomy and paternalism are superseded by the obligation to act beneficently, that is to say, the choice of whether one acts to foster autonomy, or acts paternalistically should be based on that which most benefits the patient and not the intellectual convictions or emotional impulses of the physician.

2) Primacy of the Existential Condition of the Patient

The second feature of the beneficence model is the primacy of the existential condition of the patient rather than of traditional professional codes. A good example can be found in Mark Siegler's list of criteria for deciding the limits of autonomy to be accepted by a physician treating a seriously ill patient. These criteria include the patient's ability to make rational choices about care, the nature and past values of the patient, the age of the patient, the nature of the illness, the values of the physician who must make a choice in the care of the patient, and the clinical setting, especially the diffusion of care. The first four items deal with the personal condition of the patient, and the last two deal with the health care professional and the environment. Presumably, Siegler does not mean that age should be considered an independent variable in making decisions, but rather as his subsequent writings would suggest, age is a valuable marker of the condition of the patient.

3) No Automatic Ranking of Values

Both the patient's autonomy and medical paternalism models emphasize single values which are always to be preferred. For example, the patient's right to autonomy is always to be preferred over other values in the patient's autonomy model. In the paternalism model, each patient must be treated as if he or she did not know what is best. By contrast, in the beneficent model, no such "automatic" ranking of values takes place. The elements of the beneficence model are not ranked in any pre-set hierarchy. Each patient must be handled individually not only for the medical but also for the moral implications. No ethical stance, other than acting for the patient's best interests, is applied beforehand. This model requires that patients and physicians become able to identify, rank, discuss, and negotiate values, and to define

42. Thomasma, Training in Medical Ethics: An Ethical Workup, 1 F. Med. 33 (1978).
the particular good of a particular patient. This is not to say, however, that general ethical axioms applied to more than one patient are invalid.

4) Consensus

The fourth feature of the model is consensus. Because there is to be no imposition of values, or decisions made in the best interests of patients without their participation, a consensus with the patient and with other members of the health care team is needed. Admittedly, a consensus model takes time and energy but it also wards off many agonizing hours of later conflict in the course of a serious illness. In fact, one of the seductions of the autonomy and paternalism models is the comparative ease of their decision-making mechanisms — either the physician makes all the decisions, or the patient does so. Both models abandon the trials and rewards of a mutual dialogue and exchange between doctor and patient.43 Both also can assault the moral agency of the patient or the physician.

A consensus reached at the beginning of a patient’s care cannot be assumed to continue unchanged as new developments occur. The consensus must be monitored for its continued validity. This requires a continuing dialogue between the patient and his medical attendants.

5) Prudential Moral Object

The fifth feature is a prudential moral object; i.e., an attempt must be made to resolve difficult ethical quandaries by preserving as many values of both the patient and physician as possible. Ackerman has argued that this should be the goal of bioethics.44 Whether or not one agrees entirely, it is a goal of a consensus-driven, patient-oriented approach in which prudential judgments are made on a patient-by-patient basis.

6) Axioms

Explicit axioms comprise the sixth and last major feature of the beneficence model. Just as the physician examines each patient in light of generalized theories or categories of disease and health, his prudential judgment about each patient must adhere to a series of more general ethical axioms, or moral rules. These are necessary to avoid the moral pitfalls of the autonomy and paternalism models, and of situational studies.

Axioms of the Beneficence Model

1) Both doctor and patient must be free to make informed decisions and to

43. J. Katz, supra note 3.
44. Ackerman, What Bioethics Should Be, 5 J. MED. & PHIL. 260 (1980).
act fully as moral agents. The values of both doctor and patient must be respected since each is a person deserving of respect as such. Value consensus results only if each can, without coercion or deception, express his own values in discourse and action. Neither can impose his values on the other; neither can “use” the other for selfish ends; each must be free to withdraw from the relationship if value conflicts are not resolvable.45

2) Physicians have the greater responsibility in the relationship because of the inherent inequality of information and power between themselves and those who are ill. Physicians are obliged therefore to provide the information patients need to make genuinely informed decisions, and to use their power with due regard for the vulnerability and exploitability of the sick. These obligations are rooted in the special nature of the healing relationship. The self-imposed moral aims of the profession and the expectations of society derive their force from this fact as well.

3) Physicians must be persons of personal moral integrity. The physician must have the capacity to make prudential judgments that factor in the particulars of each case, the general features of the disease and general moral principles. Ultimately, the good of the patient depends as much on the physician’s character as his capacity to make these judgments. Furthermore, it depends on the extent to which he can be trusted to keep the good of the patient as his primary aim.46 In a morally pluralistic society, there is a tendency to downplay moral character in the education of the physician. However, there are qualities of moral judgment that should apply to all physicians and for this they will need to be educated. As Aristotle noted, “it is impossible, or not easy, to do noble acts without the proper equipment.”47 Yet, skills without moral integrity will not suffice in those moments when no one is there to watch, thus the good of the patient hangs on the moral integrity of the physician.48

4) Physicians must respect and comprehend moral ambiguity yet not abandon the search for what is right and good in each decision. By training and disposition, physicians are inclined to diagnostic closure and problem resolution. They are dismayed when there is no single “right” answer to a moral dilemma. Yet in the beneficence model this may often be the case since the

47. ARISTOTLE, NICOMACHEAN ETHICS BOOK 43 (T. Page ed. 1934).
good is defined by principles and individuals in their life contexts without standardized formulae. Physicians must avoid the pitfalls so aptly described by Alasdair MacIntyre: "It is a central feature of contemporary moral debates that they are un unsettleable and interminable . . . [B]ecause no argument can be carried through to victorious conclusion, argument characteristically gives way to the mere and increasingly shrill battle of assertion with counter assertion."49 No matter how frustrating moral "debates" may be, the physician must still make moral decisions with, and for, his patients. It is incumbent upon him, therefore, to learn how to deal with the reality of moral ambiguity. He has not the scholar’s luxury of "on the one hand" and "on the other hand," etc. He just acts, and to act is to choose among alternatives — moral as well as technical.

CONCLUSION

The values of patient welfare and patient autonomy — which translate into the corresponding moral duties of beneficence and respect for persons — may come into tension with each other. In our view, however, these duties cannot remain in conflict if medicine is to achieve its goal of healing.

But healing, as we define it, is a form of assistance in making the patient whole again by working through his body. If the values of patient welfare and patient autonomy remain in conflict, then authentic healing cannot take place. A physician, therefore, must become a moderate autonomist, and a moderate welfarist, at once. This can be accomplished in a beneficence model like the one we suggest.

Another way of arriving at this position is to consider the principle of respect for persons. This principle leads to two moral duties. The first is to respect the self-determination or autonomy of others. The second, often-neglected duty, is to help restore that autonomy or help establish it when it is absent. Looked at in this way, beneficence is seen to be a direct consequence of a fundamental moral principle and the guiding duty of medicine. If this is true, then the autonomy model is necessarily incomplete.

Beneficence is the principle that prompts physicians to cite their moral commitments and personal support for patients beyond just respecting their rights. It is beneficence, not authoritarianism, as he incorrectly supposed, that prompted Ingelfinger to argue that doctors must recommend a course of action, not just lay out alternatives and abandon patients.50 It is also beneficence, not just respect for autonomy, that properly protects patients' rights.

50. Ingelfinger, supra note 29.
It is the primary duty of beneficence, and not paternalism, that has historically been the guiding norm of medicine.

To be sure, beneficence can be and has been subverted into paternalism. But if our task is “proposing revised values” as Callahan asserts, then it is important to focus on the virtue of benevolence (or the principle of beneficence) rather than on the rule of autonomy. This virtue is consistent with the ethical tradition of persons united in community. This is a tradition keeping more with the ethical roots of medicine than one that stresses autonomous individualism.

51. Callahan, Shattuck Lecture — Contemporary Biomedical Ethics. 302 NEW ENG. J. MED. 1228 (1980).