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MEDICAL PATERNALISM AND THE QUESTION OF PATIENTS' RIGHTS

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ABSTRACT
Medical paternalism refers to a practice in which healthcare professionals make decisions for patients on the grounds that doing so promotes the patients' welfare, even when those decisions conflict with the patients' expressed wishes. This paper examines the ethical tension between medical paternalism and patient rights, asking whether physicians can ever be morally justified in overriding a patient's autonomous choices for that patient's own good. The debate centers on a conflict between two foundational principles of bioethics: beneficence, the obligation to promote patient well-being, and respect for autonomy, the commitment to honoring individuals' rights to make their own decisions. Although modern healthcare places strong emphasis on informed consent, significant practical and philosophical disagreements remain regarding the limits of autonomy and the circumstances, if any, under which paternalistic intervention is warranted. Using a normative philosophical methodology, this paper engages in conceptual analysis and draws on influential liberal and bioethical theories, particularly those influenced by John Stuart Mill's harm principle and contemporary autonomy-focused accounts. It ultimately argues for a balanced ethical position that permits weak paternalism only when a patient's decision-making capacity is impaired, while firmly rejecting strong paternalism toward fully competent adults.

Keywords: Medical Paternalism, Patients' Rights, Ethics, Autonomy, Informed Consent, Beneficence

Introduction

Medical paternalism has historically been a key concern in bioethics, prompting important questions about medical authority, patient autonomy, and the essence of healthcare. In the past, physicians followed the Hippocratic Oath, prioritizing beneficence and non-maleficence, often with little attention to patient preferences. Tom L. Beauchamp and James F. Childress outlined what they described as the four foundational principles of biomedical ethics: autonomy, non-maleficence, beneficence, and justice. These principles are regarded as the basis of ethical decision-making and collectively emphasize the protection of human rights, especially in the context of patient care. The researchers identify autonomy as the first principle in biomedical ethics, applying it to assess how individuals make decisions in healthcare and research (Beauchamp et al, 2009: 99). Autonomy, derived from "autos" (self) and "nomos" (rule), refers to self-governance-being free from controlling interference by others and from limitations, such as insufficient understanding, that would hinder meaningful choices (Beauchamp et al, 2019: 99). Frequently regarded as a core ethical value, it reflects the strong emphasis placed on individual choice and self-determination. Also, for Wilkinson D, and Levy, autonomy is a key principle in medical ethics. It connects self-governance with rational thought and highlights the importance of individuals having both the ability and the freedom to make choices concerning their own lives (Wilkinson et al, 2024: 8).

Contemporary medical ethics, however, emphasizes patients' rights, especially the right to informed consent and the ability to refuse treatment just as Sarosh Saleem's in his paper titled, "*Argument for Consensual Paternalism in Shared Decision-Making: Rediscovering Autonomy in Western Bioethics*" (Sarosh, 2025:21) questioned the rigid divide between autonomy and paternalism in Western medicine and introduces the concept of "consensual paternalism," a model in which patients can voluntarily delegate decision-making to clinicians in partnership with them, promoting a more flexible, relational understanding of autonomy and shared decision-making. Although, Sarosh's position seems plausible but fail to take into account strong paternalism over fully competent adults. This evolution has sparked a philosophical debate: under what, if any circumstances is it morally acceptable for doctors to override a patient's decisions for their own benefit? Also, for Pugh, Autonomy is a central concept in medical ethics. It links self-governance with rationality and expresses the importance of individuals having the capacity and the freedom to make decisions about their own lives (Pugh, 2020).

Western bioethics has shifted over time from debates focused on paternalism versus individual autonomy toward an emphasis on shared decision-making. This model seeks to respect patient autonomy while fostering transparent communication and collaborative dialogue. In the context of decisions involving children and infants, responsibility is shared between parents and physicians, with parents' lived experiences and personal values playing a pivotal role. Nevertheless, Sarosh fails to tell us to what extent should physicians disclose their own values, preferences, or specific recommendations within this process.

Medical paternalism can be acceptable in certain situations where a patient's autonomy is compromised (weak paternalism); however, strong paternalism-disregarding the informed, voluntary choices of competent patients-is typically considered morally indefensible, as it infringes on both autonomy and human dignity (Christman, 2020). However, medical paternalism is often justified on the basis of beneficence. Physicians have specialized knowledge and clinical expertise that patients generally lack, and since health is widely considered an objective good, doctors are thought to be better equipped to determine what benefits a patient's well-being. From this viewpoint, intervening when a patient makes a harmful choice is framed not as oppression, but as a professional duty.

Historically, this perspective shaped medical practice. Physicians frequently withheld information or made decisions without patient input, believing that full disclosure could cause

distress or lead to poor choices. This paternalistic approach was grounded in the belief that doctors acted in the best interest of their patients. Thus, this position fails to take into account cultural and religion disposition of patients who believes that health is not the sole priority people may hold. A patient may place greater importance on religious obligations, quality of life, autonomy, or a sense of personal identity than on simply extending lifespan. A physician is not justified in enforcing one uniform vision of the "good life" on all patients, which also contradict the principle of informed consent just as been postulated in the works of both Mill and Kant while emphasizing the importance of autonomy and posits thus:

> Kant argued that respect for autonomy flows from the recognition that all persons have unconditional worth…To violate a person's autonomy is to treat that person merely as a means; that is, in accordance with others' goals without regard to that person's own goals…Mill's position requires both not interfering with and actively strengthening autonomous expression….In their different ways, these two philosophers both support a principle of respect for autonomy (Beauchamp et al, 2009: 103).

So, strong paternalism can amount to moral overconfidence, presuming that medical professionals have not only clinical expertise but also superior authority over deeply personal values.

Consequently, paternalism is categorized as either weak or strong. Weak paternalism occurs when a patient's choice is not fully voluntary-due to misinformation, coercion, mental illness, or impaired capacity-and intervention serves to restore or protect genuine autonomy. Strong paternalism, by contrast, overrides the informed and voluntary decisions of a competent adult simply because the physician deems the choice unwise or potentially harmful. Advocates of limited paternalism argue that patients are often vulnerable, anxious, or overwhelmed. Medical information can be complex, and cognitive biases may distort judgment. Consequently, an uncompromising insistence on autonomy could leave patients without adequate support or exposed to serious harm. Thus, this paper aim to critically assess whether medical paternalism can be morally defended, distinguishing between its weak and strong versions and examining how each aligns with current theories of autonomy and liberal ethical thought.

Moral Concerns of Medical Paternalism

The contemporary focus on patients' rights arose in part as a response to historical abuses in medical practice and experimentation, particularly those revealed during the Nuremberg Trials which exposed unethical practices in medicine. This movement strengthened (a) informed consent, bodily integrity, right to refuse treatment, shared decision-making; and (b) autonomy-based arguments assert that: individuals are moral agents, each person has sovereignty over their body and respecting autonomy is not merely instrumental but intrinsic. Therefore, even when a patient makes a decision that doctors view as irrational, overriding that choice could be morally wrong.

These events underscored the ethical importance of informed consent and respect for bodily integrity. Logically, opposition to strong paternalism draws heavily on liberal political thought, especially the ideas of John Stuart Mill's "On Liberty", Mill's harm principle holds that power may only be exercised over individuals against their will to prevent harm to others, not to shield them from themselves (Beck, 2014). In a medical context, this principle implies that a competent adult has the moral right to refuse treatment, even if it is life-saving. However, respecting autonomy is rooted in the recognition of individuals as self-governing moral agents. Overriding a competent patient's choice treats them as incapable of rational decision-making, undermining their dignity and reducing them to passive subjects of professional authority.

Similarly, Beauchamp opines that, 'paternalism willfully jettisons patients rights to autonomy in which it becomes difficult for patients to make informed decision about their health care' (Beauchamp, 2001:106). Paternalism can also undermine patient education and empowerment, both of which are essential for effective healthcare management. Advocates of paternalism fail to admit that it often fails to uphold patients' rights to privacy, self-determination, and confidentiality. Because it places considerable authority in the hands of physicians, there is a risk of that power being misused. It may also contribute to systemic injustices, such as sexism and racism, within the healthcare system. By prioritizing physicians' values over patients' beliefs, paternalism disregards individual perspectives and preferences. Furthermore, it can weaken the trust that is crucial for effective and efficient care, thereby damaging the physician–patient relationship, whereas, patients who actively ask questions and participate in discussions with their healthcare providers tend to experience improved health outcomes, greater satisfaction, and enhanced quality of life. When comprehensive medical training supports clinicians in developing strong communication skills, they are better equipped to build trust and strengthen the doctor–patient relationship (Micelle, 2019).

Furthermore, one highly influential and widely cited framework is that of Emanuel and Emanuel. In their groundbreaking paper, they examined the "doctor–patient relationship" (Emanuel et al, 1992: 2221) in the context of information sharing and medical decision-making. They outlined four types of interactions, ranging from an 'informative model' at one end (where the doctor provides factual information and the patient makes the decision) to a 'paternalistic model' at the other (where the doctor determines the best course of action and simply seeks the patient's agreement). In between, they described an 'interpretive model', where the physician, acting like a counselor, helps the patient clarify and apply their personal values to the decision. Lastly, they proposed and recommended a 'deliberative model', in which the doctor engages in a discussion to persuade the patient about the most beneficial choice for their well-being. Over the years, others have built upon this framework. For example, Veatch introduced the concept of deep value pairing, where patients seek physicians who share their core values (Veatch, 1995:5). In response, Savulescu advocated for a 'liberal rationalist model',(Savulescu, 1997: 115) similar to the deliberative model, focused on promoting objective well-being. More recently, Davies and Parker have proposed an 'appointed fiduciary' model, offering a structure for cases in which patients explicitly ask doctors to make the decision for them with the instruction, "Doctor, you do what you think is best"(Davies et al, 2022: 23).

Conversely, we believe that when a physician succumb to a pressure from a patient without recourse to his/her family especially when the patient is impaired, this proposed model is amounted to euthanasia, i.e practice of mercifully ending a person's life in order to release the person from an incurable disease, intolerable suffering, or undignified death. Rather than physicians seeing their assistance as a duty, there is a better choice; namely addressing the underlying despair that leads to suicidal thoughts in the first place. It bears concern for the well-being of the patients and the medical personnel as well. Health sciences professor Amber Comer points out the position of the AMA:

> The American Medical Association (AMA) Code of Medical Ethics does not condone physician participation, calling the practice "fundamentally incompatible with the physician's role as healer." As an alternative to PAD (physician-aid-in-dying), the AMA advocates aggressive multidisciplinary interventions including emotional support and adequate pain control (Amber, 2019).

Although arguments based on autonomy are compelling, completely rejecting paternalism is not without challenges. Autonomy depends on a patient being competent, adequately informed, and free from coercion-conditions that are not always present in practice. For example, patients suffering from intense pain, depression, or cognitive impairment may lack the full capacity for

rational decision-making. In such cases, temporary paternalistic intervention can help safeguard the patient's long-term autonomy. Even competent individuals, however, can be influenced by misinformation or emotional biases, meaning a strictly hands-off approach may overlook the relational aspects of medical decision-making. Further, public health situations further complicate the picture. When an individual's choice endangers others-such as refusing vaccination during an infectious outbreak-the justification for intervention shifts from protecting the patient to preventing harm to the community. Here, limiting autonomy may be ethically defensible not for the patient's benefit, but for society's safety. Thus, the principle of autonomy cannot be applied rigidly. Ethical medical practice requires careful evaluation of competence, context, and potential outcomes rather than adherence to an absolute rule.

From the foregoing, this work critically explores the ambiguity surrounding medical paternalism and patients' rights, analyzing the historical and cultural influences that have shaped this dynamic. It examines the ethical implications of medical paternalism, its impact on vulnerable groups, and the need for a shift toward patient-centered care that emphasizes patients' values, preferences, and capacity for decision-making.

Critical Evaluation of Medical Paternalism

The core philosophical conflict centers on beneficence versus autonomy. Beneficence focuses on promoting a patient's well-being, while autonomy emphasizes respecting an individual's right to self-determination. Both are ethically important, but autonomy carries particular weight in modern liberal societies, as it safeguards dignity and protects against abuses of power.

Weak paternalism may be ethically defensible when a patient's autonomy is clearly impaired, with interventions aimed at ensuring decisions are truly informed and voluntary. In contrast, strong paternalism over competent adults is generally morally unacceptable because it imposes the physician's values over the patient's own.

A balanced approach-commonly referred to as shared decision-making-provides a practical middle ground. In this model, the physician offers expertise, guidance, and recommendations, while the competent patient retains the authority to make the final choice. This framework respects autonomy while recognizing the value of professional input. One major factor that vitiates this approach is the non recognition of input from the patient's relative. On his part, Machado noted that, over time, paternalism has often restricted patients' education and empowerment. Rather than promoting open communication, it fosters a culture of silence and compliance. Paternalism also conflicts with key ethical principles, including beneficence, respect for autonomy, and social justice, while undermining the value of patient-centered care and shared decision-making (Machado, 2012: 46). Conversely, implicit bias shapes the dynamics of the physician–patient relationship, influences subsequent care, and ultimately impacts patient health. Many healthcare professionals harbor implicit biases toward certain racial and ethnic groups, particularly in the management of conditions such as cancer and diabetes. As a result, clinical interactions may feel strained or inauthentic. Continuity of care can also be compromised when patients must see multiple clinicians before finding one with whom they feel at ease. Machado also fails to make case for handling of implicit bias on the part of physicians in this particular instance.

Justification of Medical Paternalism

Although medical paternalism has been widely criticized, it may be defensible in certain circumstances when applied carefully and within appropriate limits. For example, it can be justified in emergencies-such as severe bleeding or cardiac arrest-when immediate action is required and the patient is unable to provide informed consent. It may also be acceptable in cultural or religious contexts where decision-making authority is traditionally vested in the family or community rather than the individual. Additionally, paternalism can be warranted in cases involving patients with significant cognitive impairment or incapacity, or when patients

voluntarily choose to delegate decision-making authority to their physicians (Harris, 2018:251). However, notwithstanding strong objections to paternalism, Douglas argues that a temporary, beneficent intervention in a person's actions may at times be morally justified, and maintains that:

> A person who is ignorant of a significant risk for example, in starting to cross a dangerous bridge may justifiably be restrained in order to ensure that he or she is acting intentionally and with adequate knowledge of the consequences of this action. Once warned, the person should be free to choose whatever course he or she desires. Because mill did not regard this temporary intervention as a "real infringement" of liberty, he did not view it as paternalistic (Douglas, 2003:49).

However, paternalism is unjustifiable when a physician's decisions are shaped by personal bias or emotion, when patients are capable of making informed choices, when they are considering alternative options, or when treatment decisions are complex and require time for careful deliberation. It is also inappropriate when patients' values and preferences differ from those of the physician and are disregarded. Paternalism can undermine patient education and empowerment, both of which are crucial for effective healthcare management. It often fails to uphold patients' rights to privacy, self-determination, and confidentiality. Physicians holding considerable authority may misuse this power, and paternalism can reinforce systemic injustices, including sexism and racism, within the healthcare system. By prioritizing physicians' values over patients' beliefs, it disrespects individual values. Moreover, the trust essential for efficient and effective care between physicians and patients can be weakened, further eroding the physician–patient relationship. Therefore, it is suggested that paternalism should be limited to exceptional circumstances. Greater emphasis must be placed on patient-centered care, shared decision-making and consistent respect for patients' autonomy, dignity, and informed consent.

Thus, Tradition significantly influences medical practice by upholding established procedures and hierarchical structures. It emphasizes acting in the patient's best interest according to the principle of beneficence, maintaining high efficiency in professional duties, and ensuring that physicians protect patients from harm while confidently exercising authority within their area of expertise (Sandman, 2010: 60).

Similarly, medical decisions often affect individuals beyond the patient receiving treatment. For instance, during treatment and recovery, a man may be unable to help care for his children. Someone might believe that prolonged suffering would place an emotional burden on a partner and choose to decline treatment for that reason to the extent that such decisions consider the impact on others and evaluate how pursuing or foregoing treatment may affect them, it is appropriate that they be made in consultation with those involved.

Conclusion

Medical paternalism highlights the enduring tension between providing care and exercising control. Historically, medicine emphasized the authority of physicians, but contemporary bioethics places greater importance on patients' rights and informed consent. Philosophical examination suggests that while limited (weak) paternalism can be justified when a patient's autonomy is compromised, strong paternalism over competent individuals infringes on basic principles of liberty and human dignity. A morally sound healthcare system, therefore, must treat patients as autonomous decision-makers while applying professional expertise responsibly (Alsan et al, 2023). The goal is not to choose between autonomy and beneficence, but to balance them in a way that safeguards both individual well-being and personal freedom. The aim is not to remove professional guidance entirely, but to ensure that medical authority aids and reinforces patient self-determination rather than supplanting it. It is therefore recommended that physicians should prioritize the following: address health disparities where it exists and respect patients' cultural sensitivity. Conferences, discussions

and research must continue to examine the impact of medical paternalism on the vulnerable and efficiency of patients-centered approaches. Laws and policies that would protect patients' rights should be enacted as well as respecting the decision-making rights of patients, and patients must have access to education which will enlighten them to play active roles in their health matters.

References

Amber, M. (2019). "Choosing Death over Suffering", Harvard *Medical School*. (https://bioethics.hms.harvard.edu/journal/choosing-death)

Alsan, M., et al. (2023). Healthcare in U.S. Correctional Facilities—A Limited and Threatened Constitutional Right. *New England Journal of Medicine*, 388, (9). (https://www.nejm.org/doi/full/10.1056/NEJMms2211252)

Beauchamp, T. L., & Childress, J. F. (2019). "Principles of Biomedical Ethics" (8th ed.). Oxford University Press.

Beck, J. (2014). "Do no harm": When Doctors Torture. *The Atlantic.* (https://www.theatlantic.com/health/archive/2014/12/do-no-harm-when-doctors-torture/383677/)

Christman, J. (2020). "Autonomy in moral and political philosophy". In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Fall 2020 ed.). (https://plato.stanford.edu/archives/fall2020/entries/autonomy-moral/)

Davies, B., & Parker, J. (2022). Doctors as Appointed Fiduciaries: A Supplemental Model for Medical Decision-Making. *Cambridge Quarterly of Healthcare Ethics*, 31, 23–33.

Douglas, H. (2003). Legal Paternalism. In H. LaFollette (Ed.), *The Oxford Handbook of Practical Ethics*. Oxford University Press.

Emanuel, E. J., & Emanuel, L. L. (1992). Four Models of the Physician-Patient Relationship. *Journal of the American Medical Association*, 267, 2221–2226.

Harris, P. L., Koenig, M. A., Corriveau, K. H., et al. (2018). Cognitive Foundations of Learning from Testimony. *Annual Review of Psychology,* 69, 251–273.

Machado, K. K., & Hoff, P. M. (2012). Autonomy versus Paternalism in Latin America. *Oncology* (Williston Park), 26(1), 46–47.

Micelle, P. (2019). Patient Care: How to Master the Doctor-Patient Relationship. *National Library of Medicine*.

Pugh, J. (2020). Autonomy, Rationality, and Contemporary Bioethics. Oxford University Press.

Saleem, S. (2025). Argument for Consensual Paternalism in Shared Decision-Making: Rediscovering Autonomy in Western Bioethics. *Journal of Medical Ethics*, 40(1), 21–26.

Sandman, L., & Munthe, C. (2010). Shared Decision Making, Paternalism and Patient Choice. *Health Care Analysis*, 18(1), 60–84.

Savulescu, J. (1997). Liberal Rationalism and Medical Decision-Making. *Bioethics*, 11, 115–129.

Veatch, R. M. (1995). Abandoning Informed Consent. *Hastings Center Report,* 25, 5–12.

Wilkinson, D., & Levy, N. (2024). Scaffolding Informed Consent. *Journal of Medical Ethics,* 2, 1–8. (https://doi.org/10.1136/jme-2024-110105)