Ackerman and Goldman on Paternalism

Posted on October 11, 2022

Medical paternalism concerns the extent to which healthcare professionals may limit a patient's choices in order to protect that patient's health or welfare. The debate becomes especially important when a physician believes that a patient is making a harmful decision, while the patient believes that personal values, risks, or goals justify that choice. Alan Goldman and Terrence Ackerman approach this problem differently. Goldman emphasizes autonomy and argues that competent adults generally have the right to decide what happens to their bodies, even when physicians disagree. Ackerman accepts autonomy as an important value but argues that illness can sometimes undermine the conditions required for meaningful self-direction, creating situations in which professional intervention may be justified. The disagreement is therefore not simply between a doctor who cares and a patient who refuses care. It concerns the meaning of competence, the limits of professional authority, and the ethical relationship between medical expertise and personal values.

Ackerman and Goldman on Paternalism

Medical Paternalism and Patient Autonomy

Paternalism occurs when one person restricts another person's choices on the grounds that the restriction will protect or benefit that person. In medicine, paternalism may involve withholding information, overriding refusal, limiting options, or proceeding with treatment because a clinician believes the patient's decision is misguided. Historically, medicine often assumed that the physician's training gave the physician broad authority to decide what was best. Modern bioethics shifted toward informed consent, privacy, disclosure, and the right of competent patients to accept or refuse treatment.

Autonomy does not mean that physicians become passive technicians who simply carry out whatever a patient requests. A physician remains responsible for explaining the diagnosis, realistic alternatives, likely benefits, risks, uncertainties, and consequences of refusing care. Patients need accurate information before they can make informed choices. The ethical question is what should happen after that information has been provided and a competent patient still chooses an option that the clinician believes is unwise.

Goldman's Critique of Medical Paternalism

Goldman's argument gives strong weight to the patient's right to organize life according to personal values. A medical decision is rarely about health alone. Treatment may affect pain, independence, family responsibilities, religious commitments, work, finances, identity, and the amount of risk a person is willing to accept. A physician can estimate medical outcomes, but cannot automatically determine how every patient should rank these competing goods. This is one reason Goldman argued that medical paternalism can violate a person's own "value ordering."

Goldman also challenges the assumption that professional expertise creates general authority over another adult's life. Clinical knowledge is highly relevant to diagnosis and prognosis, but the patient possesses knowledge of personal goals, tolerances, relationships, and priorities. A treatment that maximizes survival may not be the option a patient values most if it produces severe disability, prolonged dependence, or burdens the patient considers unacceptable. Respecting autonomy therefore recognizes that healthcare decisions combine medical facts with judgments about what kind of life is worth pursuing.

This position does not require accepting every patient preference as reasonable. Physicians may question inconsistent beliefs, correct misinformation, recommend strongly against dangerous choices, and ask whether a decision reflects coercion or misunderstanding. What Goldman resists is the move from persuasion to control when the patient remains competent and understands the consequences.

Ackerman’s Argument for Intervention

Ackerman emphasizes that illness can affect autonomy itself. Severe pain, fear, depression, delirium, intoxication, cognitive impairment, trauma, or overwhelming anxiety may interfere with a patient’s ability to understand information or connect present decisions with long-term goals. In such situations, simply stepping back in the name of autonomy may fail to respect the person. If a temporary condition is preventing the patient from acting according to stable values, intervention may help restore the conditions under which genuine self-direction becomes possible.

This argument is strongest when it focuses on impaired decision-making rather than on the idea that patients are generally less rational than doctors. A patient should not be considered incompetent merely because the physician dislikes the decision. Competence and decision-making capacity require attention to whether the person can understand relevant information, appreciate the situation and consequences, reason about options, and communicate a choice. A refusal that appears medically risky may still be autonomous if these conditions are present.

Ackerman’s position also highlights the duty of beneficence. Physicians are not indifferent observers. They are professionally obligated to prevent avoidable harm, especially when a patient is temporarily unable to protect personal interests. Emergency treatment for an unconscious patient, for example, is usually justified because immediate action is necessary and the person cannot express a preference. The ethical challenge is preventing this limited justification from expanding into routine override of capable adults.

Capacity, Trust, and Informed Consent

The most defensible approach is to treat autonomy as a process rather than a single signature on a consent form. Patients may need time, repeated explanation, interpretation, pain control, family support, or mental-health assessment before they can make a stable decision. Clinicians should ask whether confusion can be corrected and whether the patient’s reasoning changes after reversible barriers are addressed. A person who initially refuses treatment while panicking may choose differently once fear is reduced, while another may understand the same risks clearly and continue to refuse. Those situations should not be treated as identical.

Capacity is also decision-specific. A person may be able to choose what to eat, where to live, or which routine medication to take while lacking the ability to understand a highly complex treatment decision involving uncertain outcomes. Capacity can also fluctuate over time. Delirium, medication effects, severe infection, or acute mental distress may temporarily reduce understanding and later improve. For this reason, clinicians should avoid treating one impaired moment as proof of permanent incompetence. Reassessment, supported communication, and attention to reversible causes can protect both autonomy and safety.

Trust is central because patients are more likely to consider difficult recommendations when they believe the clinician is honest and respectful. Withholding information or overriding preferences without clear justification can damage that trust. The patient may begin to suspect that cooperation means surrendering control. By contrast, a clinician who explains concerns openly, acknowledges uncertainty, and invites questions can influence decisions without coercion. Good communication therefore reduces the perceived need for paternalism.

Family, Nurses, and the Wider Care Team

Medical decisions often involve more than one physician and one patient. Nurses, social workers, therapists, interpreters, pharmacists, family members, and other professionals may contribute information about the patient's values, daily functioning, and support system. Their involvement can improve understanding, but they should not displace the competent patient. Family members may be emotionally important and may help clarify longstanding preferences, yet their wishes are not automatically decisive when the patient can decide independently.

When a patient lacks capacity, family or legally authorized surrogates may be asked to decide according to prior wishes or the patient's best interests. Even then, the goal should be to preserve as much participation as possible. A person who lacks capacity for one complex decision may still be able to express values, preferences, and fears that should shape the final plan.

When Paternalism May Be Justified

Limited paternalistic intervention can be ethically defensible in emergencies, severe temporary incapacity, or situations involving immediate danger when meaningful consent cannot be obtained. The justification becomes weaker as the patient's capacity, understanding, and ability to deliberate increase. A competent adult's refusal should not be overridden simply because the physician believes another choice would be healthier.

The distinction between soft and hard paternalism is useful. Soft paternalism intervenes when decision-making is impaired or insufficiently informed and aims to restore autonomous choice. Hard paternalism overrides a competent and informed person for that person's own benefit. Contemporary medical ethics generally finds soft paternalism easier to justify because it protects autonomy rather than replacing it. Hard paternalism requires a much stronger argument and is ordinarily inconsistent with informed-consent standards.

Conclusion

The debate between Goldman and Ackerman shows that autonomy and beneficence should not be treated as enemies. Goldman correctly emphasizes that medical expertise does not give physicians

authority to determine every competent patient's values. Ackerman contributes the important insight that illness can sometimes weaken the very capacities that make autonomous choice possible. The ethical task is therefore to distinguish disagreement from incapacity. Physicians should provide accurate information, assess understanding, address reversible barriers to decision-making, and persuade when they believe a choice is dangerous. Intervention may be justified when capacity is genuinely impaired, but a competent adult's informed decision should ordinarily remain controlling. Respectful medicine protects health without turning professional expertise into ownership of the patient's life.

References

Goldman, A. "The Refutation of Medical Paternalism." In Steinbock, London, and Arras, eds., *Ethical Issues in Modern Medicine*, 7th ed., McGraw-Hill, 2009, pp. 62–70.

Ackerman, T. "Why Doctors Should Intervene." In Steinbock, London, and Arras, eds., *Ethical Issues in Modern Medicine*, 7th ed., McGraw-Hill, 2009, pp. 73–77.

Beauchamp, T. L., & Childress, J. F. *Principles of Biomedical Ethics*. Oxford University Press.

Appelbaum, P. S. Assessment of patients' competence to consent to treatment. *New England Journal of Medicine*.

Grisso, T., & Appelbaum, P. S. *Assessing Competence to Consent to Treatment*. Oxford University Press.