Paternalism in Nursing and Healthcare: Central Issues and Their Relation to Theory

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Paternalistic practices, wherein providers confer a treatment or service upon a person or persons without their consent, ostensibly by reason of their limited autonomy or diminished capacity, are widespread in healthcare and in societies around the world. In the United States, paternalism in health and human services is widespread and probably increasing with newly emergent forms. Numerous issues surround paternalistic practices. In this column, the author examines these issues in relation to theory development in healthcare and nursing as well as theory as a guide to practice. It is suggested that scientific and ethical knowing are not separate but must be united in theoretical structures that include both in unity, along with an appreciation of the infinite complexity of life as it is humanly lived. It is also suggested that nursing’s unique theory base of frameworks that honor human dignity and focus on human experience offers an opportunity for leadership in further developing theoretical frameworks that transcend paternalistic practices.

For millennia, persons possessing knowledge and power have made assertions about how other members of society should live and have held sway over the conduct and life patterns of people deemed to be less competent than they. Civilizations around the world have systematized beliefs, policies, and methods to ensure that what these powerful persons believe to be good is the permitted and prevalent mode of conduct among the less knowledgeable, less competent, and less powerful. The authority of a patriarch over his family, clan, or tribe was the model for such power relations, which are therefore now considered paternalistic. The word paternalism also alludes to patriarchal power structures and thus has a certain fit with the historical roots of contemporary dilemmas raised by paternalism.

Paternalism, Beneficence, and Autonomy

Generally, an act (or the omission of an act) can be said to be paternalistic when it is carried out intentionally on behalf of a person other than oneself, against that person’s wishes or without consent, with the explicit purpose of doing good for, or avoiding harm to, that person (Beauchamp & Childress, 2001; Mead, 1997; Szasz, 1994; VanDeVeer, 1986). Importantly, it is the good of the targeted person or group that provides the impetus for paternalistic decision making and action. It is equally important to note that paternalistic rationales for decision making and action have been invoked systematically to dominate and control persons on the basis of their sex, sexual orientation, race, ethnicity, religion, class, and other’s judgments about their sanity and health (Szasz, 1994; White, 2000). In democratic societies, paternalism is increasingly regarded as outdated, rarely justified as a relation between adults, and diminishing rightly in our time. Yet paternalism is without a doubt very widespread. VanDeVeer (1986) lists 40 common examples of paternalism in contemporary Western societies, and the reader, upon reflection, can easily name others. As a widespread yet controversial way of organizing and delivering healthcare and other services to people, paternalism is an important topic for scholars in nursing and healthcare to consider.

In healthcare, paternalism is commonly framed in terms of the conflict between the primary obligation of physicians, nurses, and other provider-practitioners to abide by the principle of beneficence in their practice and the assertion of the rights of persons who are receiving services to make autonomous decisions about their lives. Often embedded in the discussions of the conflict of ethical principles in paternalism is an assumption that the recommended interventions of healthcare professionals are encompassed by and represent beneficence with regard to the care of people’s health. It is evident that authorities in healthcare and bioethics tend to be-
lieve that persons ought to do what healthcare professionals recommend to maintain their health. Despite the historical abuses of paternalism, this bias remains remarkably consistent. Beauchamp and Childress (2001) noted, “Medicine has in recent years increasingly confronted assertions of patients’ rights to make independent judgments about their medical fate. As assertions of autonomy rights have increased, the problem of paternalism has loomed larger” (p. 176).

Paternalism as Essentially Interventionist

It is important to keep in mind that paternalism as defined by scholars in bioethics and public policy is more than just an attitude. Paternalism involves an intervention that is unwanted, or the deliberate withholding of something that is wanted, by the targeted person or group (Beauchamp & Childress, 2001; Mead, 1997; Szasz, 1994; VanDeVeer, 1986). While much attention has been given to the question of the capacity or lack of capacity for autonomous decision-making among the targeted persons or groups, far less attention has been given to the question of the depth and genuineness of the beneficent intent of provider-practitioners and policymakers. Paternalism almost always means that events unfold in persons’ lives in ways that they themselves have not explicitly chosen, since the provider-practitioner instead overrides the preferences of the recipient(s) of care.

The relation between the knowledge bases of health-related disciplines and paternalistic policies and actions is crucial. Since all health-related disciplines purport to be guided primarily by scientific principles, and, indeed, their academic branches exist to generate and disseminate such principles, it is important that such principles be constructed, tested, and offered as guides to practice within the context of an abiding awareness of the potential for abuse. Anything can be said to be beneficent in intent. For scholars and practitioners in the health sciences the paternalistic pattern of relations, assuming both beneficence on the part of the scholar-practitioner and a problem on the part of the healthcare recipient, is the path of least resistance and of self-interest. It is all too easy to produce frameworks to guide practice that perpetuate historical patterns of paternalistic relations between provider-practitioners and recipients of care, even if the frameworks are used to generate new and better interventions.

Paternalism Is Widespread and Probably Increasing

In this widely heralded era of consumerism, apprehending the scope of paternalism in contemporary healthcare calls for a broad examination of extant policies and patterns of practice. Real life is infinitely more complex than Huxley (1946) or Orwell (1949) could have anticipated in their dystopian novels Brave New World and Nineteen Eighty-Four, respectively. The growth of democracy and the incremental advances in the political freedoms extended to people make it more difficult to discern the ways in which powerful elites and depersonalized social systems continue to exert power over others. Further complicating attempts to understand the extent of paternalism in today’s world is the success of public health initiatives over the past two centuries and the convincing justifications in beneficence that underpin these endeavors. In broad terms, many policies, acts, and patterns of relating can be said to be paternalistic, such as the following examples: building codes; legal requirements for clean water and the safety of agricultural products; restrictions on com-
merce; restraint of the free market; compulsory education of the young; prohibitions on public drunkenness; fluoridation of water supplies; prohibitions on purchasing and possessing firearms; and minimum wage laws prohibiting wages for which some persons would be willing to work.

Mead (1997) and others have explicated a number of ways in which many contemporary social policies constitute a new paternalism. Indeed, Mead and colleagues advocate for continued and expanded use of such policies in the interest of human betterment. Examples include welfare-to-work programs, enforced child support programs, and abstinence-only policies (as in drug rehabilitation, pregnancy prevention, and so on). When framed in beneficence and oriented toward narrowly defined objectives, the goals of peace and order in society and the resolution of many individual problems can be pursued effectively in many instances through paternalistic policies and interventions. Although there may be a need to revisit and reconceptualize what is currently regarded as paternalism, it cannot be regarded simplistically as an evil to be eliminated from the world.

Some common paternalistic policies in healthcare include the following: legal requirements for vaccinations against diseases; restrictions on drug availability and use; requirements for informed consent to undergo medical procedures; requirements for informed consent to participate in research; and legal confinement of persons deemed to be a danger to themselves in psychiatric care facilities. These are just a few of the broad and overt examples. Equally or more pervasive are the subtle one-on-one acts of provider-practitioners who behave paternalistically toward individuals. The impression that paternalism is outdated, rarely justified, and diminishing in our time seems to stem from an assumption that there is an unambiguous dividing line between overt paternalism and pervasive public and institutional policies, an assumption that does not stand up to scrutiny. Policy making, like science, is fraught with fundamental uncertainties, shifting foundational assumptions, political pressures, competing interests, and imperfect communications. Even the utilitarian principle of the greater good for the greater number cannot be applied in real life with certainty since it is impossible for all members of society to participate in the process of defining what is good. It is no accident that beneficence is the foundational principle that occurs in the contexts of these relationships. The assumption that the provider-practitioner’s well-intentioned best judgment adequately represents the desired outcome for the person is untenable.

**Weak and Strong Varieties of Paternalism**

Beauchamp and Childress (2001) make a distinction between weak paternalism and strong paternalism. “In weak paternalism, an agent intervenes on grounds of beneficence or nonmaleficence only to prevent substantially nonvoluntary conduct—that is, to protect persons against their own substantially nonautonomous action[s]” (p. 181). This is commonly the case when persons are deemed to be too uninformed, too depressed, too much under the control of their addiction(s), or otherwise incapable of making a decision that most adults would judge to be informed and at least minimally reasoned. “Strong paternalism, by contrast, involves interventions intended to benefit a person, despite the fact that the person’s risky choices and actions are informed, voluntary, and autonomous” (p. 181). The preponderance of the literature indicates that most authors find weak paternalism to be widely justifiable and strong paternalism far more difficult to defend. Beauchamp and Childress (2001) go so far as to say that weak paternalism may really need no defense, as serious objections are rarely raised against it. They go on to outline conditions that justify strong paternalism.

1. A patient is at risk of a significant, preventable harm.
2. The paternalistic action will probably prevent the harm.
3. The projected benefits to the patient of the paternalistic action outweigh its risks to the patient.
4. The least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted. (p. 186)

They add, “We are tempted to add a fifth condition requiring that a paternalistic action not substantially restrict autonomy. This condition could be satisfied only if vital or substantial autonomy interests are not at stake” (pp. 186–187). The case example given is one that is generically familiar to most nurses, a case of whether to put side rails up on the bed of a hospitalized patient who did not want the side rails up (the nurse did put them up). The authors argue that strong paternalism was justified to prevent the patient from the potential harm of a fall. Here it should be noted that research has not shown that having side rails up reduces falls (Capezuti, Maislin, Strumpf, & Evans, 2002; Mosley, Galindo-Ciocon, Peak, & West, 1998).

The judgment rendered was based on a belief that the intervention unwanted by the patient was likely to have the result desired by the provider-practitioner—a belief that even bioethicists who later cited the example failed to question—but this belief was unsupported and turns out to have been in error. More scholarly inquiry of all kinds, including philosophical and qualitative-descriptive as well as quantitative/empirical, is direly needed to enhance understanding of the multidimensional processes involved in relations between provider-practitioners and clients and the decision making that occurs in the contexts of these relationships. The assumption that the provider-practitioner’s well-intentioned best judgment adequately represents the desired outcome for the person is untenable.

**Paternalism Is Aimed at the Poor, Minorities, and Those With Less Power**

Paternalism may be extremely widespread, but this does not mean that paternalism is not practiced selectively. Certain
persons are far more likely than others to be treated in a paternalistic manner. In paternalistic modes of relating, it is those persons more in need of assistance and less capable of autonomous decision-making upon whom paternalistic interventions are imposed. Thus, it should come as no surprise that the familiar categories of privilege and advantage in society—sex, race, ethnicity, class, sexual orientation, physical attractiveness, and social conformity—are strongly in evidence in the real world in which paternalistic patterns of practice prevail. Paternalistic interventions are aimed selectively at the poor, at minorities, and at those with less power, such as those who live with chronic physical illness or serious and persistent mental illness.

Social Constructions of Beneficence and Autonomy: Real-Life Interventions

Beneficence and autonomy are concepts that are socially constructed and can be bent to the argumentative needs of the persons invoking them. Both the beneficent intent of the provider-practitioner and the relative autonomy of the recipient of care are always open to debate in light of the infinite complexity of human affairs. Historically, beneficent intentions have led to interventions such as forced medication, restraints, incarceration, prolonged bedrest, forced icebaths, electroconvulsive therapy, castration, lobotomy, forced drug withdrawal, isolation, mandated psychotherapy, sterilization, and mandated attendance at religiously based 12-step groups, to name but a few. The presumption of diminished autonomy has been imposed on women, enslaved persons, poor persons (especially those who are indigent or homeless), persons of minority races and ethnicities, persons of minority sexual orientations, persons living with disabilities, and persons living with mental illness. Szasz (1994) quoted C. S. Lewis describing the resulting pattern of relations vis-à-vis paternalistic mental healthcare.

Of all the tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive. . . . To be “cured” against one’s will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason or those who never will; to be classed with infants, imbeciles, and domestic animals. . . . For if crime and disease are to be regarded as the same thing, it follows that any state of mind which our masters choose to call “disease” can be treated as a crime; and compulsorily cured. . . . Even if the treatment is painful, even if it is lifelong, even if it is fatal, that will be only a regrettable accident; the intention was purely therapeutic. (p. 8)

Science Is Not Neutral

In many cases, then, it would appear that strong paternalism has masqueraded successfully as weak paternalism and that the wisdom to determine the difference has been uncommon among healthcare provider-practitioners. It is insupportable to claim that science in and of itself is neutral in these matters or that it has merely been used as a tool of oppression by misguided practitioners. The relevant science in and of itself has been intricately involved in the oppressive practices that have brought harm to real people in a way that, in retrospect, is roundly regarded as unjustified, though it was regarded as quite justified at the time. Scholars and practitioners in the healthcare sciences cannot take refuge in an assertion that scientific theory itself and the actual manner of implementing a theory-based intervention are somehow in separate ethical categories. Rather, we are obliged to examine the theory base of our disciplines for ways in which unjustified paternalism (or strong paternalism masquerading as weak paternalism) may be embedded subtly in the theory base that guides practice.

Paternalism and Nursing Theories

Many kinds of knowledge and rules guide actual, ordinary nursing practice, including medical science, institutional policies, and professional standards. The discipline of nursing has stewardship, however, only of nursing theories—the frameworks rooted explicitly in a philosophy of nursing and intended solely to guide nursing research and practice. The purpose of this section is not to provide in-depth analysis of the potential for paternalism in nursing’s major frameworks. Such an analysis of even one framework would require the full length of a journal article. It is enough for this column to illustrate that the ideas, words, and phrases embedded in nursing’s theoretical bases represent conceptualizations of the nurse’s role, the client’s role, and the nature of beneficence and autonomy that can lead to paternalistic application of the framework or lead to explicit rejection of paternalism. In certain nursing frameworks, the evidence of paternalism is glaring; in others, there is a more subtle suggestion; and in still others a stance is taken which mitigates against or completely proscribes paternalism. The frameworks with greater ties to conventional objectivist science show greater evidence of paternalistic tendencies. The frameworks associated with newer, more unconventional philosophies show a greater tendency to eschew paternalism; the more radically non-objectivist the framework, the more adamantly paternalism is rejected.

Frameworks Consistent With Objectivist Science

Johnson (1980) referred to nursing as an external regulatory force which acts to preserve the organization and integration of the clients’ behavior at an optimal level under those conditions in which the behavior constitutes at threat to physical or social health, or in which illness is found. (p. 214)

Peplau (1952) originally posited the nurse as a mother surrogate and the patient as infant, child, and adolescent, with the nurse-patient relationship hopefully leading the patient to become an adult person. King’s (1981) conceptual framework rooted in systems theory includes overtly hierarchical traditional concepts of organization, authority, power, and status.
that impinge upon the role of the nurse and the goal-directed decision making of individuals. Neuman (1995) has made a hallmark of prevention as intervention within her systems model, strongly implying that the nurse’s central activity of identifying and reducing environmental stressors occurs largely prior to the client’s own understanding of the problem.

Other frameworks are more subtle in outlining patterns of practice with potential to become paternalistic. In Roy’s (Roy & Andrews, 1999) adaptation model, the goal of nursing intervention is “to maintain and enhance adaptive behavior” and “to change ineffective behavior to adaptive” (p. 81). In her practice method, the nurse gathers data about the behavior of the person or other human system and judges the state of adaptation. In collaboration with the client, she or he makes a tentative judgment about behaviors in each of four adaptive modes. Orem (1995) describes how the social system legitimates nurses’ contractual relationship with clients and how nursing’s professional-technological system includes techniques for nursing diagnosis and prescription, meeting the therapeutic self-care needs of clients, and regulating the exercise of self-care agency. The central idea in her self-care framework is related to the notion of compromised autonomy, which may indicate that efforts to guard against paternalism are warranted. Levine (1973) pointed to the “organic dependency of the individual human being on his [sic] relationships with other human beings” (p.1) as a component of the foundation of nursing practice. Her tropichocognosis methodology involves testing the nurse’s hypothesis as to what is going on in the person’s life situation and what she or he believes will help. While such scientism in practice may be motivated by a deep altruism, the framework itself lacks any assertion that would mitigate strongly against paternalism in a practice guided by it. I say scientism because it is the frameworks that are more completely oriented toward objectivism and quantification, as evident in the many quantitative instruments described in their literature (see Fawcett, 2000, for examples), that appear to be structured more in alignment with paternalistic intervention.

Frameworks That Are Rooted in a New Paradigm, Qualitative in Orientation

Theoretical frameworks for nursing practice that are more qualitatively oriented and those that assert a new paradigm for nursing practice frequently take a stand against paternalism and in favor of client autonomy. For example, Watson (1985) wrote explicitly about “nonpaternalistic values” (p. 34) related to human autonomy and freedom of choice, which are central to her philosophy emphasizing personhood, human dignity, and humanity. In practice guided by Rogers’ (1970) conceptual system, the focus is on life patterns from the person’s perspective, and both the late Rogers and subsequent authors using her framework (Barrett, 1990), emphasized that there is no attempt to change the person in a given direction. In Newman’s (1994) theory of health as expanding consciousness, pattern recognition by the person is posited as the key process in practice and research.

Parse’s (1998) human becoming school of thought is radically noninterventionist. The nurse is guided by Parse’s practice method to offer true presence focusing on quality of life from the person’s perspective and there is no attempt to change the person. The very concept of intervention, central to paternalism, is philosophically and conceptually incongruent with Parse’s framework. Bournes (2000) specifically explicated how living the values and beliefs of Parse’s framework centers on a commitment to honoring people’s choices in contrast to paternalistic approaches.

Medical Paternalism, Nurses, and Nursing Science

The paternalism of medicine, in which nurses play a part, will only be touched on here, and only in reference to nurses who participate in it. Consider the language of doctor’s orders, putting the patient on a regimen, the patient failed on this regimen (rather than the regimen failed the patient), the drama of telling the doctor, and so forth. Paternalistic medicine is deeply embedded in American culture. Rare indeed is the experienced nurse who has never tried to persuade a client to follow doctor’s orders without knowing fully why the client was resisting. But nursing does not have stewardship of the medical knowledge base. True, nurses practice within the political reality of a medically dominated healthcare system, but it would be an abrogation of duty for nurses to fail to attend to the problems of paternalism within our own discipline of nursing while focusing attention and energy on problems of paternalism within medicine.

Justifying Paternalism: Never a Simple Issue

Paternalism is traditionally justified either by reference to the benefit conferred upon the person who is the target of the intervention (or from whom something is withheld) or by reference to the person’s consent—albeit a consent that is subsequent to the intervention, or implied by action or inaction on the part of the person, or hypothesized as inferable were the person more fully informed or rational (Beauchamp & Childress, 2001). Typically, the arguments pivot on consideration of the weight of the benefit and the degree to which the person’s autonomy is less than that of a fully competent and informed adult. Justifications arise from both the left and the right, with both sides stressing the good to be wrought by some intervention or the withholding of something, and the consideration that is warranted by various forms of compromised autonomy.

The New Paternalism: Justified or Faulty, or Both?

Over the past decade, programs such as welfare-to-work have been instituted that proactively diminish the effective autonomy of the recipient by imposing stringent rules of behavior on them (Mead, 1997). Consent is inferred by the person’s very participation in the program. It is not only the purported increase in benefits and the demonstrated (albeit coerced) consent of the recipient to which such interventions appeal for justification, but also the cost of the intervention to
the provider-practitioners and to society. Obviously, resources are limited and cost is a very real consideration in human affairs. However, in terms of policy deliberations, monetary cost as a variable is plainly aligned with objectivist and quantitative outcome indicators and a variable that is not commonly evaluated by the recipients of services. Such an approach, then, does little to engage subjective indicators of health, quality of life, or satisfaction among the recipients, and the benefit to society is given as much if not more weight than the benefit to the individual. Thus the perceived benefit is difficult to determine. The imposition of a diminished autonomy on the targeted person(s) shifts the terms of the debate in relation to paternalism and further clouds an already murky realm. Categories more complex than the aforementioned weak and strong paternalism must be defined, since more variables have been folded into the mix. Paternalistic interventions now require evaluation in terms of benefits to individuals and society, limitations of autonomy either pre-existing or imposed or both, costs to provider-practitioners and to society, and undoubtedly many other factors.

The new paternalism, in the United States of America, is a commingling of neoconservative ideas with the traditions of the welfare state—or, some would say, a cooption of the welfare state by powerful persons with neoconservative ideas. The new paternalism for the most part seems to me to fail to meet the standards of justification for strong paternalism outlined by Beauchamp and Childress (2001). Specifically, the benefit of the intervention is uncertain and is probabilistic at best; the risk to the patient of having one’s life substantially controlled by others is essentially a threat to human dignity and is not calculable; and the least autonomy-restrictive alternative is not even regarded as a standard to be pursued but is rather decisively removed from the list by the imposition of strict rules necessary to receive the benefit.

**New Conceptualizations and New Analyses Needed**

As previously indicated, the new paternalism and related developments in contemporary society may call for an entirely new analysis with emergent concepts and assumptions radically different from the analyses found in the literature today. Indeed, such a line of thought is suggested by White (2000), for one, in a discourse that is unfortunately beyond the scope of this article. It may be fruitful, for example, to revisit and reconceptualize the constructs of justice, community, care, self, dependence, and need (White, 2000). While we await scholarship that will wield Occam’s razor against this Gordian knot, we can still examine here the extent to which frameworks that guide or influence nursing practice lead to paternalistic patterns of practice.

In the realm of societal paternalism, as in the realm of science, it is of crucial importance to regard all participants from all sides as real persons (not abstractions) with real, complex and shifting values, beliefs, biases, concerns, relationships, abilities, limitations, hopes, dreams, and fears (not merely one-dimensional preferences and selfish interests). Such an appreciation for the infinite complexity of human affairs is needed to avoid overly simplistic conceptualizations and justifications for acts of great consequence, such as designing systems of care for people, that should never be trivialized.

**Some Problems in Justifying Paternalism: Meaning, Control, Intervention, and Access**

Among the countless considerations suggested by such a real-world approach are concerns about the very limited understanding that provider-practitioners may have (and usually do have) of the values, beliefs, hopes, dreams, and fears of the persons, families, and communities to whom they provide services. Paternalistic service delivery entails an over-riding of the preferences of the recipients based on the presumed benefits they will receive. But values, beliefs, hopes, dreams, and fears are deeply cultural and deeply personal, and in many ways extremely difficult for any outsider to come to know. This is of particular concern since we know that paternalistic interventions are imposed on less powerful people by provider-practitioners who are relatively more powerful. What does the idea of a benefit even mean in this light, and to whom?

The model of paternalistic practice and the very notion of paternalistic intervention rest on an assumption that a level of control of human conduct prevails which healthcare authorities rarely have in relative terms and never have in absolute terms. A beneficent intent connected with a specific intervention must always be weighed against the possibility that the intervention, although deemed by some to be the best way to achieve a particular result today, may be shown to have unforeseen consequences or to be ineffective or inappropriate. For example, as late as the 1970s some members of the healthcare establishment countenanced aggressive aversion therapy for minority sexual orientations (Murphy, 1992). A mounting number of medications, approved by the United States Food and Drug Administration and widely prescribed, have been shown to have unforeseen side effects (Cohen, 2001). The current American mania for weight loss is ironically closely associated with twin epidemics of morbid obesity and anorexia nervosa (Alexander-Mott & Lumsden, 1994). Compounding the risks of unforeseen consequences of interventions is the frequency of medical/healthcare errors that has recently been highly publicized in the United States (Kohn, Corrigan, & Donaldson, 2000). For provider-practitioners, then, the often stark uncertainty of the success of interventions, as well as their (likely profound) lack of understanding of their clients’ values, hopes, and fears should trigger an extreme caution with regard to designing and participating in paternalistic interventions.

In the United States, where we do not have universal access to healthcare and access to healthcare commonly entails sizable outlays of cash, what are we to make of paternalistic interventions in the context of a predominantly for-profit healthcare system? How can a provider-practitioner purport to be intervening systematically for the good of recipients of care who either lack autonomy or do not consent or both, while the main purpose of the enterprise is to generate profits?
for shareholders? Juxtaposing this reality with the practices of the new paternalism wherein loss of autonomy is imposed (now access often equals loss of autonomy, officially) further problems in justifying paternalism are glaringly apparent.

**The Drive Toward Quantitative Evidence: Supporting Paternalism**

One of the strongest influences in leading-edge nursing practice and nursing academe today is evidence-based practice (EBP), a veritable juggernaut in healthcare, bringing with it potential for changes in standards of practice. The gold standard of evidence in this movement is the integrative review of multiple randomized, double-blind, controlled studies. This standard of evidence (while appropriate for objective benchmarking in some instances) is extremely rare and applicable to only a narrow range of healthcare questions. This radical privileging of quantitative evidence, while consistent with decades-old traditions in Western science, carries with it the risk of further devaluing philosophical and qualitative bases for healthcare practice. Many human experiences, values, beliefs, and motivations cannot be quantified, or at best can be quantified only in a decontextualized, arbitrary, or simplistic manner.

In an increasingly technological healthcare environment, concerns about cost dictate that health services researchers take the cost of care into account. Costs expressed in dollar amounts further contribute to the quantification of healthcare concerns and the privileging of quantitative factors in healthcare decision-making. Where in these equations does one find the fundamental respect for human dignity that underpins nursing’s societal mission? One is reminded of Wilde’s (1909) definition of the cynic as one who “knows the price of everything and the value of nothing” (p. 134).

**Nursing Theories Vis-à-Vis Mounting Pressures Toward Quantification**

Theorists and researchers over the past several decades have provided valuable leadership to nurses seeking guidance for their practice in relation to philosophical and qualitative questions about health and healthcare. Nursing frameworks, creatively conceptualized as guides for nurses to provide care to human beings, have been largely based on philosophical beliefs, and a sizable portion of the research supporting their use has been in qualitative studies. Nursing is unique in its whole-person, lifespan perspective, its focus on human experiences of health, and its mission to provide care for all persons. Unique though nursing’s disciplinary perspective and mission may be, there can be little doubt that the increasing emphasis on the objectification and quantification of evidence will influence decision making among healthcare practitioners and policymakers, including nurses at all levels.

To what extent the EBP movement will diminish attention to philosophical and qualitative dimensions of life as considerations in healthcare decision making is not known. However, if one were to base an estimate of the relative weight of these considerations in healthcare decision making on the proportion of federal funding for research dedicated to philosophical and qualitative questions, one would have to conclude that the appropriate estimate would be tragically small. In today’s nursing research, the overwhelming emphasis is on middle-range theory, which further exacerbates the diminution of philosophical and qualitative considerations in the design of nursing care, as narrowly-framed studies aimed at establishing causal relationships among measurable factors related to circumscribed phenomena dominate the research literature. Fawcett, Watson, Neuman, Walker, and Fitzpatrick (2001) offer a proposal for nursing as a discipline to generate and use multiple kinds of evidence, including philosophical and qualitative, but the juggernaut of EBP shows no signs of expanding its established parameters and admitting of a broader range of evidence.

**Concluding Reflections**

Paternalism is already widespread and may be increasing, with new forms of paternalism emerging that do not merely acknowledge preexisting compromised autonomy in adult persons but impose nonautonomy on persons as a condition of receiving services and benefits. Paternalistic intervention is clearly considered justified in most situations where it is currently in place, despite the fact that a common perception is that paternalism is on the decline. There is an increase in the sociopolitical recognition of individual autonomy in adult decision making, but there is also a pervasive assumption that interventions recommended by provider-practitioners are offered with beneficent intent and should be followed.

Paternalistic practices dictate that people must do or receive something that they don’t want, or refrain from doing something or have something withheld that they do want, usually with significant life consequences. This alone is a profound ethical concern. But paternalistic interventions are also aimed at certain persons perceived as having less power (women, minorities, gays and lesbians) selectively. Further, frequently policies/interventions/treatments are imposed that are later found to be ineffective or harmful, or treatments are given completely in error.

Since it is very difficult for the provider-practitioner to know the shifting meanings of perceived benefits to persons in the contexts of their own lives, it is dangerous for provider-practitioners to act as if they know what these are. Similarly, is it dangerous for provider-practitioners to behave as if it were they who were truly in control, when adult people really do make decisions autonomously and even against practitioners’ recommendations?

It is crucial for the healthcare disciplines to understand that the knowledge bases that guide science and ethics are not and cannot be entirely separate. If we appreciate the multidimensional unity of knowledge and the infinite complexity of life, we understand that science is never neutral and that ethical
dimensions of practice are inherent in our frameworks of practice.

An examination of some of the central issues in paternalism in healthcare today underscores the need for the continued development of nursing’s own unique theory base. Nurse scholars are the stewards of nursing’s knowledge base which resides primarily within the structures known as nursing theories—the only theories rooted in philosophies of nursing and intended solely to guide nursing research and practice. Paternalism is deeply ingrained in medical practice and in American culture. New conceptualizations, new visions of how to provide services, and new guides to practice are needed. Nursing’s unique knowledge base already provides major insights that may be helpful in reconceptualizing paternalistic practices in ways more consistent with respect for human dignity.

Nurse scholars need to continue to generate and expand theory to guide nursing practice that incorporates an understanding of the unity of knowledge with an appreciation for the infinite complexity and mystery of life as it is humanly lived. There are frameworks in nursing that are rooted in philosophies of nursing and a nonjudgmental ethic, dedicated to enhancing our understanding of life as it is humanly lived, and are fertile grounds for the emergence and development of new conceptualizations that will cut through the Gordian knot of paternalistic healthcare policies. Further, expanded research in nursing is needed in which concerns for human experience and philosophical aspects of healthcare are not subordinated to the current mania in healthcare research for endless quantification of human experience and cost analysis.

The theoretical basis of nursing is unique in its emphasis on respect for the human dignity, values, beliefs, meanings, and relationships of all people, expressed in frameworks that acknowledge the unity of scientific and ethical knowing. There is evidence in today’s healthcare system that much reflection and innovative thinking is needed with regard to how to provide quality care with dignity to all people. Perhaps the appropriate response to the new, expanded paternalism is a new, expanded universalism.

References


NINTH ROGERIAN CONFERENCE
EMERGING POSSIBILITIES FOR UNITARY HEALTH CARE

JUNE 25, 26, 27, 2004
NEW YORK UNIVERSITY
DIVISION OF NURSING

A DIALOGUE AMONG NURSE THEORISTS
John R. Phillips (Rogers' Science of Unitary Human Beings)
Rosemarie Rizzo Parse (Theory of Human Becoming)
Margaret A. Newman (Health as Expanding Consciousness)
Marlaine C. Smith (Watson's Caring Science)

MARTHA E. ROGERS' SCIENCE OF UNITARY HUMAN BEINGS
IT'S NOT JUST FOR NURSING: A MULTIDISCIPLINARY DIALOGUE

KEYNOTE SPEAKERS: Barbara Joyce, Marlaine C. Smith; Pre and Post Conferences with Nursing Leaders; Poster Sessions; Other Speakers

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