

Medical Maternalism: Beyond Paternalism and Antipaternalism

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Abstract:

This paper argues that the concept of paternalism is currently overextended to include a variety of actions that, while resembling paternalistic actions, are importantly different. I use the example of Japanese physicians' nondisclosures of cancer diagnoses directly to patients, arguing that the concept of *maternalism* better captures these actions. To act paternalistically is to substitute one's own judgment for that of another person and decide in place of that person for their best interest. By contrast, to act maternally is to decide for another person based on a reasonable understanding of that person's own preferences. The concept of maternalism allows for a more thorough assessment of the moral justification of these types of actions. I conclude that it is possible, at least in principle, to justify Japanese physicians' nondisclosures, and that this justification must be based on an understanding of these actions as maternalistic.

INTRODUCTION

While a contested concept, paternalism can be most simply defined as deciding to act in an autonomous person's best interests without taking that person's will decisively into account (or deciding expressly against it)[1]. Whether for or against the defensibility of paternalism, most arguments about paternalism begin by assuming that the actions of concern fit the core features of this definition [2, 3]. This assumption is problematic because paternalistic actions are usually not considered to be normatively neutral. In the classic example of a physician who performs a transfusion on a Jehovah's Witness despite their religious objection to transfusions, the physician violates the patient's clearly expressed will[4]. The burden of proof in such cases is on the side of the paternalist, who must explain why the benefit of the action overrides the harm of interfering with the person's liberty, restricting their opportunity, or disabling their will.

Due to this presumption against paternalism, asserting that an action is paternalistic occasions an immediate call for the action's harm to be morally justified. Yet some actions with paternalistic features may nevertheless be different kinds of actions. Decisions might be made for autonomous others without directly asking them what they want but attending to what they most likely would want, based on knowledge about their character and preferences. It is morally significant that such a decision would not disregard the other's will. If actions such as these are too quickly described as paternalistic, other morally relevant features may be missed.

In this paper I use the example of Japanese physicians' nondisclosures of cancer diagnoses directly to patients to show that an action that is assumed to be paternalistic and therefore morally problematic may in fact be "maternalistic," and that a maternalistic action does not bear the same burden of justification as a paternalistic one.¹ On my

¹ While in Japan diagnoses need not always be disclosed to patients, they must be disclosed to someone, often the family. To focus on the paternalism/maternalism distinction I do not deal with the inclusion of the family in medical decision-making

definition, maternalism is deciding to act in an autonomous person's best interests and likely in line with that person's will, but in the absence of the affected individual's expression of consent or assent. Despite the fact that a poorly done maternalistic action is very similar to a paternalistic one, I show how paternalistic actions and maternalistic actions are distinct; they have different motivating factors and different bases for judgment, although the desired effect in both cases is the same (improved welfare or the prevention of harm).

Maternalistic actions are not necessarily justified – a poorly done maternalistic action violates a patient's will, despite the intention to act in line with it. Nevertheless, maternalism offers a useful alternative to paternalism in conceptualizing decisions made for others. Paternalism, based on one individual's disregard for another's will, focuses conceptual attention on a general form of relationship that is at once the relationship of anyone and no one. Maternalism, by contrast, is predicated on the existence of relationships in which one party can discern the will of another without explicit communication. Interrogating the requirements for ethical justification of a maternalistic action leads to further analysis of fundamentally relational concepts such as trust and interpersonal understanding. Maternalism offers a window into aspects of decision-making not often considered in analyses of paternalism in addition to describing a novel conceptual category.

This paper begins by considering normative arguments about paternalistic actions by medical professionals and moves to a conceptual conclusion. I argue that the concept of paternalism is often overextended to include a variety of actions that, while resembling paternalistic actions, are different in morally significant ways. I introduce the concept of maternalism to better capture these actions and to more thoroughly assess the possibility of their moral justification.

PATERNALISM'S BURDEN OF PROOF

The modern concern with paternalism traces back to John Stuart Mill's *On Liberty*, as developed by Gerald Dworkin, Joel Feinberg (*Harm to Self*), and others. Dworkin defines paternalism as interference with another person, against her will, defended or motivated on the basis of improving her welfare or protecting her from harm[5]. To capture the intuition that paternalism is problematic not just because it interferes with another person but because it disregards another's will when making a decision that will affect them, I use a simplified version of Daniel Groll's definition of paternalism in this paper. According to Groll, person A acts paternalistically towards person B when, for the sake of B's good, A does not take B's will decisively into account or decides expressly against it. While there are important differences between the Dworkin and Groll definitions of paternalism, at their core they share the intuition that paternalism entails a failure to take another person's will decisively into account when making a decision that is ostensibly for that person's own good. Here, "will" is best

directly. However, it is an important feature of decision-making that is recognized beyond Japan. For a more detailed examination of the role of the family in the Western context, see Lindemann Nelson and Lindemann Nelson, *The Patient in the Family* (1995) and Donchin, "Autonomy, Interdependence, and Assisted Suicide: Respecting Boundaries/Crossing Lines" (2000).

understood as a reflectively considered want or desire. For such a will to be taken into account, most antipaternalist theorists agree that it must be explicitly expressed.

Paternalism's core intuition can be otherwise described in terms of a conflict between the subjective expression of will and the objective assessment of welfare. For the antipaternalist, any decision based on the latter that affects autonomous individuals must also include the former – hence the antipaternalist's exclusion of anything but explicit consent. To decide based solely on an objective assessment of welfare would be a violation of individual autonomy. As Gerald Dworkin writes,

Any sensible view has to distinguish between good done to agents at their request or with their consent, and good thrust upon them against their will. So the normative options seem to be just two. Either we are never permitted to aim at doing good for others against their wishes, and in ways which limit their liberty, or we are permitted to do so[5].

Arguments that share this core intuition nevertheless dispute the conceptual distinctions between different types of paternalism and the normative justifications for various kinds of paternalistic actions. Some arguments distinguish state paternalism from paternalistic actions by individuals such as parents, teachers, or physicians[4]. Others suggest that libertarian or soft paternalistic actions that temporarily interfere with behavior to determine whether an individual is acting autonomously are justified, while hard paternalist actions that interfere with autonomy based on best interests alone are not[6].

Despite this variety of arguments about paternalism, most agree that a paternalistic action would be justified if the good of the action overrode the harm of interfering with the person's autonomy. This places the burden of proof on the side of the paternalist. As Coons and Weber note, “normative debates about paternalism... don't usually concern *whether* it is problematic but rather *how* problematic it is”[3]. While some have argued for normatively neutral definitions of paternalism, the dominant approaches remain normatively charged against paternalistic interventions[7].

The placement of burden of proof in the justification of paternalistic actions is tied up with the definition of paternalism as “interference with another person” and the inherent value that is thought to attach to individual autonomy qua independent self-determination.² Individual autonomy through independent self-determination is considered an absolute good, so any action that interferes with self-determination is wrong. This presupposition leads many arguments about paternalism to elide “absence of self-determination” with “paternalistic interference with autonomy.”

The either/or justification of paternalism is conditioned by the definitions of paternalism as interference with another person's autonomy and of autonomy as independent self-determination. If interfering with individual autonomy is justifiable or not, then paternalism is either justifiable or it is not. However, to better assess actions that *seem* paternalistic, autonomy and paternalism must be redefined such that a lack of autonomy via an expression of will does not equal a definitive judgment of paternalism.

² There is instrumental value to autonomy as well: autonomy may lead to greater emotional well-being, to social respect, and to a successful career. Paternalistic actions' interference with these goods is harmful. However, for simplicity of argument I set aside this instrumental value, as it does not contribute to the argument for paternalism's *prima facie* harm.

Indeed, as arguments in favor of relational autonomy point out, while some social relationships will impede autonomy, others, such as supportive family members and trusted partners, will enhance or develop capacities for autonomy[8]. In other words, interpersonal relationships are complex, and cannot be divided into cases where an individual decides for himself and cases where someone else decides in his place; there are gray areas between the two[9]. While much work has been done to redefine autonomy relationally, here I focus on how relational considerations might affect how we conceive of deciding for others beyond paternalism and antipaternalism.

The insights of relational autonomy suggest we cannot assume that if an individual is not expressly making his own decisions or is not explicitly expressing his will, then someone else is deciding for him without taking his will into account. There may be cases where one person decides *for* another person, i.e. with another person in mind, without substituting their judgment *in place of* that of the other person, and thus depriving them of autonomy. This is not just a problem of allowing implicit rather than explicit consent – in some cases, there will be no clear expression of will through a statement of consent. Lack of full self-expression at the moment of decision-making does not necessarily imply paternalism and lack of autonomy.

Yet many arguments about paternalism miss this feature of interpersonal decision-making. Whether for or against the defensibility of paternalism, most arguments about purportedly paternalistic actions begin with a brief explanation of why these actions are paternalistic before assessing whether or not the paternalistic features of the action are justified[2, 3]. There is a general assumption that all actions which one person undertakes for another autonomous person, without express consent, are paternalistic.

These actions must be examined more closely. If the action in question includes more morally relevant considerations than those included in the definition of paternalism, then the ethical justification of the action must consider additional reasons for the action beyond its alleged paternalistic features. In such a case, an argument against paternalism will not suffice, and whether or not the action is justified will need to be reassessed. Before determining degrees of justifiability, arguments should consider whether the definition of paternalism accurately describes the actions to which it is applied.

Consider the case of paternalistic physician behavior in the United States. Informed consent policies were enacted to avoid paternalism in which physicians assumed their judgment of what was best for the patient was more reliable than the patient's own judgment. These policies were designed to ensure that physicians did not interfere with the right "to determine what shall be done with his own body," as in Justice Benjamin Cardozo's famous 1914 decision in *Schloendorff v Society of New York Hospitals*. The elision of paternalism with lack of self-determination is first found in this particularly American development of informed consent as a safeguard against physician paternalism. Informed consent was, in many ways, a product of American case law and the particular social and medical conditions of the U.S. in the middle of the 20th century. Nonetheless, as a general policy, informed consent has been extended to other countries, where there is agreement that establishing ethical medical practices includes avoiding physician paternalism. However, it has not been established that protection against paternalism entails patient autonomy nor that lack of independent self-determination entails paternalism.

This is particularly salient in Japan, where the adoption of so-called American-

style informed consent policy has not been universal. Despite arguments mounted in Japanese academia and the popular press favoring individual autonomy over paternalism, in some cases physicians disclose diagnoses to families rather than directly to patients. As recently as 2006, the mean proportion of cancer patients who had been told their diagnosis was 59.3% in hospitals with less than 50 beds and 83.3% in hospitals with over 500 beds[10]. The Japanese Medical Association (JMA) endorses this practice. Their ethical guidelines state that: “in the case that informing the patient of malignant cancer or incurable disease would cause an extreme emotional shock, prudent consideration regarding disclosure is necessary for the physician. Also, if the patient does not desire to know the correct disease name or condition, and it is anticipated that it would be a hindrance to further treatment, it is permitted to refrain from disclosure. However, this judgment must be made prudently, and at times it is necessary to consult with another member of the medical staff. In principle, it is necessary to inform the appropriate family member involved in caring for the patient of the correct disease name and condition”[11]. The possibility of such nondisclosure has also been upheld by the Japanese Supreme Court, provided that a family member receives the disclosure instead[12]. When viewed from abroad, this nondisclosure is described as paternalistic and is often declared morally unacceptable[13, 14, 15]. This may be because of the practice’s apparent similarity to the exercise of therapeutic privilege (withholding information that may be damaging to the patient), a practice allowed by *Canterbury v Spence* but absent in subsequent cases and currently disallowed by the American Medical Association.

In the Japanese context, however, many find these nondisclosures to be defensible. To counter arguments against these so-called paternalistic actions, some attempt to define a particular Japanese type of autonomy, such that the physicians’ nondisclosures can be described as respecting patients’ autonomy via a concept of family autonomy[16, 17, 18]. Yet few have inquired into the reasons for Japanese physicians’ nondisclosures, and it has not been established that these actions are paternalistic in the terms given above. Accordingly, it is not certain that antipaternalistic arguments apply to Japanese physicians’ nondisclosures. If these nondisclosures of diagnoses to patients are paternalistic, they must: (1) ignore the patient’s will or decide expressly against it and (2) be motivated by a desire to improve patients’ welfare or protect them from harm[1]. Do Japanese physicians’ nondisclosures meet these requirements?

NONDISCLOSURES OF DIAGNOSES IN JAPAN

An inquiry into Japanese case law, the JMA’s ethical guidelines, and studies of Japanese physicians’ policies and attitudes towards disclosure reveals three factors as yet unrecognized in arguments about nondisclosure of cancer diagnoses.

The first factor is that nondisclosure of a diagnosis is restricted mainly to cases where the patient has not exhibited a positive exercise of self-determination, which is to say, in cases where the patient has not expressed a wish to know the details of his or her diagnosis and has not attempted to become involved in the decision-making process despite invitations to do so[19]. Nondisclosure is also allowed in cases where the patient has expressed a desire for positive self-determination, but this self-determination takes the form of asking not to be told the diagnosis and to be excluded from the decision-making process[11]. In both of these situations, the patient’s will is neither ignored nor opposed. Rather, either the patient’s will not to know the diagnosis is respected or the

patient's incommunicative behavior is interpreted as a withdrawal from the decision-making process.

Second, when Japanese physicians choose not to disclose a cancer diagnosis to a patient, they do so not because they believe that they know better than the patient what is in the patient's best interests, but because they believe that nondisclosure is what the patient really wants. In other words, they (along with the Japanese courts and the JMA) consider it to be part of the physician's role to determine "whether the patient needs to know, would want to know, and could deal with the information"[20]. This suggests that despite what some may see as practical difficulties in discerning patients' unspoken wants, Japanese physicians' intentions are neither to supplant patients' wills with their own nor to decide expressly against them. Rather, the Japanese practice of nondisclosure is understood as respecting patients' wills by acknowledging that whether or not a patient should be told a diagnosis depends both on their current preferences and on what their preferences might be if they knew the nature of their diagnosis.

Finally, the third factor is that nondisclosure is only permitted when it is thought that disclosure of the diagnosis would cause such a great shock to the patient that the patient would be harmed and attempts at future treatment would be adversely affected[6]. In other words, these nondisclosures are motivated by a desire to protect patients from harm (this harm is statistically evident - in April 2014, a national study found that the risk of death by suicide or externally caused injury among Japanese cancer patients in the year following diagnosis is 20 times that of the healthy population)[21].

Based on these three factors – no positive signs of a patient's self-determination, the physician's intention to act in accord with the patient's will, and potentially harmful disclosure – Japanese physicians' nondisclosures are not paternalistic. In cases where a Japanese patient explicitly asks a physician for nondisclosure, nondisclosure does not violate the patient's will, and therefore does not fit the first condition of the definition of paternalism. Even when the patient does not make a positive assertion either way, the physician does not understand him or herself as making a decision in place of the patient, but as responding to the patient's unspoken wants. In some cases the physician may believe that the patient has communicated their will, albeit nonverbally. These are cases of implicit consent. In other cases, physicians may believe they know the patient and the situation well enough to know the patient's will without it being communicated at all. These would not be cases of implicit consent. Nevertheless, they would still not fit the definition of paternalism, because in all of these cases the physician neither fails to take the patient's will decisively into account nor decides against it. Japanese physicians' nondisclosures do fit the second condition for paternalism, since they are motivated by a desire to avoid harm in the form of a significant psychological shock to the patient that could affect treatment.

If Japanese physicians' nondisclosures of cancer diagnoses are not paternalistic, then in what terms might we describe them? They do not quite fit any of the fringe theories of paternalism, such as soft paternalism or libertarian paternalism, because they can be interpreted neither as interfering with patients' choices to determine their level of autonomy nor as nudging patients in the direction of a certain type of choice (as even a "nudge" disregards the patients' will in order to facilitate a decision thought to be better for the patient by the "nudger"). Rather, these nondisclosures are the withholding of information from patients because it is thought that this withholding is in some patients'

best interests and is what they really want. As a foil to the concept of paternalism, I describe this type of action in terms of *maternalism*.³

MEDICAL MATERNALISM

I define maternalism as deciding to act in an autonomous person's best interests and likely in line with that person's will, but in the absence of the affected individual's expression of consent or assent. Defined as such, maternalism is not a new paradigm for physician behavior to rival paternalism, but is a concept describing a category of medical professionals' actions that are assumed to be paternalistic, but in actuality are not. While paradigmatic paternalism is for a father to decide what is in his children's best interests and support his decision "because he said so," paradigmatic maternalism is for a mother to select her children's activities based on her understanding of their emerging interests. The distinction of maternalism from paternalism is meant to capture the significant differences between these two paradigms and the implications for justifying a variety of decisions and actions.

Despite the above association, the word *maternalism* is not meant to imply a gendered dimension to the action in question; just as both women and men can act paternalistically, so can both women and men act maternally. Additionally, while this definition of maternalism draws from cultural tropes associated with motherhood and mothering that are familiar to an American audience, such behavior is in no way necessarily associated with motherhood, and mothering need not include these types of actions. Furthermore, it is important to note that maternalism is a concept that applies to interpersonal relationships, not to relationships between an individual and a state.⁴ With these provisos out of the way, I suggest that a *maternalistic action* is any action that: (1) is thought to be in line with an autonomous patient's will, (2) is motivated by a desire to improve the welfare of the patient, and (3) is not based on the patient's expression of consent or assent.

Although both aim for the improved welfare of or prevention of harm to the patient, paternalistic and maternalistic actions have clearly distinct foundations and orientations. The critical difference between paternalism and maternalism is that the former describes a general kind of medical judgment. Justification of a paternalistic action is independent of the form that the physician-patient relationship takes. A physician whom I have just met may refuse my request for an unnecessary procedure without first determining my reasons for wanting the procedure. Likewise, a physician whom I know and trust may nevertheless withhold information about a treatment option she knows I will find attractive, but which she thinks will not benefit me. Both of these

³ I intend no relation to previous uses of maternalism in the medical context, indicating either women acting paternalistically or acting only with regard to a patient's autonomy. For example, see Mahowald, M.B. Sex-Role Stereotypes in Medicine, *Hypatia* 1987; 2(2):21-38. Other references to the term are ambiguous, and do not develop it substantially. For example, Joan Tronto refers to "paternalism/maternalism" in *Moral Boundaries* (1993, p. 170), and Nel Noddings suggests that there might be maternalistic/parentalist responses to drug addictions in addition to paternalistic ones (*Two Paths to Morality*, 2010, p. 202).

⁴ This "maternalism" was a public policy initiative in the U.S. in the 1950s.

physicians act paternalistically (one soft, one hard), yet whether or not their actions are justified depends on the balance between the benefit of the action and the harm of restricting my choice.

By contrast, maternalism is predicated on a long-standing personal relationship of trust and understanding between a physician and a patient. The concept of maternalism suggests that it is only the basis of such a relationship that a physician may make a decision on behalf of a patient. In the case of maternalism, justification depends on the form of the physician-patient relationship. A physician I have just met might think that my unwillingness to choose a treatment option shows that I do not care about the decision and that I want her to decide for me. Alternatively, a physician who knows me well might recognize that my persistent questioning about a procedure reveals not that I am interested in the procedure, but that I am anxious about it, and that I want her to take that option off the table. In both of these cases, the maternalistic action's justification depends on the physician's relationship with me (and, arguably, close members of my family) in addition to the balance of benefit and harm.

Based on different paradigms of deciding for others, the justification conditions for maternalistic actions are also different from those of paternalistic actions. I suggest that a maternalistic action, while affecting a patient's life, would be morally justified if it were indeed in line with the patient's will and if it either prevented the patient from being harmed or improved the patient's welfare; such an action would both respect the patient's autonomy and be in his or her best interests.

Fulfilling the second condition, that a given action is in fact in a patient's best interests, requires case-by-case epistemic proof – does the action actually benefit the patient or protect him from harm?

Satisfying the first condition also requires an epistemic check – is this what the patient really wants? However, one may question the theoretical possibility of fulfilling this first condition by asking whether a medical professional can ever know for certain that his or her action is in line with the patient's autonomous will without an explicit statement to this effect by the patient. I argue that it is not impossible for this first condition to be satisfied, for three reasons.

First, if a medical professional has known a patient for a sufficient length of time, he can have a sense of the patient as a person, including her interests, desires, and values, on the basis of which he can carry out a maternalistic action responsibly. This means that a maternalistic action cannot be justified if enacted by someone whom the patient has just met in the emergency room or the ICU. However, a family doctor, a nurse whom the patient knows well, or a specialist whom the patient has seen for a good length of time, has had sufficient time to get to know the patient such that their maternalistic action is morally justified.

Second, if the patient trusts the medical professional, she can reveal herself to the professional without pretense or barriers. The requirement of a trusting relationship ensures that the professional has a reasonably accurate understanding of the patient and that, in certain contexts, the patient authorizes the physician to act from that understanding[22]. The nature of this trust may differ based on the type of decision to be made and how it is made. I may trust my physician to determine which prescription best fits my lifestyle without requiring her to describe every possible option, but expect that she will discuss more complex surgical treatments with me directly. If she decides upon a

surgical treatment without consulting me, then she has misjudged the nature of our trusting relationship and her maternalistic action is not morally justified. However, if she correctly appraises the nature of our trust and restricts her maternalism to prescription-related choices, then her action stands a good chance of being morally justifiable.

Third, while it may seem as though a professional can never be certain that a maternalistic action is what a patient really wants, even in cases where the patient has made an explicit statement of his wishes, there is no certainty that this will be what he wants at the time of action. For example, even though a patient may fill out an advance directive instructing his physician to “do everything possible” to keep him alive, when he experiences the reality of mechanical ventilation, he may regret his previous decision and request to be taken off life-support. If it is difficult to determine his decisional capacity, this may place his care providers in a quandary. So while there is no certainty that a maternalistic action is what a patient truly wants, a professional’s sense of a patient may at times be a better guide than a pro-forma signature by the patient. In both cases, the medical professional is acting upon generally reliable, but uncertain, data. Based on these considerations, moral justification of a maternalistic action does seem possible.

Japanese physicians’ nondisclosures seem to fit the definition of maternalism better than paternalism. Physicians make these decisions when there are no positive signs of the patient’s self-determination, they intend to act in accordance with the patient’s will, and they believe that disclosure will be harmful. This is not to say that Japanese physicians’ nondisclosures are never problematic. The Japanese medical system keeps physicians very busy, so they may not have time to establish trusting relationships based on mutual understanding with their patients. In addition, Japanese medical schools may now stress technical skill to such an extent that physicians do not have the communication skills needed to pick up on nonverbal cues. Finally, despite the support of the JMA and the Japanese Supreme Court, physicians may fear legal ramifications if they perform an action that is not explicitly consented to by the patient. Nevertheless, it is possible, at least in principle, to justify these nondisclosures by understanding them as maternalistic. If Japanese physicians’ nondisclosures are not justified, it is not because they are paternalistic, but because they are a poorly done maternalistic action.

CONCLUSION

Deciding that an action will benefit a patient does not necessarily mean substituting one’s own professional ideas in place of a patient’s. Rather, a well-trained and sensitive medical professional whom the patient knows well may reliably know what her patient wants, without the patient having to make these desires explicit. This is best described as medical *maternalism*, not medical paternalism. While the concept of maternalism requires further work, including delineations of different forms of maternalistic actions and explanations of possible dangers associated with these actions, this does not indicate that maternalism is not a viable concept; rather, maternalistic actions have been inadequately investigated and insufficiently explained. Asking what a maternalistic justification requires further develops aspects of the medical decision-making process disregarded by the paternalistic paradigm, namely the nature of the physician-patient relationship, the degree of trust, and the extent of interpersonal understanding. We should take care that we do not condemn potentially justifiable

actions by labeling them paternalistic without due consideration of all the factors involved.

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