

Scientific Contribution

How Can We Justify Physicians' Role as a Value-Provider?¹

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Abstract: What is the ideal role of physicians in shared treatment decision making – especially in light of how physicians should contribute to the assessment of patients' values? Traditional, dichotomously categorized models, i.e., the physician-centered model and the patient-centered model, do not provide a sufficient understanding of the issue. This paper attempts to explore a model in which physicians can and should strongly commit themselves to patients' value-judgments in shared decision making. By reviewing Emanuel and Emanuel's argument for four models of the physician-patient relationship (namely, the paternalistic model, the informative model, the interpretative model and the deliberative model), and analyzing the notion of fact-value distinction, which Emanuel and Emanuel's argument tacitly assumes, and the incorrigibility claim on patients' value-commitment, I will contend that physicians necessarily *have to* make value-commitment in shared treatment decision making. Emanuel and Emanuel argue that four models descriptively and prescriptively serve under different circumstances; that is, in different contexts a physician and a patient are in, different models may be appropriate and justified. But if my analysis is correct, physicians unavoidably have to take a role of value-committed advocate.

Keywords: the physician-patient relationship, fact-value distinction, autonomy, paternalism, value-committed advocate

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To explain the physician-patient relationship in medical decision making, bioethicists have proposed several models. But how physicians should contribute to the assessment of patients' values has been a controversial question. As mere fact-providers, should physicians avoid committing themselves to patients' values? To examine the roles of physicians and patients in the relationship, let me first categorize the relationship, for the sake of argument, roughly into two types: The physician-centered model and the patient-centered model. In the former model, physicians themselves are expected to make decisions for their patients (normally considering the patients' best interests); physicians authoritatively provide patients with

information on the diagnosis and the possible prognoses without treatment, and give medical decisions (preferably with alternative treatments), based on their knowledge, training and experiences, i.e., their expertise. In deciding available medical treatments, the physicians tend to ignore the patients' full self-determination or, at best, encourage the patients to assent their decisions. Thus, the model is, as it is normally pointed out, *paternalistic*. This is considered to be a big drawback of the model, as patients' self-determination or autonomy has come to be a crucially important goal in shared decision making. Many contend that the patient-centered model better achieves this goal. In the model, patients make decisions on treatments by themselves and for themselves, that is, autonomously, based on the information provided by physicians. Here, patients' autonomy is most likely to be much better respected (the model is often labeled as "consumer model" or "independent choice model"²). Some point out, however, that this model too has many problems; for instance, patients are forced to experience the burden of overload in making crucial medical decisions because they are essentially laypeople on medical issues. Nonetheless, it is in this model that patients' autonomy is well respected, and hence it usually serves as a preferred guidance with normative force in the physician-patient relationship except in acute care or during emergencies for which normally the physician-centered, paternalistic model is better justified. It is also argued that the shift from the first model to the second roughly represents the historical developments of the doctor-patient relationship which reflect the recognition of the human right in society.

Recent developments in medical ethics have been emphasizing the principle of autonomy, according to which a person (a patient in this case) is entitled to make a decision on the treatment he or she will receive based on the facts and information regarding his or her medical condition. The physician-centered model tends to conflict with this principle as I sketched above. But when physicians make decisions on medical interventions on behalf of patients, they usually do so for good reason or cause; normally, physicians attempt to promote patients' health and well-being considering their best medical interests. This idea is expressed by the principle of beneficence, according to which medical providers should act to promote patients' good in making decisions. The principle of beneficence has long been a component of medical providers' ethics and is the core idea of the physician-centered model. Thus, the conflict between the two models possibly translates into the conflict between the principle of beneficence and the principle of autonomy. This description may sound a little simplistic, but I believe that it serves as a sufficient foundation for the line of argument presented in this paper.

This paper explores a model in which physicians strongly commit themselves to patients' values in shared decision making. In a sense, this model is a type of what is normally called "mutual participation model" (MPM) or shared-decision-making model (SDMM)³, with strong emphasis on the physicians' role as value-providers. I will argue that medical decisions, as are

done in the procedures of informed consent, for instance, should not be paternalistically forced, but basically be *accepted by the patients' value-systems*. Here, "values" include not just ethical values but also values of many other kinds, such as needs, hopes, desires, preferences. Sackett *et al.* provide a helpful definition of values that serves well in medical contexts: "By *patient values* we mean the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient" (Sackett *et al.* [2000: 1]). To use Fulford's terms, the model I propose hence integrates "value-based practice" not just on "evidence-based practice" (Fulford [2004][2008]). Fulford argues that in recent years, medical practitioners have recognized the importance of "value-based practice" as well as evidence-based practice in underpinning all decisions (Fulford [2008:10]). I contend that values in the above sense should play an explicit role in making shared medical decisions. One good example is gastrostomy (or percutaneous endoscopic gastrostomy), which is a medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, usually to provide nutrition for the patient who is having difficulty swallowing. Some people may willingly or unwillingly accept the procedure; but others may refuse to do it, as they believe that it lowers their QOL, finding it unacceptable according to their life-plan or value-systems. What will be discussed in this paper are not just mere shared medical decisions, but how they are *interpreted and accepted* by patients and what they mean for the patients' life. We thus have to see how a medical decision is made or evaluated vis-à-vis a patient's values or how the meaning of a medical decision is integrated into a patient's value-system.

Before starting the discussion, let me set out the assumptions for my arguments. First, the situations assumed here are not those in acute care or emergencies, in which normally physicians can solely decide what procedures should be given to their patients; in short, paternalism can or should be accepted in acute care. Also in what follows, I take that our understanding or decisions presuppose the *holism of belief*. Roughly, the holism of belief holds that the content of every belief depends to a large degree on a broad range of one's related beliefs or the web or system of beliefs. Suppose a person obtains (understands, accepts, makes) an idea (belief, decision). When the new idea obtains its content, it necessarily has to be integrated into his or her system of beliefs, that is, necessarily be connected to other beliefs or pieces of knowledge already held by the person. When a patient makes a decision, it thus has to be coherently (to a certain extent) connected to other beliefs or knowledge held by the patient. Also I assume that since values are or can potentially be expressed by beliefs, one's belief system encompasses his or her value-system. This may require further philosophical elaboration, but given insufficient space of this paper I take it as an assumption here.

In the following sections, I will first examine in more detail the two types of models, that is,

physician-centered and patient-centered models. Also I will review related discussions presented in recent years in order to evaluate my dichotomous categorization of the physician-patient relationship (the section 2). In the section 3, I will present some conceptual discussions regarding the roles of physicians and patients and related philosophical issues. Based on the discussions, I will argue that physicians can and should play a value-committed advocacy role to the extent that it does not deny patients' self-determination or in such a way it can respect patients' autonomy. In the final section, I will see some approaches that are considered to meet the theoretical requirements I propose.

2

In the physician-centered model or position, physicians *paternalistically* make medical decisions for patients, usually with the aim of promoting the patients' medical benefits or good⁴. This position allows doctors to make decisions rather easily, compared to the position in which physicians must get permission or consent from patients every time they have to determine a medical intervention. The decisions should be medically and professionally trustworthy, as they are made chiefly based on physicians' medical and professional expertise that is considered to be accurate. The physician-centered position is, however, currently sharply criticized, as it ignores the patients' autonomy – a core notion in recent bioethical debates.

On the other hand, in the patient-centered model, physicians should inform patients of options, primarily in the form of a list of *factual* pros and cons, and the odds of treatment success, refraining from making any value or moral judgments; basically, it is competent patients who have to make decisions on what treatment to receive. Patients may ask questions, but physicians must objectively answer them and avoid influencing the patients one way or another. Physicians' duty is to simply implement the objective, medical aspects of decisions; it is preferable that physicians stay in *morally neutral space*. Based on the factual information provided in the morally neutral form, patients are expected to make decisions on their treatments considering how the treatments can realize their values, expectations, desired goal, and so on. In short, patients, not physicians, are expected to make value-judgments. Importantly, patients' autonomy is respected in this position. However, the model has a few drawbacks.

First of all, patients are not in a perfect condition, physically and psychologically, to make serious medical decisions on treatment. The patient-centered position requires patients some degree, often a great degree, of rationality in making decisions. But usually, patients are hardly in a sufficiently rational state of mind; they are ill, often gravely ill, first of all (that is why they come to see a doctor), and they are possibly quite upset after being told they suffer

from a serious disease. Besides, they have to make decisions on the issues they have never been specialized in. Worse, in that state of mind, they may not understand accurately what they are told. Second, even putting aside their psychological and physical difficulties, patients are knowledge-wise fairly ill-equipped. It is impossible for them to have accurate understanding of medical, technical and statistical issues, given no proper knowledge, good experiences, or medical training. It is not just that patients, who are laypeople about medical issues, cannot get the meaning of complex medical terms, but that they can hardly grasp the significance of a statement, say, “this medicine has a 5 % side-effect.” In addition, if patients want to make right decisions as objectively as possible, they must have a sufficient amount of information, possibly in a long list of pros and cons. This, however, is an unrealistic requirement, as it is easy to see that the list cannot be completely understood by patients and would turn out to be yet another large burden placed on them. Then, as Sherlock rightly points out, in this kind of situation, patients may desire to place the decision making in the hands of medical care professionals they can trust (Sherlock [1986]).

In addition to these practical difficulties, the patient-centered model is subject to a couple of theoretical challenges. First, patients cannot always pick relevant or right values to apply in making judgements. Normally, people’s values are not always known to them; it is often the case that we happen to find out what we truly desire or expect after we have some discussion with someone else or have seen particular desires or expectations be unmet in particular circumstances. The above cited gastrostomy case is a good example. A person’s belief system which encompasses his or her value-system likewise is not completely known to him or her. If so, there can be a chance that patients make grossly poor value-judgements, even if they managed to understand the information given by physicians. Another theoretical challenge attacks the assumption that patients never make mistakes as long as they make value-judgments. There has been some tacit understanding that we never commit errors in making value-judgments, just because it is *not about facts* which are usually verified in light of or by virtue of what actually happens; patients are *incorrigible* as long as they make value-judgments in decision making. This understanding needs to be examined, and I will come back to address this in the next section.

The above line of argument leads to the idea of active exchanges between a physician and a patient. The idea is well-captured by the oft-quoted “conversation model,” which requires two-way communication between a physician and a patient, and has been endorsed as it is considered to promote the patient’s autonomy. It has been pointed out, however, that the model has a number of problems, particularly in terms of its practical efficacy and legal applicability. For example, the model is based on the idea of more or less perfect conversation or communication, but almost no perfect conversation or communication can be achieved between

a physician and a patient who have different experiential and knowledge backgrounds. Second, if the consequence of a treatment turns out to be unacceptable for a patient, the case will go to court, but all the decision-making processes based on subtle, and possibly long, conversations are hard to reproduce or replicate. To address various problems found in the model and make it more practically feasible, Brody proposes to add to the model what he calls a “transparency standard”; it allows physicians to provide a non-complete list of pros and cons, but requires, through physician-led dialogues, that a physician make the reasoning behind his or her medical decisions *adequately revealed* (i.e., “transparent”) to a patient by allowing him or her to ask any type of questions to the physician (Brody [1989]). Though this fix enhances the practicality of the model, it is nevertheless the physicians who *primarily* provide the information. The conversation model *plus* the addition of the transparency standard (CMTS, hereafter) thus still seems to be *paternalistic* (though in a moderate sense, as it is open to any questions posed by patients.) What is more, the CMTS, namely a model in which the transparency standard is exercised, does not give good guidance on how to integrate patients’ values in their shared decision making, whether it is paternalistic or not.

What is missing from the CMTS is the explicit requirement of physicians to commit to patients’ values which evidently play a big role in patients’ decision making. When a competent patient makes an autonomous decision (or self-determination), ideally the patient’s decision should be more or less coherent with his or her beliefs including those about his or her preference, desired QOL, life plan and so on; that is, given our assumption that a person’s value-system is determined by that person’s belief system, the decision should be part of that value-system. A patient’s decision on gastrostomy, for instance, must fit well with her value-system, ideally speaking. (However, in reality, patients often make decisions suppressing their own desires or preferences for the sake or benefit of their family, for example.) Patients’ value-systems must include their unconscious beliefs and unconscious motivations. Some patients who are about to undergo a percutaneous endoscopic gastrostomy (PEG) procedure may unknowingly or unconsciously believe, at the moment of the decision to choose PEG, that eating through oral intake is not important for their well-being, though possibly they later comes to realize the importance. Patients’ conscious decision, at the moment of their decision, can thus conflict with their well-being. Still, of course, patients may not be knowingly aware of their unconscious beliefs and unconscious motivations. So, if patients’ autonomous decision must ultimately contribute to their well-being, it is essential to help them realize what their unconscious beliefs and unconscious motivations are. It is hence most sensible and advisable to give guidance to patients in some way or other so that they come to realize their own value-system *along with their yet unrealized or unconscious beliefs and motivations*. In the context of the physician-patient relationship, some types of dialogue between a physician and a

patient can reasonably achieve that end. Importantly, as long as the dialogue is done in such a way as to promote a patient's self-discovery in terms of his or her beliefs and motivations, we can safely say that the patient's autonomous decision is respected as the patient's active participation in the dialogue is its essential component.

To make the CMTS a viable option, the following has to be proposed, then. Physicians have to provide patients with necessary information for their decision on medical treatments (including alternative treatments); it does *not* have to be a complete list of pros and cons (since providing a complete list may not be practical). Physicians can take initiative in discussing patients' values and beliefs including such issues as goals, preferences and life plans, so that patients can come to realize their own genuine values. There can be at least a couple of obvious benefits with this approach: physicians can thereby get rid of patients' psychological burden, since the patients are not expected to be alone in making decisions. Also, the dialogues between them can work as "bias remover"; that is, patients' mistakes can be corrected through the dialogues. This approach seems to be much more practical in the sense that it allows physicians to take initiative in the physician-patient dialogues while keeping patients' values in sight. But how should physicians deal with patients' values? Should physicians not be involved in the assessment of patients' values as mere fact-providers? To answer these, let me follow the argument, presented by Ezekiel J. Emanuel and Linda L. Emanuel, which attempts to delineate physicians' role as "value-providers."

Emanuel and Emanuel discuss four models of the physician-patient relationship: the paternalistic model, the informative model, the interpretative model and the deliberative model (Emanuel *et al.* [1992])⁵. They precisely define and analyze each of these models in terms of the physician-patient interaction, how physicians act, the nature of the information given by physicians, how patients decide on their treatments, and the nature of patients' autonomy. We can see that by moving from the first model to the last, the ideal considered as the physician-patient relationship model is pursued as they focus on how patients' values, known and unknown to them, become realized in shared decision making processes, while specifying physicians' roles.

In the paternalistic model, the goal of the physician-patient interaction is to ensure that physicians promote patients' best interests and well-being. Physicians determine possible medical treatments *for* patients who lack adequate medical knowledge. The physicians authoritatively present the patients with selected information and encourage them to consent to the intervention which the physicians consider to be best for the patients. The paternalistic model assumes that the physicians can know the patients' best interest, even with limited patient participation. Here the physicians' main emphasis is on the patients' well-being, rather than on their autonomy and choice. The conception of patient autonomy is thus patient assent

to the physician's determinations of what is best. Second is the informative model. In this model, the objective of the physician-patient interaction is to have physicians provide patients with all relevant, truthful information – information on their medical conditions, the nature of diagnostic and chosen medical interventions, the possible risks and benefits of the interventions, and so on, and to have the patients decide on the medical treatments they receive. In principle, patients are expected to know all medical information relevant to the treatments that physicians are convinced best realize the patients' goals and values. It should be noted here that this model assumes *a sharp distinction between facts and values*. While patients' values are expected to be known, physicians are obliged to provide all the relevant and available facts; patients determine what treatments are to be taken based on their values and the provided facts. Here, the physicians' values, or their judgments of the patients' values, play no role. The conception of patient autonomy is patient control over medical decision making.

Third is the interpretive model, whose physician-patient interaction is ultimately aimed at elucidating the patients' values and what patients actually want, and helping them select the available medical interventions that realize these values. As in the informative model, physicians provide patients with factual information on the nature of the condition and the risks and benefits of possible treatments. But the physicians also assist the patients in finding and interpreting their values and in determining what medical interventions best realize these specific values. The model assumes the patients' values are not necessarily known to the patients. They are often inchoate, and may only partially be understood by the patients. They may even conflict when applied to specific situations. The physicians hence have to help to make these values clear and coherent. To this end, the physicians may often need to help patients reconstruct their goals, priorities, aspirations, and life plan; the patients' life should be regarded as a narrative whole. It is the patients, not the physicians, who ultimately decide which values and course of action best fit who they are. The physicians do not judge the patients' values; they simply help the patients to understand and use the values in the medical situations, engaging the patients in a joint process of understanding. The conception of patient autonomy is thus self-understanding; through the process, patients come to know more clearly how the various medical options bear on their identity.

Fourth is the deliberative model that goes further than the interpretive model. Its goal is to help patients, through dialogues, determine and choose patients' best health-related values that can be realized in the available choices. For that purpose, physicians must delineate factual information on patients' conditions and *then* help elucidate the types of values. The presupposition here is that the patients' values need to be interpreted, discussed and deliberated *through dialogues*. The physicians and the patients engage in deliberation about what kind of health-related values among the patients' should be respected. But the physicians

discuss only health-related values, that is, values that affect or are affected by the patients' conditions. In so doing, they will recognize that what aspects of morality are related or unrelated to the patients' diseases and treatments. It is important that the physicians should avoid any coercion, and instead aim at moral deliberation and persuasion. By engaging in moral deliberation, both of them can come to assess the worthiness and importance of the health-related values. Based on the discovery through their dialogues, the physicians recommend what decision regarding medical treatments would be most influential on the patients' morality. The conception of patient autonomy is moral self-development: "the patient is empowered not simply to follow unexamined preferences or examined values, but to consider, through dialogues, alternative health-related values, their worthiness, and their implications for treatment" (Emanuel et al. [1992: 2222]).

Emanuel and Emanuel argue that the deliberative model descriptively and prescriptively offers an ideal model for the physician-patient relationship, principally for the reason that it encourages patients' moral development and that the physicians' caring attitude embodied in the model is the ideal that should concern laws and policies that regulate the physician-patient interaction. But they do not simply dismiss the other models; under different clinical circumstances, different models may be appropriate and justified. For instance, in an emergency where delays in treatment to obtain informed consent could harm the patient, the paternalistic model is justified. Or in situations, such as in a walk-in center, where no more than a physician-patient interaction is expected without an ongoing relationship, the informative model will be appropriate. Emanuel and Emanuel contend that we should selectively apply the models. Their argument seems strong and persuasive. A further examination of the physician-patient relationship, however, can reveal that physicians are in the position where they *essentially have to* make value-commitment and provide value-judgements in the dialogues with patients. Let me explore that in the following section.

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Emanuel and Emanuel's informative model assumes *a sharp distinction between facts and values*. The other unpaternalistic alternatives (namely, the interpretive model and the deliberative model) too integrate a basic approach according to which physicians *first* provide factual information on patients' conditions, and *then* choose to discuss or deliberate about the patients' values. The three models (i.e., the informative model, the interpretive model, and the deliberative model), which I label here as "patient-oriented approach," basically assume that physicians provide factual information while patients give, are open to discuss, or deliberate on values based on the provided facts. This type of approach has been backed up by two

presumptions. The first is the presumption of *fact-value distinction*; assuming a clear-cut distinction between fact and value, this approach claims that physicians should only provide factual information and patients can (ultimately) make value assessment based on the information. Further, this understanding based on the fact-value distinction can be enhanced by another presumption of the *doctor-patient division of labor*. In this presumption, the physicians' role is to merely provide information in a form that is expected to be value-neutral, whereas the patients' role is to make value-assessment based on the given information and on the values or beliefs that they already hold.

The presumption of fact-value distinction is strongly held among many, but I have to agree with Brock who sharply criticizes it. Brock rightly argues that physicians' advice is *not* value-free, denying the presumption (Brock [1991]). Here I summarize some of his important arguments. *In theory*, one can question whether the sciences on which medicine is based are, or can be, value-free. Now, very few philosophers of science defend a simplistic empiricism according to which science and scientific theories are fully grounded on a value-free and concept-neutral data. Moreover, the notions of health and disease, or "normal" and "abnormal" are basically value/theory laden, as is often pointed out. Normality makes sense only when it is presented with a certain scale of values. *In practice*, physicians may fail to achieve value-neutrality. The language they use may not be solely descriptive; for example, a word "suffering" may not convey merely descriptive nuance, at least to patients. As well, a physician can never provide all possible relevant facts to a patient without providing a value-judgment about which facts are *most* important. Physicians hence must *unavoidably* make ethical choices and commitment.

The presumption of fact-value distinction appears to be essentially supported by the doctor-patient division of labor. But that is not the case. Even given the doctor-patient division of labor, which is hard to deny, it is possible that physicians make value-commitment, as I alluded to above. As Emanuel and Emanuel point out, there are good chances that patients are not aware of all the values they hold, implying that they make errors in assessing their genuine goals or expectations. That is, it is wrong to assume that patients are always *incorrigible* in their decision-making. Actually, the fact-value distinction is often coupled with the presumption that patients are *incorrigible* in their decision-making, that is, patients cannot be mistaken. This idea is backed by the claim that physicians are not in a position to know reliably what is in patients' best interests, in particular in terms of their values, thus should *not* be committal to value-judgments. Nevertheless, theoretically speaking, even though physicians cannot accurately grasp patients' values, that does not preclude the possibility of physicians' making value-commitment or value-judgments, as proposed by Emanuel and Emanuel above. The incorrigibility claim is not strong enough to prevent physicians from making value-judgments. I

hence concur with Brock who states that underlying the view of physician-patient division of labor are unwarranted beliefs about facts and values, or science and ethics, which are largely the legacy of Logical Positivism that has long been rejected by most philosophers. We have to replace these unstable foundations for our normative ideal of physician-patient relation with more reasonable and defensible underpinnings (Brock [1991]).

When thinking of our usual medical practice in everyday life, we must find odd the presumption that patients are *incorrigible* in their decision-making. But given the fact-value distinction and the understanding that patients should make certain determinations on their values, we need a careful examination of why patients' determinations are corrigible. Any self-determination is reached usually by exercising a person's capacities. Naturally, the capacities are more or less the source of errors or mistakes. It is understandable that the capacities are based on a combination of many functions of which we can be aware or unaware, such as the functions of biological body parts (organs and visual sensation, for instance), those of reasoning and memories, and those of emotional capacities (desires, for instance); some functions in the combination (for example, blurred vision and strong desires) somehow cause our mistakes. Brock elaborately delineates this mechanism in terms of "objective-subjective continuum" (Brock [1991: 68-9]). For Brock, "primary functional capacities," which include biologic (e.g., well-functioning organs), physical (e.g., mobility), mental and social (e.g., the ability of communication) functions, are objective. Besides primary functions, there are agent-specific functions that are necessary for a person to pursue successfully particular purposes and life plans (e.g., physical dexterity for a musician). More agent-relative are the particular desires pursued by particular persons on particular occasions. Moving from primary functions to agent-specific functions to agent-specific desires, one moves across a continuum of objectivity to subjectivity in assessing a person's values. According to Brock, the objective-subjective continuum explains why the incorrigibility claim regarding patients' values is mistaken at the objective end of the continuum, hence allowing physicians to play a role as mistake-removing advocates in patients' formation of value-judgments. As Brock states, "The more the patient's values and choices in shared decision making appear to be in conflict with his or her objective good, that is, ideals and functions at the objective end of the continuum, the stronger the case for the physician being an advocate for those ideals and functions and seeking to ensure that the patients values and choices do not, in fact, conflict with them" (Brock [1991: 69]). Given the patients' possible mistakes in decision making, the physicians' role should include the advocacy of some values and they should be permitted to make value-commitment.

The above arguments show that it is theoretically unavoidable that physicians make value-judgments or ethical commitments. It is *not* "by physicians' choice" as Emanuel and Emanuel contend in their argument: physicians *are* value-committed advocates. Physicians

help patients discern what the patients' values are so as to help ensure that the treatment choices serve these values. To sum up the physicians' practice, its role is to provide facts necessary for medical decision making but this role does not exclude their moral commitment. Emanuel and Emanuel are right in saying that physicians are value-advocates when promoting and deliberating health and well-being; as long as physicians aim at promoting patients' health, they are committed to important values, i.e., the value of health (even if we assume the notion of health itself as value-free). But physicians *cannot* do so by choice; they have no other choices. Importantly, this line of argument does not entail or imply physicians' *paternalistic* intervention. Competent individuals (e.g., patients) can be mistaken in making decisions and evaluating their good. But this claim should be distinguished from the following claim: if patients tend to be mistaken, physicians *should* paternalistically interfere with patients' treatment choices. The former does not necessarily entail the latter. Physicians' role as value-committed advocates should *not* include any paternalistic intervention or violation of patients' autonomy, even if the intervention is intended for beneficence. Here the contrast between the principle of beneficence and the principle of autonomy, presented at the beginning of this paper, has to translate in the contexts of shared decision making to the contrast between physicians' value-committed advocacy and physicians' willingness to accept patients' autonomy or self-determination. Physicians being value-committed advocates can be coherent with their accepting patients' autonomy which has been claimed to be one of *the* central notions in modern biomedical ethics.

I think we have a substantial number of arguments presented that are intended to support this view. In recent years, there are theoretical movements that attempt to combine value-based medical practice with evidence-based medicine (EBM). For example, Fulford proposes a value-based medicine (VBM) and shows how to transform, with the help of philosophical value theories, the traditional fact-centered medical model into a more balanced fact and value model (Fulford [1989]). According to Fulford, VBM is premised on a mutual respect for physician and patient values; physicians and clinicians have to develop the skills to ascertain patient values and to get in touch with their own values and beliefs in order to grasp those that can play in shared decision making contexts.

Shimizu's endeavor in presenting his "information-sharing and consensus-seeking model" appears to be another example (Shimizu [2015]). According to Shimizu, a patient and his or her family, as crucial members of an interested party in a decision-making process, have to be advised to form an informed intention; on the basis of the intention, they are expected to build consensus with other participants, such as medical workers, through communication with the aim of making shared decisions. More importantly, Shimizu presents the model as a type of shared decision-making model that is designed to include a process of communication, through

which the patient and other participants share information and seek consensus *on the basis of the patient's way of life*. Through such a process, the participants support the patient (often with his or her family) to reach an informed decision. Shimizu argues that the model applies well in ACP (advance care planning), i.e., the process of making a care-plan in advance; in ACP, physicians' or care-takers' sharing the patients' values, way of living, and preferences, can serve as the foundation for the advanced shared care planning. This seems to be a good, promising practical application of our proposed view.

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I have argued that physicians necessarily have to make value-commitment in shared treatment decision making, and thus it is logical for them to play a value-committed advocate role in the physician-patient relationship. According to my proposed approach, physicians can interfere in patients' medical decisions through dialogue or exchange while allowing them to maintain autonomy. Some might object that the view turns out to be paternalistic. But if physicians endeavor to apply the right and proper way of having dialogues (respecting patients' values and experiences), I take that patients' autonomy can be much *enhanced*, rather than undermined. Though there is insufficient space to develop this point, I want to close my discussion by citing Quill and Brody's words that well underline this idea (Quill and Brody [1996]).

In place of the "independent choice model," Quill and Brody propose what they call an "enhanced autonomy model," which they claim encourages patients and physicians "to actively exchange ideas, explicitly negotiate differences and share power and influence to serve the patient's best interests" before fully informed patients make final decisions. The model is hence considered to "promote an intense collaboration between patient and physician so that patients can autonomously make choices that are informed by both the medical facts and the physician's experience" (Quill and Brody [1996: 763]). Quill and Brody's point is that any significant discrepancies between patients' *values and experiences* and *those* of physicians must be addressed through a process of mutual exchange. Physicians and patients can reach a common ground through a process of mutual exchange despite or rather *due to* the differences between the two parties, while patients' personal values and experiences are being respected. Most importantly, through the exchange and the input from well-informed physicians, autonomous medical choices are usually enhanced rather than undermined. As Quill and Brody state,

Enhancing patient autonomy requires that the physician ... explore both the patient's values and their own, and then offer recommendations that consider both sets of values and experiences. This model is "relationship-centered" ... rather than exclusively

patient-centered. It denies neither the potential imbalance of power in the relationship nor the fact that some patients might be inappropriately manipulated or coerced by an overzealous physician. It assumes that an open dialogue in which the physician frankly admits his or her biases, is ultimately a better protector of the patient's right to autonomous choice than artificial neutrality would be (Quill and Brody [1996: 765]).

Quill and Brody's proposal is that patients' autonomy is based on the balance of power and the impartial view of value. The model I have proposed in this paper likewise is a "relationship-centered" model with the balance of power, though the nature of powers of physician and patient can be different. Physicians have to respect and pay attention to patients' values and experiences by treating them as important as their own.

Finally, Quill and Brody's argument proposes a couple of practical issues. First, training for medical students, practitioners, and medical specialists can integrate the type of skills for the exchanges that helps make stronger commitment to patients' values. Second, this view leaves room for cultural consideration, as "the proper way of having exchange" may be different from culture to culture; that is, in discussing a physician-patient relationship, we may have to consider the cultural or communal aspects of its background. It means that we may thus need *specific* or culture-sensitive approaches, rather than a *general* approach. Physicians' value-committed advocacy role that is expected to integrate good skills of exchange with patients who come from certain cultural backgrounds may well require the physicians to pay attention to the cultural aspects.

Notes

¹ I thank the scholars invited from overseas, for the helpful comments on my presentation they made during the "2014 International Conference" organized by the Japanese Association for Philosophical and Ethical Researches in Medicine. I would also like to thank the referees for the significant comments they made after reviewing my first draft of this paper.

² Normally in the "independent choice model," physicians are considered to objectively present patients with options and odds, but withhold their values and experiences in order to avoid overly influencing patients.

³ Some well-organized assessments of the shared-decision-making model are well documented in Sandman & Munthe [2010].

⁴ In rather precise terms, I formulate "paternalism" in the following fashion:

A's decision, D*, of doing some act, X, with regard to S is *paternalistic* if and only if:

- (1) A deliberately makes a decision D*;
- (2) A decides D* with the primary or sole aim of promoting a benefit for S [a benefit which, A believes, would not accrue to S in the absence of A's doing X] or of preventing a harm to S [a harm which, A believes, would accrue to S in the absence of A's doing X];
- (3) S is not involved as a reasoning party and a partaker in making D*; or A is not authorized by S to make D* by herself.

(cf. Sandman and Munthe [2010], Van De Veer [1992]).

⁵ I don't have sufficient space to elaborate on my precise assessment of Emanuel and Emanuel's argument, but I referred to the following discussions to evaluate the argument: Borza *et al.* [2015], Sandman and Munthe [2010], Widdershoven [2001].

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