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Persons over models: shared decision-making for person-centered medicine

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Abstract

In the last decades “shared decision-making” has been hailed as the new paradigm for the doctor-patient relationship. However, different models of clinical decision-making appear to be compatible with the core tenets of “shared decision-making”. Reconsidering Emanuel and Emanuel (1992) classic analysis, in this paper we distinguish five possible models of clinical decision-making: (i) the ‘instrumental’; (ii) the ‘paternalistic’; (iii) the ‘informative’; (iv) the ‘interpretative’; and (v) the ‘persuasive’ models. For each model we present its fundamental assumptions as well as the role that patients and doctors are expected to play with respect to value-laden dilemmas. We argue that, with the exception of the instrumental model, each of the other four models may be appropriate depending on the circumstances. We conclude by highlighting the importance of structuring clinical care around actual persons - and their unique lives and philosophies - rather than around abstract frameworks.

Keywords

Autonomy, doctor-patient communication, informed consent, paternalism, person-centered medicine, shared decision-making

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Introduction

In the last decades “shared decision-making” has been hailed as the new paradigm for the doctor-patient relationship by institutions, policy-makers and scholars alike. However, the meaning and practical implications of such a new paradigm remain unclear; a wide variety of different models of clinical decision-making appear to be compatible with the core tenets of “shared decision-making”. A panoply of different models arises, we argue, because clinical practice is too variegated and complex to be reduced to a single overarching theoretical ideal: depending on the circumstances, different decision-making models may be appropriate. Delving into these themes, this chapter is organized into three sections. First, we present a clinical case to introduce the rationale beneath the call for shared decision-making. Second, we distinguish five possible models of clinical decision-making: (i) the ‘instrumental’; (ii) the ‘paternalistic’; (iii) the ‘informative’; (iv) the ‘interpretative’; and (v) the ‘persuasive’ models. For each model we present its fundamental assumptions as well as the role that patients and doctors are expected to play with respect to value-

laden dilemmas. Finally, we argue that, with the exception of the instrumental model, each of the other four models may be appropriate depending on the circumstances. We conclude by highlighting the importance of structuring clinical care around actual persons - and their unique lives and philosophies - rather than around abstract frameworks.

“Issues of facts” and “issues of values” in shared clinical decision-making

Anna (27 yrs) is two months pregnant when she is diagnosed with an oestrogen-positive breast cancer. She is presented with three therapeutic options: (1) standard treatment, which has the highest survival rate but is incompatible with pregnancy; (2) surgery followed by adapted chemotherapy, which has a lower survival rate but is compatible with fetal development; (3) surgery with the postponement of all other treatments after the delivery,

which has the lowest survival rate but is the safest option for the fetus (adapted from Boniolo and Sanchini, 2016).¹

In this situation, it may be difficult to decide what to do. This choice is particularly challenging because it concerns not only “issues of fact” - that is, empirical considerations - but also “issues of values” - that is, normative or moral evaluations [1,2]. Specifically, in Anna’s case, the “issues of fact” comprise all empirical facts related to her condition and therapeutic options (e.g., their survival rates, risks, *etc.*). The “issues of value”, instead, comprise all the normative issues raised by her choice; for instance, which moral status ought to be attributed to human fetuses. Indeed, in this case, identifying the best course of clinical actions requires addressing both empirical *and* moral issues.

Difficult cases like this have always existed in clinical medicine; yet nowadays they are increasingly frequent due to the plethora of therapeutic options afforded by medical progress. For instance, when considering treatment for early breast or prostate cancer, today more than one reasonable therapeutic option may exist, just as in Anna’s case. Similarly, decisions to undergo major surgeries or screening and diagnostic tests for potentially stressful and serious pathologies may all lead at decisional crossroads between issues of facts and issues of values [3]. This precipitates an important question: What should be done when crucial clinical decisions depend not only on factual issues but also on value-judgments?

For centuries, at least in Western contexts, the dominant view has been that, in contentious situations, doctors retain the authority and responsibility to decide. Yet this might lead to questionable outcomes, as doctors’ value-judgments may differ or conflict with patients’ preferences and best interests. Indeed, from the 1970s, the traditional paternalistic model of clinical decision-making has gradually been superseded by a different model based on patients’ autonomy and informed consent. According to the latter, patients should be the ones making important value-laden decisions - provided that they are sufficiently competent to do so.

However, leaving *all* value-laden decisions to patients may also be problematic. Sometimes, deciding between diverse therapeutic paths may be difficult even for competent patients due the interplay between issues of fact and issues of value. For instance, in the above example, Anna may have a perfectly clear idea of the success rates, risks and practical implications of all available therapeutic options; and yet she may be uncertain about which one best represents her normative preferences and values. In such difficult cases, leaving patients to decide alone seems to promote an impoverished idea of patient’s autonomy and misconstrue the proper end of a clinical relationship: to care for and aid vulnerable persons in need.

Acknowledging the potential limitations of both paternalistic and autonomy-based models, in the last decades a new paradigm has emerged: “shared decision-making” (henceforth, SDM). In SDM, clinicians and

patients “share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences” [4]. In order for a decision to be informed, patients and doctors have to address both matters of fact and of values. In particular, in SDM patients’ values and preferences are paramount; hence SDM has been labeled as both the “future of the doctor-patient relationship” and as “the pinnacle of person-centered medicine” [5]. Furthermore, SDM has been linked with positive patient outcomes (e.g., satisfaction and improvement in functional status) [6-8].

Yet, despite a general consensus on the importance of SDM in clinical contexts, the meaning and practical implications of such a new paradigm remain unclear [7,9]. This is because the concept of a “shared decision” is often undefined and because more than one model of clinical decision-making seems to be compatible with the core tenets of SDM [10]. What does it mean that doctors and patients must “share” important clinical decisions? How should doctors engage patients in cases like Anna’s one? Should doctors refrain, encourage or nudge patients in confronting difficult issues of value whenever important clinical choices depend on them?

To begin answering these questions, in the next sections we analyze diverse models of clinical decision-making that have been recognized, and sometimes advocated for, in the literature. Contrary to the view that is possible to elevate one of these models as the ideal prototype of clinical-decision making, we argue that, with the exception of the instrumental model, each of the other four models may be appropriate depending on the circumstances.

Five models of clinical decision-making

Scholars have elaborated diverse models of doctor-patient relationship and decision-making [9-13]. Against this background, we distinguish in this section five approaches: (i) the instrumental, (ii) the paternalistic, (iii) the informative, (iv) the interpretative, and (v) the persuasive model. For each model examined we outline its fundamental assumptions as well as the role that patients and doctors are expected to play with respect to value-laden dilemmas [14,15].² These models are to be understood as Weberian ideal types [12], that is, as different regulative ideals around which the doctor-patient relationship - and consequently clinical decision-making - can be understood and organized. For simplicity, we consider only a simplified set of clinical situations in which a competent patient interacts with a physician.

First, the *instrumental* model; conceptually it occupies the negative extreme of the spectrum – here, doctors are understood to have all the power and then use it for their

¹ Boniolo, G. & Sanchini, V. (Eds.). (2016). Ethical counselling and medical decision-making in the era of personalized medicine. A practice-oriented guide. London, Germany: Springer Nature.

² While the assumption that a clean distinction can be made between matters of ‘facts’ and ‘values’ is subject to criticism, in this paper we confine ourselves to the conventional parameters of the ethical debate about shared clinical decision-making [10].

exclusive benefit. This kind of instrumental doctor-patient relationship was common during the early middle ages, when doctors were “self-taught” and rivaled with other healers and quacks in using outright lying, deception and scams to secure new clients and their payments [16]. For instance, one author of the time suggested that doctors should always tell patients and their family that their condition is “critical”: if they die, the doctor can thus defend himself (“I told you so!”) and if they survive, he can instead take credit for it (“I saved him!”) [16].

Nowadays, Western medical ethics codes explicitly forbid this kind of instrumental relationships in clinical settings. Yet, it seems clear that instrumental doctor-patient relationships continue to resurface; for example, when physicians prescribe unnecessary or unproven treatments for their economic benefit or to promote their scientific career. At least sometimes, these tendencies may arise unconsciously, embedded a set of unreflective biases that emerge without the physician’s deliberative judgment but are perpetuated by the healthcare culture in which the physician works; for example, the phenomenon of overtesting in pay-per-service health systems [17]. Nonetheless, in such circumstances, patients are indeed treated as *means* (or instruments) for doctors’ *ends*, rather than as “ends in themselves” - that is, as autonomous agents. The instrumental model is thus connoted by an essentially exploitative relationship in which physicians have the monopoly of truth and, in extreme cases, may resort to deception and lying. With respect to value-laden decisions, patients’ views and preferences are typically not even discussed or taken into account.

Second is the *paternalistic* or “priestly” model [12,13]. Traditionally, this model has exemplified the typical doctor-patient relationship throughout the history of Western medicine, from the time of Hippocrates until, at least, the late 20th Century. In general, “paternalism” can be defined as “the intentional overriding of one person’s preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or preventing or mitigating harm to the person whose preferences or actions are overridden” [18]. The fundamental assumption beneath the paternalistic model is that doctors know how to restore and promote patients’ health and wellbeing even better than patients themselves. Hence, for patients’ own good, sometimes paternalistic doctors have to decide *instead of* or *contrary to* patients’ expressed preferences. Classic examples of paternalism are when doctors withhold a negative diagnosis to avoid traumatic shocks or impose unwanted safety measures to preserve patients from injuries [19].

As with the instrumental model, in the paternalistic one the doctor also has the monopoly of truth and authority and, ultimately, decides what ought to be done in each case. Differently from the instrumental doctor, however, the paternalistic physician always acts for the patient’s good, rather than for his own - just like a benevolent father who acts for the good of a beloved child.

With respect to conflictual “issues of value”, adopting the paternalistic model of decision-making may lead to different scenarios. In some cases, paternalism effectively prevents the expression of patients’ preferences. For

instance, by withholding bad prognoses, a paternalistic doctor may prevent patients from expressing their preferences about important issues of value, for example, whether or not the time has come to switch from active therapy to palliative care. In such cases, and perhaps against the physician’s intuitions, recent evidence shows that when patients select early palliative care (somewhat counterintuitively) this may extend life [20]. On other occasions paternalism entails that doctors override patients’ preferences. For instance, paternalistic doctors may resort to coercive care even though patients have clearly expressed their veto. In general, in the paternalistic model, doctors’ professional obligations toward patients’ health and wellbeing is prioritized above patients’ implicit or expressed preferences.

Third is the “scientific”, “engineering”, “consumer” or *informative* model [12]. This model came into existence only recently: i.e., after the “discovery” of autonomy as one of the fundamental values of medical ethics in the second half of the past century [18]. It assumes a sharp division between facts and values, and thus an equally sharp “division of labor” between doctor and patient: the former should provide all the necessary information about the relevant issues of fact; the latter should then decide, on the basis of this information, about all relevant issues of value. With reference to this view:

“[B]oth physicians and patients make active and essential contributions. Physicians bring their medical training, knowledge, and expertise - including an understanding of the available treatment alternatives - to the diagnosis and management of patients’ condition. Patients bring knowledge of their own subjective aims and values, through which risks and benefits of various treatment options can be evaluated. With this approach, selecting the best treatment for a particular patient requires the contribution of both parties” [21].

This informative model embodies perhaps the simplest form of “shared decision-making”, for in it both parties have to share at least the information about relevant issues of facts [10]. Contrary to the paternalistic model, however, patients retain exclusive authority over issues of value. Accordingly, clinical decision-making is conceived as a two-step process:

“The first step is a question of facts. The anchor is empirical evidence ... [T]he second step is a question not of facts but of person values and preferences. The thought process is not analytic but personal and subjective ... [I]t is the patient’s preferences that should determine the decision ... Ideally, you and I [the physicians] are not in the picture. What matters is what Mrs. Smith thinks” [22].

Thus, in this model, the doctor’s role with respect to problematic issues of value is simply that of promoting patients’ autonomy through adequate disclosure. In turn, patient’s autonomy is conceived as the ability to decide according to one’s values free from coercion and external interferences. The primary scope of the doctor-patient communication is to empower patients by facilitating their making informed decisions without engaging with any

issue of value; hence physicians's own normative preferences are intentionally left in the background.

Fourth is the *interpretative* model [12]. As with the informative model, this one is also based on the recognition that patients must decide between competing clinical options without external interference on issues of value. However, the interpretative doctors also acknowledge that sometimes patients are not ready to confront the complex interplay between issues of facts and issues of value. This may occur for different reasons. First, a patient may have a clear set of *ends* (i.e., his/her values and preferences) and still be unsure about how such *ends* map onto available *means* (i.e. the clinical options). For instance, in Anna's case, she might think that "all human lives" are important, and yet be unsure about which clinical option best embodies such a principle. Second, as it is often the case, patients may not have a pre-determined, coherent and clear idea of what their *ends* are. In both scenarios, interpretative doctors provide not only the necessary information about relevant issues of facts, but actively engage patients in exploring, articulating and making explicit their values and preferences, with the ultimate goal of reaching a final deliberation and select the best clinical option [1,2]. In this model, therefore, the doctor acts as an agent-counsellor whose task is to aid patients in discovering and making clearer their preferences and values.

Crucially, however, in so doing, the doctor/counsellor refrains from dictating or imposing any particular set of values, or from suggesting a ranking of patient's preferences. The role of the interpretative doctor, in fact, is not that of imposing any predetermined set of preferences or ends, but rather that of aiding patients in making more explicit their own beliefs and preferences, thus forming a considered opinion and possibly finding a solution to the dilemma at hand.

Lastly is the "deliberative" or *persuasive* model [12]. As with the interpretive model, the persuasive doctor provides all relevant factual and contextual information, encouraging patients in making explicit their normative preferences. However, in engaging with problematic issues of values, in this model the doctor takes a more active role with the aim of *persuading* patients to autonomously embrace the best health-related values. Here, the physician no longer acts as a neutral counsellor, but rather as a friend, teacher or mentor, that is, of someone who has a moral obligation of telling patients what ought to be done from a health perspective. The doctor, employing this model, is an active advocate of certain health values.

At the extreme, doctors and patients "engage in deliberation about what kind of health-related values the patient could and ultimately should pursue. The physician discusses health values that affect or are affected by the patient's disease and treatment; he or she recognizes that many elements of morality are unrelated to the patient's disease or treatment and beyond the scope of their professional relationship" [12]. For instance, persuasive doctors might directly engage overweight or diabetic patients about their life-priorities in an effort to nudge them to adopt healthier lifestyles. Crucially, the proposed scope of the physician, on this model, is not to manipulate or coerce patients in choosing some health-related values,

but that of *persuading* them toward such ends.³ To explain this key difference between persuasive and paternalistic models, Emanuel and Emanuel [12] quote the following passage from Plato's *Law*:

"A physician to slaves never gives his patient an account of his illness ... the physician offers some orders gleaned from experience with an air of infallible knowledge, in the brusque fashion of a dictator ... the free physician, who usually cares for free men, treats their diseases first by thoroughly discussing with the patient and his friends his ailment. This way he learns something from the sufferer and simultaneously instructs him. Then the physician does not give his medications until he has persuaded the patient; the physician aims at complete restoration of health by persuading the patient to comply with his therapy."

Considering this view, the ideal conclusion of a process of benevolent persuasion is thus a process of "moral deliberation" whereby the patient autonomously comes to endorse the proposed health-related values - albeit after the case for these values has been persuasively presented. In such a process, both patients and doctors play an active role, as both are asked to express and share their ideas about specific health-related values and their relative ranking.

Choosing a model of clinical decision-making

Since doctors may choose between different models of clinical decision-making, the question arises whether such models are equally viable or one is better than others. In their classic contribution, Emanuel and Emanuel [12] argue that, other things being equal, the persuasive model of clinical decision-making - which they call the "deliberative" model - must be preferred. Although they recognize that "under different clinical circumstances different models may be appropriate", they also maintain that it is important "to specify one model as the paradigmatic reference; exceptions to use other models would not be automatically condemned, but would require justification based on the circumstances of a particular situation". In their view, the persuasive model is therefore a sort of "first among equals".

While it is true that the choice of whether a model is adequate is always contextual, we disagree that the persuasive model provides the ideal type of doctor-patient interaction for clinical decision-making, and that all exceptions to it require a justification. As we proceed to show, barring the instrumental model, all other models

³ This should be distinguished from other kinds of clinical approaches such as 'narrative medicine' where the goal is for the physician and the patient to co-construct - as well as 'deconstruct' - the illness experience, in order to determine the meaning of illness for the patient (see: Charon, R., 2001. Narrative medicine: a model for empathy, reflection, profession, and trust. *Journal of the American Medical Association* 286 (15) 1897-1902). A distinctive goal of narrative medicine, then, might be understood as the co-construction of the patient's preferences and values where the physician plays an active role in this process.

may sometimes be appropriate. In addition, we argue that doctors owe patients a “moral justification” for lines of questioning relating to shared decision-making – for example, an explanation of why certain value-laden questions might be posed. To support this view, in this section we consider a series of potential cases that highlight the relative shortcomings of each model.

The deliberative / persuasive model

Let us begin with the deliberative/persuasive model. We shall address only one of the justifications provided by Emanuel and Emanuel, as it is the most problematic: that such a model may easily metamorphose into paternalism. Indeed, attributing to doctors the tasks of persuading patients about certain values sounds inherently paternalistic. Certainly, there is a fine line between persuasion and manipulation. There is a clear risk, in this model, of doctors leading decisions about issues of value instead of allowing patients to reach such judgments themselves; medical paternalism would thus re-emerge, though in a subtler form.

Against this risk, Emanuel and Emanuel [12] argue that doctor’s persuasion should be limited only to “health-related values”. For instance, “physicians frequently urge patients with high cholesterol levels who smoke to change their dietary habits, quit smoking, and begin exercise programs before initiating drug therapy. The justification given for these changes is that patients should value their health more than they do”. By contrast, physicians should not persuade patients to embrace or change their preferences about values unrelated to health.

However, while such a distinction between “health related” and “life-related” values may hold in *ad hoc* cases, under a closer scrutiny it becomes problematic. Consider again Anna’s case. In this example, it is undeniable that the clinical decision to be taken concerns Anna’s health. Yet, it is also undeniable that the ethical dilemma at stake concerns divisive ethical issues, such as the moral status of the fetus and how it should be evaluated with respect to Anna’s survival. Now, suppose that Anna’s doctor, Jill, belongs to a religious group for which the abortion of a human fetus must always be avoided, as it is considered an act that is never morally permissible. In such delicate and potentially controversial cases, the risk that Jill might ultimately impose - more or less unconsciously - her values over Anna’s ones cannot, we maintain, be ignored or discarded. In similar circumstances, embracing the persuasive model as the reference model for clinical decision-making could provide a justification for interfering with Anna’s value-judgments, on the basis that “guiding a patient’s choice is one of doctor’s tasks and responsibilities”.

Furthermore, clinical decision-making often occurs in less than ideal circumstances. Doctors are often unprepared to properly confront patients’ issues of value; and, especially while facing difficult and unexpected choices, patients may defer to the socially high-in-status doctor as a source of both technical *and* moral authority, conflating issues of facts and issues of values and undermining the

very premises of shared decision-making. The same risk, we argue, is likely to occur anytime an ethical dilemma involves divisive moral issues and which, for their own nature, we take to represent the majority of the cases for which implementing SDM could be desirable in clinical contexts. They include, but are not limited to, all dilemmas involving reproductive rights and choices, end-of-life decisions and palliative care, coercive care, and so on. In all these cases it is impossible to distinguish sharply between health and life-related moral values. Accordingly, by identifying the persuasive model as the ideal archetype, Emanuel and Emanuel’s proposal may inadvertently promote medical paternalism rather than shared decision-making.

Therefore, sometimes it might be better to aid patients in exploring their values and preferences, rather than persuading them toward certain (health-related) ends. In Anna’s case, this could be accomplished, in the first place, by letting her speak about what matters the most to her and by gradually uncovering her unique “personal philosophy”, that is, that “wide set of more or less deep, coherent, and justified metaphysical, methodological, religious, political, aesthetical, ethical, *etc.*, beliefs, assumptions, principles and values that an agent possesses and that characterizes in a unique way how he/she approaches the world and his/her life” [23]. Hence, there are cases in which the interpretative model is conceivably better than the persuasive one, as resorting to the latter might eventually cause more harm than good.

The interpretative model

Opting for the interpretative model, however, sometimes mandates an additional explanation by the doctor. Patients may be naïve to the relationship between values and clinical decisions and expect that doctors will know what is the right treatment; in such cases, patients may recoil and feel uneasy about certain lines of personal questioning apparently unrelated to their health. For instance, a doctor facing a request for contraceptive pills may ask personal questions about patient’s current relationships, desires and life-priorities in order to select the best option. In the absence of further clarifications, however, patients may interpret such reason-giving process not as a way of making explicit their values to facilitate clinical decision-making, but as an unprofessional intrusion of their personal life. To prevent or mitigate such risks, doctors adopting an interpretative model of SDM may consider explaining their behavior; for instance, by saying “Let’s discuss what’s going on in your life because that way I can assist you in making the right decision re: the medical treatments available to you. Some may be better suited to you, and we can discuss why that might be the case.” Importantly, this disclosure would not be similar to informed consent (e.g., “Do you mind if I ask you some personal questions?”), but rather to what doctors say prior to giving an injection to make patients feel more comfortable (“Here come some questions about x”/ “here comes the injection it won’t hurt”).

The informative model

However, there are other cases in which neither the persuasive nor the interpretative model would be ideal and where, instead, the informative one represents the best option (once the doctor has assessed the patient's competence and preferences, as we explain below). Consider a situation in which Clare confronts the same choices as Anna. Differently from Anna, however, Clare has a very clear and articulated view of what she ought to do. Perhaps this is due to her deeply held religious beliefs; or because she is an expert both in medical ethics and oncology and she had already pondered at length what she would have done in these circumstances.

Clare is a thus competent patient who is determined about her value-laden clinical choice: she just needs all the technical and practical information to proceed forward. Beyond the assessment of her intentions and competence for the purpose of informed consent, asking her to re-state, confront and explain at length her reasons in front of a physician may be unnecessary and even harmful. Clare could perceive such requests - even if well-meant - as an undue intrusion into her private sphere: a paternalistic attempt to persuade her in reconsidering her views and decision, casting unneeded doubts and uncertainty over an already difficult choice. Thus, depending on the person and circumstances, there are conceivable cases in which opting for the informative model, rather than for either the interpretative or the persuasive one, would be preferable; and letting a competent patient decide for herself in such a case does not obviously require any additional moral justification on the doctors' part.

Yet, to discern Anna's case from Clare's, and thus to adopt the most appropriate model of decision-making in this particular situation, doctors should consider starting a prior conversation to give to each patient an opportunity of expressing her or his competences and views. Through such preliminary confrontations patients such as Clare will be able to reveal their value-laden competence about medical decisions, hence facilitating decisions about which model of clinical decision-making is most appropriate in such particular circumstances.

At this point, it is worth emphasizing that all models so far considered - the persuasive, the interpretative, and the informative one - share three important features. First, they are all compatible with the respect for the patient's autonomy: as in all cases patients retain the ultimate authority in selecting the therapeutic option that best suits their needs, values and beliefs. Depending on the decisional model, however, different ideals of autonomy (self-determination, relational, or deliberative) can be realized. Second, they are all compatible with the core idea of "shared decision-making", for in all cases the final decision is eventually "shared" by both parties, although what is shared depends on whether the doctor avoids (informative), engages (interpretative) or concurs in deliberating (persuasive) about issues of values with a patient. Third, provided these two requirements are met, choosing which model is eventually adopted may require doctors to explain the need and possibility of exploring patients' values by posing non-medical questions.

Respecting patient autonomy and promoting shared decision-making are always *prima facie* important, even though the specific model through which such values are realized depends on the contextual features of the specific clinical encounter.

The paternalistic model

By contrast, the paternalistic model always entails a breach of patient's autonomy, as ultimately it leaves it to the doctor to decide about complex value-laden issues. This does not imply, however, that paternalism *per se* is unethical. For instance, in emergency situations paternalism may be the only viable option. Also, not every patient is competent: infants, children, and persons with severe mental disabilities are all not-autonomous subjects for which paternalistic decision-making (by doctors or surrogate decision-makers) may be justified. Finally, competent patients may deliberately and autonomously delegate important clinical decisions to doctors - even though such decisions touch upon issues of value. As evidence suggests, not all patients want to know the truth about their condition and prognosis; and some patients may prefer a passive role with respect to complex clinical decisions rather than engaging in SDM. Therefore, paternalistic decision-making may sometimes be the only or the best option to adopt.

Contrary to other cases mentioned, resorting to paternalism *always* requires not only a prior assessment of patient's competences and preferences, but also an explicit moral justification. At least in contemporary Western contexts, doctors have a *prima facie* obligation to respect patient autonomy and secure a valid informed consent [18,23]. Contravening such *prima facie* obligations requires a justification in order to explain why, in that particular case, paternalism would ultimately be in patients' best interest, even though it infringes on their autonomy and right to informed consent. Additionally, such justification also ensures that doctors do not advocate for themselves all the power and authority just for instrumental purposes. Recall that what distinguishes the previous models from the instrumental one is that the former are all meant to promote the patient's good; in contrast, the instrumental model serves only the doctors' interests. Yet, doctors may sometimes be tempted to act instrumentally and then unconsciously disguise their behavior as an instance of justifiable paternalism.

Therefore, providing a moral justification places the burden of proof on the paternalistic doctor to demonstrate that (i) the paternalistic act is primarily meant for the patient's good rather than for the doctor's and (ii) the good that the paternalistic act ensures provides a good reason to override the *prima facie* obligation of respecting patient's autonomy.

The instrumental model

Finally, the only option that is never morally appropriate is the instrumental model. Instrumental doctor-patient relationships, in fact, misconstrue the proper *end* of clinical

medicine - to care for vulnerable patients in a humane and professionally competent way - and thus must always be avoided. Such a moral and professional duty of a doctor may translate in either paternalistic or shared decision-making, but never into an exploitative relationship.

In sum, depending on the context and persons involved, diverse models of clinical decision-making might be appropriate. The informative, interpretative and persuasive models are all compatible with the general tenets of “shared decision-making”, as they are all compatible with respect for a patient’s autonomy as well as with the principle that important decisions in clinical contexts ought to be shared by patients and doctors. To select which model is the most appropriate, doctors should consider engaging patients in prior conversations, possibly explaining why in certain cases the shared exploration of personal values could be in their best interests. In addition, there is a limited set of cases in which the paternalistic model may also be justifiable. In the latter case, doctors should provide a moral justification with the twofold purpose of demonstrating that, in that particular case, their primary intent is not instrumental and that paternalism is justified over shared decision-making.

Conclusion

As both doctors and patients know well, each clinical encounter is unique. Due to this inherent complexity, we have in this chapter argued that no single model of clinical decision-making can be identified as the ideal prototype. Of course, after the emergence of autonomy in medical ethics, doctors today have an explicit duty of respecting patients’ agency and right to informed consent and paternalistic decision-making should thus be limited to a justified set of limit-cases. However, as the recent debate over the importance and meaning of “shared decision-making” has highlighted, different models of clinical decision-making are compatible with the general principle of respecting patients’ autonomy as well as with the idea that doctor and patient ought to concur in clinical decision-making. Yet, depending on the persons and circumstances involved, one model may be preferable to the others, while none deserves the status of “first among equals”.

This conclusion raises a concrete difficulty for doctors in clinical contexts: if no abstract model of decision-making can be selected *a priori*, then how could doctors properly engage patients? In our view, the answer is that clinical care should always be person-centered rather than model-centered. This implies that, before selecting which model would be the most appropriate, doctors have first to understand *who is* the person in front of them. This entails not only an understanding of the various issues of fact at stake – for example, the person’s condition, her past clinical history, or the therapeutic regime in place - but also delving into her unique worldview regarding important issues of values and preferences – for example, whether she prefers a more active or passive role with respect to clinical value-laden decisions, or whether she has particular fears concerning her present situation. In this

view, the understanding of the *patient as a person* ought always to precede and orient the subsequent choice of what model of clinical decision-making (or mixture of models) would be the most appropriate in those particular circumstances. This preliminary form of doctor-patient dialogue should ideally arise in each medical circumstance, otherwise the doctor may problematically portray shallow and falsely rigid images of patients (e.g., Clare *always* exhibits competence in decisions; or Anna *always* needs a persuasive approach).

A potential objection to this proposal is that, currently, doctors have neither the competencies nor the time to follow up on this two-stage process. Indeed, doctors receive insufficient training in medical ethics and in other medical humanities; hence, for some professional it might be difficult to properly identify, appraise and deal with complex issues of value. Also, doctors and nurses have already many responsibilities and tasks in clinical contexts, with some categories of medical professionals at severe risk of burn-out [24,25]; adopting a more person-centered approach would require adding additional burdens in terms of time and efforts.

While we acknowledge that both of these issues present substantial practical challenges, we also hold that such difficulties are not to be understood as unsurmountable obstacles but, rather, as signposts signaling the way forward. As for the training, it is clear that, if the phrase “shared decision-making” should possess any meaning, then doctors should be adequately prepared to assume - at least - the main roles required by the informative, the interpretative and the persuasive model, and to have the capability of navigating between them as required. This, it should be stressed, does not represent an additional burden on what doctors are already expected to do in clinical contexts: such ability, in fact, is required in order to properly respect and empower patient’s autonomy, a moral and professional duty in all contemporary clinical contexts.

As for the shortage of time and resources, different measures could be implemented depending on the country and the health-care system considered. Regardless of such practical differences, however, no significant step forward could be achieved without a concomitant change at the level of national and international laws and policies concerning how therapeutic encounters - and doctor-patient relationships in particular - are conceived and defined. In this regard, an interesting step in the right direction has been taken in the recent 2018 Italian law concerning “Informed consent and advance treatment directives”. In the first article of this law, dedicated to “informed consent”, the legislator has explicitly stated that “the time allocated to the doctor-patient relationship ought to be considered time of cure” (art 1, comm 8). This phrase is important, for it embodies the view that the time that the doctor spent in talking, knowing and understanding patient’s specific needs and personal philosophy should be considered *equally important* to the time spent in formulating a diagnosis or in administering physical treatments.

In conclusion, the revolution of shared decision-making cannot be accomplished without recognizing that clinical care should be person- rather than model- or disease-

centered; for reducing a person to the abstract role of “patient” in a pre-predetermined relationship is as naive as it is to reduce the “patient” only to a list of psychophysiological symptoms and pathologies.

Acknowledgements and Conflicts of Interest

This paper reproduces Chapter 24 [a] of a forthcoming volume which is being serialised in the *Journal* in advance of the publication of the book itself in late 2020. For details see [b]. [a] Annoni, M & Blease, C. (2020). Persons over models: shared decision-making for person-centered medicine. In: Person Centered Care: Advanced Philosophical Perspectives. Loughlin, M. & Miles, A. (Eds.), pp. 347-358. London: Aesculapius Medical Press. [b] Asbridge, J.E. (2020). Progress in the conceptual understanding of person-centered health and social care. “Person Centered Care: Advanced Philosophical Perspectives”. Loughlin, M. & Miles, A. (Eds.). London. Aesculapius Medical Press. *European Journal for Person Centered Healthcare* 8 (1) 17-19. The authors report no conflicts of interest.

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