

## Putting Patient Autonomy in its Proper Place; Professional Norm-Guided Medical Decision-Making

**ABSTRACT.** The recommended model for patient participation in medical decision-making is the shared decision-making model (SDM). That model is ambiguous as to how much physician influence on patient decision-making is desirable or permissible. Most discussants suggest that physician influence on medical decisions, while allowable, should be limited. Empirical studies of medical decision-making have shown that much medical practice does not conform to the SDM. The author recommends a different model for medical decision-making, “professional norm-guided medical decision-making,” which, he suggests, much medical practice actually follows. This model does not defer to patient autonomy to the extent usually recommended by the SDM and permits a greater degree of physician influence on patient medical decisions than usual versions of that model. Having described the working of the the professional norm-guided decision-making model, the author specifies the form of patient autonomy respected by it and offers a case for preferring this model of medical decision-making to the SDM.

Since patient autonomy became a prominent theme in medical ethics in the 1970s and 1980s, it has had a troubled reputation among many physicians, to whom claims for its importance in medical decision making seem unrealistic and even undesirable (Duffy 1987; Tauber 2001; Berger 2011). Of course the discussion has moved on since the early days in which informative or interpretive models of medical decision-making—in which physicians provided information and helped patients clarify and express preferences that then determined decisions—were contrasted with usual medical practice characterized as paternalism: physicians telling patients what to do and patients acquiescing in physician direction (Katz 1984). The most plausible contemporary models of medical decision-making offer no such stark contrast between medical decisions

determined by physicians or patients exclusively. While it is not always clear what “shared-decision-making” (SDM), the model generally favored at present, amounts to, it is widely agreed that while patients should have a determining say in medical decisions, physicians are expected to advise and influence them.

Yet how much and what kind of influence physicians may properly exert in medical decision-making is controversial. That is, it is controversial whether and to what extent physicians should exert the kinds of influence that fall between rational persuasion (influence by reasoned argument) and coercion (influence by irresistible threats or force). This sphere of controversial influence is labeled “manipulation” by Faden and Beauchamp (1986) and, less pejoratively, “nonargumentative influence” by Jennifer Blumenthal-Barby (2012). She and they both divide such influence into two broad types: manipulation of information (“reason bypassing nonargumentative influence” for Blumenthal-Barby) and psychological manipulation (“reason countering nonargumentative influence”). Examples of the former, as per Blumenthal-Barby, include “framing, setting up defaults, setting up the environment a certain way, and priming with subconscious cues.” Examples of the latter, also as per Blumenthal-Barby, include social norms/pressures, inducing affective states, and playing on desires” (Blumenthal-Barby 2012, 349). Many discussants state or imply that the use of such influence by physicians is suspect as it may subvert patient values and goals in favor of physician preferred plans of action.

Blumenthal-Barby takes such a view; she does not rule out physician use of nonargumentative influence but suggests that such strategies are legitimate only insofar as they are transparent to patients and endorsed by them. She criticizes a physician using relative risk framing to persuade a patient at high risk for breast cancer to take tamoxifen<sup>1</sup> on the grounds that even if such a strategy did not violate the patient’s autonomy (which, per Blumenthal-Barby, it would not if the patient would endorse the physician’s nonargumentative persuasive strategy if given the opportunity), it would not *promote* the patient’s autonomy—which, in Blumenthal-Barby’s view, is what patients rightly expect from physicians (Blumenthal-Barby 2012).

Skepticism of physician use of nonargumentative influence is evident in many discussions of shared decision-making. Accounts of the shared decision-making model tend to divide over whether the physician should seek primarily to enable the realization of the patient’s values or also to seek to shape those values. The most plausible such accounts, which were also pioneering, acknowledge that the physician need not be neutral in the

decision-making process (Emanuel and Emanuel 1992; Brock 1991; Quill and Brody 1996). But even these accounts come down firmly on the side of patient autonomy when patients and physicians disagree. Physicians may seek to persuade patients to prefer their objective good but ought not to “ride roughshod” over a patient’s values in the process (Brock 1991, 39). “The ideal . . . physician attempts to *persuade* the patient of the worthiness of certain values, not to *impose* those values paternalistically” (Emanuel and Emanuel 1992, 2225). These ways of describing the physician’s role in decision-making are most naturally read as consistent with Blumenthal-Barby’s suspicion of nonargumentative influence if used by physicians to sway patients in a physician-preferred direction, as are many more recent discussions (e.g. Barry and Edgman-Levitan 2012; Kon 2010; Elwyn, Frosch, Thomson, et al. 2012).

Discussions of informed consent generally complement those of shared decision-making in their emphasis on the importance of patient autonomy. It is notable that Faden and Beauchamp, whose theory of informed consent has been enormously influential, suggest that manipulation in at least some forms may be compatible with patient autonomy in medical decision-making (Faden and Beauchamp 1986). Other accounts of informed consent simply emphasize its function of realizing the ends of medical care as determined by patients, which would seem to call into question the legitimacy of such physician influence (Joffe and Truog 2009).

It is commonplace to observe that much if not most of medical practice does not conform to the ideals of shared decision-making and informed consent (Braddock 1997; Karnielli-Miller and Eiskovits 2009; Agledahl, Forde, and Wifstad 2011). In what follows I shall argue that the common models of shared decision-making and informed consent not only do not conform to usual medical practice but also mistake what medical practice ought to be like; I shall describe what I shall claim to be a better model of medical decision-making, a model which, I shall suggest, much medical practice actually follows in preference to the usual models held up as ideal.<sup>2</sup> This model (call it professional norm-guided medical decision-making) permits, in many cases, nonargumentative forms of physician influence short of untruths or threats of force. It seeks patient autonomy to the limited extent of aiming at stable patient ownership of medical decisions in most cases through means exclusive of deception or threats. I shall begin by offering an account of this model as, it seems to me, it works “on the ground.” I shall then discuss the place of patient autonomy in this model and compare it with recommended models of shared decision-making.

I shall conclude by offering a justifying rationale for the more limited place of patient autonomy in professional norm-guided decision-making compared to models presently recommended.

*Professional norm-guided decision-making in medical practice*

Those physicians who practice according to the model I recommend approach medical decision-making seeking the ends of medical practice: patient healing, relief of suffering, and health (the order varying according to context). Patient self-determination operates as a side constraint on the attainment of these ends, but the way in which it figures in the attainment of them is not that envisioned by usual models of shared decision-making or informed consent. Physician conversations with patients begin from a presumption that patients share with physicians a commitment to these ends. For many patient situations, there are clear-cut means to the physician's ends that are clearly superior to possible alternatives. In such cases the physician presents the means in question to the patient as the right way to proceed; the patient has the opportunity to question the recommendation but the physician sees her task not as one of exploring the patient's preferences but instead as recommending to the patient a course of action and obtaining, if possible, patient consent. The higher the stakes and the less available are plausible alternative means to the ends in view, the less important is depth of patient understanding or the nature of the influence exerted by the physician to obtain consent, so long as deception and coercion (the latter in a restrictive sense of the word—force or the threat thereof) is avoided. For instance, if a patient presents to an emergency department with head trauma and an arterial epidural bleed, if the patient is lucid the surgeon will seek permission to operate immediately and properly seeks to obtain consent without ceremony or extended discussion—as the patient will die within hours unless the operation takes place. If the patient has qualms about submitting to surgery, the surgeon will not hesitate to exert any form of nondeceptive and noncoercive (that is, nonthreatening or forcible or untruthful) influence available to her to obtain consent to the operation.

Even in less urgent situations, if disease or trauma is at issue and there is a single remedy markedly superior to others and the expected gain in health or healing is high (e.g. the patient has pneumonia and the remedy is antibiotics), the physician seeks and expects to attain rapid patient agreement with her suggested treatment. In such cases she generally does attain such agreement with little difficulty. Physicians in the less urgent

setting of preventive primary care exhibit a willingness to use many if not all forms of nonargumentative influence short of untruths or threats of force to attain patient adherence to medical or behavioral strategies likely to improve health, particularly if the potential gain is high. If a particular rhetorical strategy involving appeals to emotion or judicious omission of potentially salient information (say, the small but significant incidence of erectile dysfunction in patients taking many antihypertensive medications) or the framing of information in a particular way will lead to consent to taking a medication or to changing a behavior in a healthful way, the physician does not scruple to use the strategy.

For other kinds of patient situations, those for which the models of shared decision-making and informed consent are especially invoked, there may be alternative ways forward involving tradeoffs between differing aspects of healing and health that are equally compatible with medical norms; for instance, between likelihood of cure and disfigurement in the case of mastectomy vs. other options in the treatment of breast cancer; or between a likelihood of improved outcome and an accompanying likelihood of important complications in the case of surgery vs. other options for localized prostate cancer. In such cases physicians discuss the options and try to reach a decision in concert with the patient that best reflects the patient's likelihood of being happy with the choice made in the long term. Physicians also seek deeper patient involvement in decisions of far less moment than those involving the treatment of cancer. If the gain in health or healing of alternative courses of action is likely to be closely comparable, discussion may be extended even if the stakes are lower. Whether or not to start statin therapy in a healthy patient with some but not many cardiac risk factors; whether to start antihypertensive therapy in a healthy patient with borderline blood pressure readings; or whether to proceed with a blood transfusion in a profoundly anemic patient who, however, is not bleeding and who would be expected to increase cell counts on her own over time: the stakes in decisions such as these are very different than in the case of the patient with the epidural bleed, but physicians generally seek patient understanding and informed choice in such decisions to a degree that they would not for decisions involving a single optimal choice such as that for emergency surgery in the case of the bleed.

*The shape of patient autonomy in  
professional norm-guided decision-making*

In the professional norm-guided decision-making model, as I have described its working, the physician's primary task is to pursue health, healing, and the relief of suffering on the patient's behalf. As self-governance is an aspect of healthy human functioning, physicians certainly respect it in the course of medical care, *ceteris paribus*. And of course to the extent that illness has interfered with self-governance, physicians consider themselves charged with restoring it. The nature and extent of self-governance sought for and respected by physicians is, however, specific to the practice of medicine.<sup>3</sup> As autonomy is the operative word for self-governance in much bioethical discussion, I will continue by seeking to unpack the content of "patient autonomy" as physicians typically construe its proper bounds.

While autonomy is a word to conjure with in ethical discussion, it is a notoriously slippery concept. Arpaly distinguishes eight different senses in which autonomy is commonly used in the philosophical literature (Arpaly 2003, ch. 4). It is common in the bioethics literature to equate autonomy to self-determination or self-government according to one's life goals. While this is probably adequate as a rough and ready definition, it needs to be qualified for the medical context. Progressively more demanding versions of autonomy move from an emphasis on control (self-determination as freedom to choose as one pleases) through self-determination characterized by intelligible means-end rationality ("rational autonomy" as per Rebecca Walker (2010)) to self-determination in light of given norms or of one's deepest or truest values and goals; that is, from a procedural account of autonomy prioritizing control to substantivist accounts of various sorts emphasizing choice that is not only owned by the agent but also authentic or in accord with a vision of the good. The patient autonomy that physicians respect is very much procedural; physicians set a low bar as regards rationality or authenticity for accepting patient decisions as autonomous. Many patients do not have "life goals" in the sense of a considered life plan into which medical priorities have been fit; in medical contexts they have preferences for or against particular treatments that may or may not fit into larger plans and that may be more or less malleable and subject to change over time. So long as a patient has capacity<sup>4</sup> physicians will honor her expressed preferences (especially as expressed negatively—see below) but will also seek to alter these to conform to norms of health and healing. Especially if the medical way forward is clear and the medical

gains from that way forward are substantial, physicians are satisfied with very rudimentary levels of understanding and are willing to exert many forms of nonargumentative influence to attain patient consent to the physician-preferred course of action.

In addition to working with a procedural version of patient autonomy, physicians honor that autonomy in a highly asymmetrical way. “Freedom from” subjection to given medical treatments is respected almost absolutely. “Freedom to” undergo medical treatments of choice is highly restricted. That is, patients have expansive negative autonomy in the form of almost unlimited freedom to refuse medical treatment but only limited positive autonomy in that their freedom to have the medical treatment they may desire is bounded by the professional norms of health, healing, and relief of suffering as these bear on the patient’s situation as judged by the physician. Patients have a legitimate expectation of being able to refuse any treatment; and of being offered a range of options for treatment in so far as such a range is compatible with professional norms. Their self-determination does not extend to choice of medical treatments beyond these bounds. This limitation of patient autonomy is often obscured by suggestions that “patient autonomy” (absent any qualification) is or ought to be the end sought by physicians with “informed consent” as the means to that end. The reality is that patients are not so much autonomous in the sense of freedom to act, as autonomous in that they may determine how (to some extent) and whether or not they are acted upon. That is a reflection of the doctor–patient relationship being a relationship not of equals but, fundamentally, of agent and patient. The medical patient is named “patient” advisedly. Unqualified patient autonomy is not realizable in the doctor–patient relationship and physicians generally do not see themselves as trying to realize it. What physicians seek is to respect a patient’s negative autonomy—choices refusing physician proffered treatment—while seeking to influence a patient’s positive choices to conform to those which medical norms would recommend.

What then are we to make of the not infrequent situations in which physicians wish not merely for patient acquiescence in a physician-determined plan but for a patient’s more considered voice in medical decisions, such as high or lower stakes decisions in which there are multiple possible paths forward equally compatible with medical norms? In such contexts, the form of autonomy respected by physicians is more demanding than in many other practices (such as buying and selling in the marketplace). It is in such contexts that physicians wish not merely for

consent, but for informed consent—consent given with an understanding of the varying implications of differing courses of action for the patient’s future. The point to make about these situations is that just as in those in which one way forward is clearly preferred, patient self-determination is sought within the bounds set by medical norms—in this case the optimal choice being the medical-norm-sanctioned choice with which a patient will be most satisfied in the long term. If optimal health or healing as determined by professional norms may be realized in differing possible ways varying with what is important to patients, it becomes the physician’s task to guide decision-making by helping patients choose the treatment that will best accord with patient long-term preferences. Patients ought not to feel that having subjected themselves to one treatment rather than another; they have been injured through failure to grasp the implications of the chosen treatment—presuming that grasp of the options was attainable through reasonable efforts on the part of physicians to inform the patient.



It might be objected that while I claim physician respect for negative patient autonomy to be part of my preferred model, my acceptance of the legitimacy of robust physician nonargumentative influence belies any such claim—as the use of such influence hardly amounts to proper respect for patients. And insofar as respect is taken to imply unqualified deferral to patient wishes contrary to medical norms, the charge is justified. My model construes respect differently, however; my suggestion is that in medical practice physicians respect patients (give them what they are due) when physicians seek patient health, healing, and relief of suffering, if necessary, in the teeth of patient wishes. Patient wishes contrary to medical norms are respected to the extent of not being violated when they are wishes not to be treated. Physicians properly seek (and usually do seek) to change such wishes if that can be done through persuasion or nonargumentative influence short of force or deception.

*The limits of patient autonomy according to  
professional norm-guided decision-making*

From the above account, the form of patient autonomy in medical practice as guided by this model is clarified. Professional norms determine a patient’s good as discerned by physicians. Sometimes that good is specified in a single best treatment option; at other times there are varying ways forward equally good, or equally acceptable even if the physician judges one or more ways better than others. The imperative for patient self-governance acknowledged by physicians demands an absolute respect for



refusals of treatment in all situations (given patient capacity). It demands physician effort to assure patient understanding more if patients are making bad choices (as the physician judges); if there are multiple ways forward rather than one way, with important but differing implications for the patient's future; and if the stakes of the decision are high. It demands relatively less effort to assure patient understanding if patients are making good choices; if there is a single way forward and the patient is acquiescent to that way; and if the stakes are low. In the contexts in which patient understanding is judged to be relatively more important, the end in view is not that the patient exercise her agency maximally determined by her considered views of whatever she wants. The ends in view are 1) patients progressing toward health and healing in ways compatible with medical norms and at the same time in ways conducive to the highest possible degree of long-term patient satisfaction (compared to satisfaction with alternative medical norm-approved ways forward); and 2) patients participating in medical decision-making and owning the resultant decisions undeceived and uncoerced (coercion construed restrictively as controlling actions induced by force or threats of force). Finally, what the imperative for patient self-governance as acknowledged by physicians does not demand is submission to patient demands for investigation or treatment outside the bounds set by professional norms.

It will be evident that this account suggests a place of patient autonomy in medical practice that is less robust than would be recommended by most if not all recent accounts of ideal doctor–patient decision-making. I leave aside the versions of shared decision-making that view the physician's role in decision-making as primarily informing the patient and interpreting her preferences, which are then properly determining of medical decisions. These versions are less plausible than those of Emanuel and Emanuel (1992) (“deliberative” decision-making), Brock (1991), and Quill and Brody (1996), in which the physician is expected not only to acknowledge the patient's views but to advocate for health and healing. These models allow a role for physician advocacy but constrain it by stipulating that it be done in such a way as not to unduly influence patient preferences.

While these models do not generally consider the limits on acceptable physician influence in depth, those who have articulated them characterize acceptable physician influence in ways broadly compatible with Faden and Beauchamp's theory of informed consent (1986). In Faden and Beauchamp's theory, choices, to be autonomous, must be sufficiently independent of controlling influence. The categories of influence are

coercion, manipulation, and persuasion. “Persuasion,” for Faden and Beauchamp, refers to rational persuasion and this form of influence never impairs autonomy. Coercion (influence by way of credible and irresistible threats) is always autonomy negating. Nonrational (non-“persuasive”) influence that is not coercive is “manipulation.” Such influence may or may not be sufficiently controlling to negate autonomy. Manipulation is modification of options or patient perception of options through differing ways of presenting information; or it is influence through nonrational appeals to or effects on someone’s psychological state (Faden and Beauchamp 1986, ch. 7). Such influence is autonomy negating if it compromises “substantial understanding” or is not reasonably “easily resistible” by the manipulatee (Faden and Beauchamp 1986, 360, 362, 367). According to Faden and Beauchamp, then, physicians may appeal to any rational considerations in recommending given treatment plans to patients. What they ought not to do is seek to influence patients through nonrational means that are subversive of sufficient patient understanding or that are not easily resistible.

Blumenthal-Barby agrees with Faden and Beauchamp that manipulation (“nonargumentative influence”) sufficiently blocking or burdening patient options negates patient autonomy. She highlights difficulties with Faden and Beauchamp’s criteria for autonomy negation (resistibility and compromise of understanding) and then draws our attention to the role of the manipulator. Whether manipulation is morally acceptable, she suggests, often turns on whether or not we legitimately expect manipulation from the manipulator. For instance, advertisers do not compromise our autonomy through attempts at manipulation, as we expect them to make such attempts. What we expect from physicians is the promotion of patient autonomy. Hence the impropriety of physician manipulation of information when negotiating treatment decisions with patients (Blumenthal-Barby 2012, 357–58).

What Faden and Beauchamp, Blumenthal-Barby, and I suggest is that the more plausible models of SDM have in common a high regard for patient autonomy construed as decisions made in accord with patient goals and plans and not unduly influenced by physician values. This regard is consistent with contemporary statements of professional norms such as the Physician’s Charter, which includes “patient autonomy” as a fundamental principle of medical professionalism (Project of the ABIM Foundation, ACP-ASIM Foundation and European Federation of Internal Medicine, 2002).



In contrast to these accounts of how physicians should regard patient autonomy, my suggested model accepts high degrees of nonargumentative physician influence, including influence that may not be easily resistible. It thus sacrifices patient autonomy (as commonly construed) in at least some clinical settings: that is, choice of an action made with understanding sufficient to allow one to pursue one's life plan and made free from controlling influences (Beauchamp 2009). This account does follow Faden and Beauchamp in respecting a procedural rather than a substantive form of autonomy; that is, refusals of treatment need not be informed by any particular vision of the good; they need merely be choices made freely with as much material understanding as a physician can engender if such is lacking (which may in some cases be insufficient if judged by the criterion of sufficiency for allowing the patient to pursue her life plan). In this regard my account has an affinity with James Stacey Taylor's preference for a political account of autonomy—in which self-determination is crucial; as opposed to a "metaphysical" account: involving a voluntary subjection of oneself to moral principles (that distinction tracking the distinction between procedural and substantive autonomy) (Taylor 2006). It is both more and less demanding than Taylor's account of autonomy, however. Taylor shares with Blumenthal-Barby an inclination to label decisions made under nonargumentative influence of which the decision-maker is unaware nonautonomous and, presumably, not legitimate in a medical context (if the decision-maker succumbs to the influence) (Taylor 2009, ch. 1; section: "the threshold condition"). My account accepts the legitimacy of such decisions when made by patients in many contexts. But Taylor's view counts decisions made with a lack of understanding as autonomous so long as they are uncoerced—which is an unacceptable standard for medical decisions made when there are many norm-approved ways forward with material differences to a patient's future state and patient understanding could be achieved by reasonable physician effort (as pointed out by Varelius (2012)). My account would demand that physicians engender material patient understanding of the options in so far as is possible and, if not possible, act in such a way that the patient's long-term interests are most likely to be furthered.

The model of decision-making in the literature closest to the model I have suggested to be operative in medical practice is Sandman and Munthe's "professionally driven best compromise" model, in which the physician drives the discussion, guided by the course(s) of action prescribed by medical norms, but strategically gets to a position as close as possible



to these that the patient can accept, in part if necessary through forms of nonargumentative influence (Sandman and Munthe 2010). Sandman and Munthe regard this model as a second best, their preferred model being “shared rational deliberation joint decision,” which envisions a consensus emerging from high level sharing and deliberation dominated neither by physician or patient (deliberation in which physicians forbear to engage in nonargumentative influence). In this model, patient autonomy and best interest as determined by medical norms “harmonize” through the deliberative process. The model of medical practice I have posited would view such harmonization as a desirable outcome but would view it as an exceptional outcome in the ordinary course of events; possible only with 1) unusually thoughtful and perceptive patients who 2) come to decisions aligned with medical norms after 3) deliberation undertaken and carried through because medical circumstances are otherwise conducive to or demanding of deliberation prior to action.

*The person as a patient; why a limited role for patient autonomy in medicine is to be preferred*

In the approach to medical decision-making that I am recommending, patient autonomy is given shorter shrift than most bioethical theory would sanction. I now proceed to a case for the superiority of my recommended approach to medical practice to possible forms of practice envisioned by more demanding accounts of proper patient autonomy. Whatever one presumes the source(s) or foundation of clinical ethics to be, I take it that most would agree that the doctor–patient relationship is fiduciary; that doctors properly direct themselves to furthering the wellbeing of patients, including some measure of patient self-determination as an aspect of said wellbeing. What doctors owe to patients is an instance of the broader issue of what we owe each other more generally—an instance of the latter specified in a particular role relationship. And the contours of the doctor–patient relationship are specific to it; what doctors owe to patients differs from what parents owe children or what we owe to each other as independent adult political actors in the polity of the United States. I propose to approach the broader outlines of what doctors owe patients from the vantage point of attention to what patients are like—what we are like as patients and what we need from those who care for us as physicians. My suggestion will be that what we as patients need as regards medical decision-making is what we now receive (by and large)

from medical practice in so far as that practice resembles the account of optimal medical decision-making that I have offered here.

What patients need from doctors follows from who persons are in their role as patients—to reverse the adjuration commonly heard among medical educators to treat “the patient as a person.” While physicians ought, of course, to do that, how they ought to treat the patient as a person should be determined by who the person is as a patient. And the first thing to be noted about persons as patients is their vulnerability, dependency, and lack of control. In so far as patients are sick they are in need of a kind of care with close affinity to a parent’s care for a child: vigilant, protecting, nurturing, and agential (agential caring involving decision-making and the taking of caring action, both on the patient’s behalf). And the sicker the patient is, the more she needs such care. To be sure, such care is aimed at the restoration of health (if that is possible), including self-determination as exercised in the healthy state. But the second thing to be noted about persons as patients is that when ill they are not as different from healthy patients as many champions of patient autonomy might wish us to believe.<sup>5</sup>

The ideal of the wholehearted and integrated person who governs herself through the exercise of rationality in pursuit of deeply considered goals is a will of the wisp in the outpatient examining room—at least in so far as we might expect such persons to include optimal health among their goals so pursued. Healthy (or relatively healthy) patients are in fact often confused, divided among conflicting desires, unwarrantedly optimistic or pessimistic about their health prospects, and prone to self-deception as regards the likely impact of their preferred lifestyle upon their bodily future. What such patients need is emphatically not the promotion of self-governance as is exemplified in the unconstrained choices that they typically make. What they need is guidance, as guidance is often construed in medical practice according to a professional norm-guided decision-making model.

Such optimal medical guidance differs from what ideal guidance might be in other relational contexts. In politics or the marketplace, it might plausibly be maintained that what we need from others above all is not guidance but instead deference to the choices we make. Hence, in these contexts optimal guidance might take the form of advice when advice is requested rather than anything more intrusive or directive. We all want and require the freedom of “framing the plan of our life to suit our own character; of doing as we like, subject to such consequences as may follow; without impediment from our fellow creatures, so long as what we do does not harm them” (Mill 1869). We deem the best interests of persons

in politics and commerce to be served by an absence of impediments to the expression and satisfaction of personal preferences in a wide range of circumstances. We prize self-governance in our political and in our purchasing choices, in spite of the possibility that we may choose badly. In medicine the case is different. In medicine physicians deem the interests of persons as patients to be in life, health, healing, and relief of suffering. Because of the vulnerability and dividedness of persons as patients, these interests and personal preferences can and do come apart. The physician role in medical decision-making should therefore be aimed at achieving the best possible reconciliation between medical interest and self-governance when the latter threatens to diverge from the former.

A case in which a physician offers guidance to a patient (arguably) exceeding the limits on permissible physician influence as stipulated by prevailing decision-making models may help in elucidating the professional norm-guided decision-making model and my case for its superiority to presently prevailing models. I offer this case from my own hospital practice:

CASE:

I walked into the bay in the emergency room where my resident was talking to Mr. Smith, a middle-aged man who, having come to the ER with worsening shortness of breath, had been given oxygen and was now lying on a gurney. His gown was open, and his chest revealed the classic appearance of end-stage chronic obstructive pulmonary disease. He was visibly working hard to breathe as he answered my resident's questions about code status. We had been told by the ER physicians that he did not appear to have pneumonia, bronchospasm, or any other reversible cause of his increased difficulty breathing. As I entered, my resident was saying, "so you're sure you want to be intubated if your heart were to stop?" and Mr. Smith was nodding his head "yes." "Mr. Smith," I interrupted. After a quick introduction I went on: "Mr. Smith, you really don't want us to put a tube down your throat and pound on your chest if your heart and lungs were to stop working. Your lungs are in very bad shape and when they give out, all that stuff isn't going to bring them back but it will make you very miserable." Mr. Smith looked up at me. "I don't want to do those things to you, Mr. Smith," I continued. "They're not going to help. What we need to do is take away your feeling of shortness of breath and treat your lungs with oxygen and medicines as best we can." There was a pause—and Mr. Smith said, "well, if it's not going to help let's forget about

it.” After a few more minutes of conversation my resident and I left the bay and I entered a do-not-resuscitate order into Mr. Smith’s medical record.<sup>6</sup>

Mr. Smith had been “full code” during previous visits to the hospital. My resident was properly revisiting the issue at the outset of what was going to be another hospitalization.<sup>7</sup> My intervention in the conversation changed the direction of Mr. Smith’s decision-making. He, while in distress, was making a high-stakes decision (or, as might be maintained, merely confirming an ongoing determination) that (I felt) was opposed to his medical interest in relief of suffering and, possibly, dying without what in his case would be the unavailing and burdensome interference of intensive care and mechanical ventilatory support. In spite of no previous acquaintance with Mr. Smith, I had no qualms about forcefully telling him he was making the wrong decision, in spite of his visible distress and likely limited ability to resist an authority figure giving him urgent advice in a forthright way, with every nuance of tone, modulation, body habitus, and facial expression calculated to influence him to choose as I rather than he was preferring.

How would my advocacy with Mr. Smith be assessed by Faden and Beauchamp, Blumenthal-Barby, or prevailing models of shared decision-making? Both Faden and Beauchamp and prevailing SDM models would countenance nonargumentative influence so long as it was not excessive. The measure of excess for Faden and Beauchamp would be whether or not the influence was “reasonably easily resistible.” For Brock or Emanuel it would be whether the physician’s values were “imposed” rather than merely advocated for in an attempt at rational persuasion. For Blumenthal-Barby, the test might be whether the nonargumentative influence in my advocacy was transparent to Mr. Smith and endorsed by him. A defense of my advocacy with Mr. Smith from the standpoint of Faden and Beauchamp or prevailing SDM models might go as follows. The content of what I said to Mr. Smith was an accurate reflection of his prognosis and of the best medical approach to his condition—that is, the approach most consistent with his interests given his likely response to the array of treatments to which he might conceivably have been subjected. My statements therefore qualified as rational persuasion. Mr. Smith was of sound mind and responded to good reasons for foregoing aggressive resuscitative measures in a rational way. Given his understanding of the options at hand and the fact that he could have insisted on more aggressive measures against my advice, any nonargumentative component of my attempt at persuading him was not autonomy negating as it was sufficiently

resistible. He had capacity and his comprehending concurrence with my suggested approach was voluntary. Therefore, nonargumentative influence in my approach to Mr. Smith did not violate his autonomy.

Nonargumentative influence in this case is more difficult to defend from the criticism that might be leveled against it from Blumenthal-Barby's position. Such influence might be identified in both my framing of Mr. Smith's possible benefit from resuscitation and in my demeanor in advising him against resuscitation. Mr. Smith was perhaps likely to have been conscious of the urgency with which I advised him of the proper decision to make about resuscitation. Whether he welcomed that urgency was another matter. He was unlikely to have been aware of my framing of information—that is, my emphasis on the burdens of resuscitation and my not mentioning that resuscitation could extend Mr. Smith's life, albeit briefly and painfully. Most likely my nonargumentative influence on Mr. Smith fell short of respecting his autonomy on the counts of both transparency and patient endorsement as required by Blumenthal-Barby.

Faden and Beauchamp's test for acceptable nonargumentative influence turns on resistibility, which, as they suggest, may be investigated by inquiring into the subjective state of the influencee (Faden and Beauchamp 1986, ch. 10). My tentative defense of my advocacy to Mr. Smith from Faden and Beauchamp's position presumes rather than establishes that Mr. Smith might have resisted it. In fact, it is plausible to suppose that he might have found the nonargumentative elements of my advocacy quite difficult to resist. Of course had Mr. Smith insisted upon aggressive resuscitation in the teeth of my contrary suggestion, his ability to resist my nonargumentative influence would have been clear. As he accepted my recommendation, whether he could have resisted the nonargumentative influence in my interaction with him is a counterfactual and thus impossible to investigate. Whether we judge influence to be resistible or "easily resistible" turns out to be a matter of whether we hold that an influencee should or should not be able to resist it—that is, our estimates of resistibility turn on normative judgments, as pointed out by M. Gregg Bloche (1996, 251–55). In Mr. Smith's case, insofar as these judgments reflect a default presumption that patient autonomy should be furthered, they would, I submit, tend toward finding my influence as exerted on Mr. Smith not easily resistible—given the gravity of his illness, his distress at the time of our conversation, and the pressing character of my advocacy.

I conclude that my counseling to Mr. Smith likely violated his autonomy by the lights of Faden and Beauchamp, by those of Blumenthal-Barby and



by those of any shared decision-making model that requires physician advocacy to be restrained by a determination not to *impose* physician values on patients. My advocacy was consistent with my professional norm-guided decision-making model, which has less deference to patient autonomy exercised in opposition to medical norms than these alternative approaches. This latter model demands patient ownership of decisions, but respects autonomy exercised in opposition to medical norms only insofar as such autonomous choice cannot be brought to conform to medical norms through forms of influence excluding deception and threats or force.

It is the frailty and weakness of patients that makes the professional norm-guided decision-making model a superior means to the reconciliation of patient medical interest and patient self-governance when these are opposed; superior, that is to more usual models of SDM, which are restrained by more restrictive limits on the kinds of nonargumentative physician influence they will countenance. Mr. Smith is an extreme case of frailty and weakness, but the professional norm-guided decision-making model regards such as Mr. Smith as the “ideal type” of patient—in contrast to the integrated rational pursuers of life plans idealized by more usual accounts of shared decision-making. If patients actually were integrated and rational, in general, then the no-holds-barred sharing and deliberation in which physician and patient participate symmetrically because the physician has sufficiently informed the patient might be a plausible model. But they do not; patients cannot (generally) participate in deliberation about treatment on an equal plane with physicians even if the latter have made a good faith effort to bridge the gap of information and experience between them. That being the case, and given the desirability of patient decisions in accord with the norms of medicine, physicians rightly prefer patient-owned decisions in accord with those norms, even if obtained in part through nonrational influence, to decisions made in the absence of such influence that are divergent from them, *ceteris paribus*.

It will be observed that to favor nonargumentative influence when such influence cannot be resisted is to favor coercion; as browbeating (as one might characterize such influence as I used with Mr. Smith if one is disposed to view it unfavorably) a susceptible patient is no less coercive than physical force used on someone less susceptible to suggestion. My account of professional norm-guided decision-making would bite this particular bullet—so long as the end in view of the “browbeating” (or less pejoratively, “irresistible nonargumentative influence”) was in accord with medical norms. It should be noted, however, that the room for

acceptable coercion in my account is very carefully circumscribed. Patient self-governance is an integral aspect of human flourishing as recognized by medical norms. Hence the kind of influence that physicians can legitimately wield upon it is sharply limited, as described in previous sections. The nonargumentative influence used by physicians cannot involve untruths, threats, or physical force. And such influence may be permissibly exerted only in favor of ends sanctioned by medical norms. Physicians unreservedly respect patient autonomy expressed negatively and, while they seek to shape patient affirmations regarding treatment, do so in ways preserving patient ownership of treatment decisions. What they do not do is hold themselves bound to avoid influencing patients in nonrational ways when patients are neither fully cognizant of such influence nor able easily to resist it. If nonrational influence offers a way to a patient decision in accord with medical norms not otherwise obtainable, the physician will embrace it—to the patient’s benefit.

The professional norm-guided decision-making model’s preference for patient self-governance, even though limited compared to the recommendations of contemporary models, rules out what might otherwise be an attractive strategy for avoiding the demotion of patient autonomy implicit in it. Instead of self-determination as the core of the concept of autonomy, we might suggest the substitution of a particular kind of responsiveness to reasons (Buss 2014, 7), responsiveness to reasons generated by medical norms, as the core. When subjecting oneself to medical practice, one would deem one’s autonomy to be realized insofar as one was able to make decisions in accord with the norms of medicine as these bore on one’s personal situation. Such a view would, of course, have affinities with many substantivist accounts of autonomy, most notably Kantian accounts (O’Neill 2003). It would, however, demote self-governance too far, to a level below that which is and ought to be demanded in medical practice. Physicians rightly value patient self-governance independently of its issue in choices conformed to the norms of medicine. But physicians also rightly seek to influence such governance in furtherance of those norms within well-defined limits.

My case illustrates another difficulty with the positions of Faden and Beauchamp, Blumenthal-Barby, and those espousing usual models of shared decision-making: the limited usefulness of a classification of forms of influence dividing reason and argument from nonargumentative influence. Both Faden and Beauchamp and Blumenthal-Barby sharply distinguish these two putative forms of influence; their respective analyses

view influence through reason as salutary and nonargumentative influence as suspect, generally speaking. But both this classification of influence and the accompanying presumption that the two forms of influence are generally distinguishable are, I would argue, at best an oversimplification. The setting and pursuit of ends in medical care as in other human activities cannot be cashed out as the exercise of instrumental reason seeking the satisfaction of preferences, with “reason” here limited to logic working on preferences and beliefs. Our apprehension of our circumstances and of what ends, given those circumstances, seem good to us is always going to be shaped by a normative stance. That is, we experience the deliverances of the world not as mere natural facts upon which reason qua logic can bring our preferences to bear. The world’s deliverances (as we experience them pre-deliberatively) have normative significance built into them as a product of our normative stance. Accordingly, our perception, or what is salient to us in what we see, is shaped by evaluations in which emotion and imagination figure prominently. Physicians seeking to persuade patients often find themselves appealing not merely to facts about a given treatment option but to the normative aspects of a patient’s more general view of the world. Such an appeal cannot be effected exclusively by reasoning about a jointly perceived reality; the physician seeks for the patient to see reality differently—to see saliences that the patient presently does not see. Such a physician will not succeed without appealing to imaginative and emotional aspects of the patient’s perception of her situation. Such appeals, even if not easily resistible, are not unacceptable invasions of autonomy; they are an essential element of the physician’s task.<sup>8</sup>

We act according to our judgments of good as regard both means and ends; and these judgments are a complex product of reason, perception, emotion, and desire. Rationality as usually conceived—that is, the checking, verifying, and discursive aspects of reason—is in play in our practical judgments to a greatly varying extent, depending upon our perceived need for caution or precipitation in acting to realize a perceived good.<sup>9</sup> Patients and physicians alike are drawn to means or ends that seem good to them, and reason’s role in shaping that “seeming” does not function for either apart from the nonargumentative influences that inevitably both affect it and are affected by it. That is not to say, of course, that we may not usefully distinguish between argument and rhetoric—it is to say that the distinction must not be pressed too far. In my appeal to Mr. Smith, normative, factual, emotional, and imaginative elements were inextricably mixed. Both in my expression and in his apprehension of that appeal,

there was no clear delineation between these elements. What legitimates the influence I exerted (if it was legitimate) is not the degree to which it was argumentative or resistible. It was the influence's conformity (or lack thereof) to medical norms, including the norm of patient ownership of decisions free of deception, threats, or force.

Nonargumentative influence (that is, influence transcending inferential reasoning from premise to conclusion) on one's volitions from within and without is unavoidable, but this ought not to worry us unless such influence is malign either in its origin or in its effects. If physicians are seeking to influence patients in ways not sanctioned by the ends they properly seek, such influence is malign. And if even well-intended influence tends to generate patient decisions out of line with proper medical ends, then that influence is malign. Nonargumentative influence rightly intended that achieves ends sanctioned by medical norms is salutary influence and ought to be welcomed rather than suspected, always provided that it respects patient autonomy to the extent required by medical norms.

It might be objected that the professional norm-guided decision-making model recognizes patient weakness but not similar physician weaknesses. Are not physicians just as fallible, divided, and irrational as patients may be? And, if so, should patients not be protected against an overweening professional authority by presumptive professional deference to patient autonomy? The answer to the first question is, of course, yes indeed. But the presumption of any learned profession is that its practitioners, when acting in role, can transcend their subjectivity and act according to the norms of the profession. Physicians qua human beings may be just flawed as anyone else, but their training, if successful, conditions and enables them to act and advise in accordance with professional norms when they are in-role. In making medical decisions they are aided by expertise, by a work setting that disciplines their decisions, and, in many cases, by colleagues and literature readily available for consultation (Schneider 1998, 103–08). No doubt they do not always live up to the high standards expected of them. That is a matter for professional regulation and self-examination. Patients will not, however, be protected by excessive physician deference to patient preferences opposed to professional norms. They will in fact be victimized by any such excessive deference. Physicians will best serve patients by wholeheartedly seeking to influence them to make medically warranted decisions—even if such influence is neither easily resistible nor purely argumentative.

## CONCLUSION

Models of shared decision-making typically fault the practice of medicine for failing to measure up to them. I have sought to vindicate a different model, professional norm-guided decision-making, which I take the practice of medicine often to conform to. Usual models of shared decision-making err, I argue, in demanding excessive deference to patient autonomy through positing an unrealistic view of the patient as a person. It is because persons are patients that medicine should and does adjust its practice to our needs as patients and exhibit the regard for patient autonomy that is properly due to patients. That regard leads physicians to seek patient self-determination within limits set by medical norms—which insist upon patient ownership of decisions but which permit physician influence on decision-making which, in many cases, negates or diminishes patient autonomy as judged by prevailing decision-making models. In the professional norm-guided decision-making model, decision-making resembling the shared decision-making idealized by usual descriptions of the SDM model or informed consent does sometimes take place. In the professional norm-guided decision-making model such decision-making is a kind of special case. Such cases are distinguished from those in which patient self-determination is given shorter shrift by there being multiple medical norm-approved ways forward with differences between them germane to patient concerns and priorities. In such cases, achieving decisions with which patients will be satisfied often requires extended discussion. In the more usual case, physicians seek patient ownership of a decision in accord with medical norms through influence excluding deception or coercion but not other forms of influence, which may be quite exigent and not easily resistible. That is as it should be, so long as physicians live up to the standards inherent in their role.

## NOTES

1. Tamoxifen is an orally administered estrogen receptor antagonist that slightly reduces the risk of breast cancer in women at high risk if taken long term. “Relative risk framing” in this case is consciously choosing to heighten a patient’s perception of likely benefit from tamoxifen by presenting the reduction in risk of breast cancer conferred by tamoxifen in terms relative to the risk of breast cancer in similarly high-risk women not taking tamoxifen. In this case, the high-risk woman taking tamoxifen has 30% less likelihood of developing breast cancer than a similarly high-risk woman not taking it over a five-year period (relative risk reduction). The alternative approach,

highlighting absolute risk reduction, would be to present the reduction in breast cancer risk conferred by tamoxifen as the bare percentage reduction in likelihood of developing cancer that the high-risk woman could expect over time. Her absolute risk of developing breast cancer over 5 years if she takes tamoxifen diminishes by less than 1%. The baseline risk of breast cancer in a five-year period, even in a high-risk woman, is small to begin with so that a 30% relative risk reduction translates to a much smaller absolute risk reduction (Nelson, Smith, Griffin, et al. 2013, appendix table 1). Relative risk reductions are generally larger and more impressive than absolute risk reductions, which latter many physicians regard as more clinically important.

2. I cannot claim any given prevalence in practice for the decision-making model I shall recommend in what follows. It is the model that I learned as a trainee in an academic medical center 26 years ago and it is the model that I have followed since in practice and in my own teaching; I have observed little or no clear deviation from this model among the conscientious physicians with whom I have worked in two academic medical centers over the course of 26 years of training and practice. While I cannot cite sociological research in support of my contention that this model is widely prevalent, I venture to predict that many clinicians (should they happen to read this paper) would find it immediately recognizable.
3. That is, specific to the practice of medicine as I contend much medical practice is conducted: in accord with the professional norm-guided decision-making model I am here recommending. In this section I describe physician action as such action accords with this model without meaning to imply that all physicians work according to this model or take it to be normative.
4. I intend “capacity” as the word is usually used in bioethics and in clinical medicine—as grasp of a decisional context sufficient for deciding upon alternative possible courses of action through (minimally) plausible reasoning; and ability to make and articulate such a decision. Patients may have capacity for some decisions and not others and for given decisions at some times and not others. See Beauchamp and Childress’s discussion of competence (interchangeable with capacity for present purposes) (Beauchamp and Childress 2001, 70–72).
5. There is considerable empirical research showing that many patients do not want to make medical decisions. Such research is buttressed by numerous patient narratives illustrating both the difficulty patients have with medical decisions and their frequent desire to delegate such decisions to others. When patients grapple with medical decisions, they often do so through instinct and intuition rather than deliberation. They often have conflicting feelings about

the decisions they face and they often seek not only direction but direction aimed at encouraging the side of themselves drawn toward physician recommendations. See Schneider (1998), chs. 2 and 3.

6. I composed this account of this case about a month after its occurrence. While the dialogue is necessarily a nearest possible approximation to the dialogue that actually took place, the resident with whom I acted in this case has confirmed the general accuracy of my reconstruction.
7. It will be noted that my resident, in revisiting Mr. Smith's code status as he did, was offering Mr. Smith treatment (aggressive resuscitative measures) he did not believe to be medically beneficial in Mr. Smith's case. I have suggested that professional norm-guided decision-making normally excludes such offers. Resuscitation in the event of cardiopulmonary arrest (even if not medically warranted) is an exception to that generalization in the United States, for complex historical and legal reasons (Luce 2010).
8. I cannot here vindicate the view of practical judgment presumed in this and the following paragraph. I can only signal the taking of sides in a wide-ranging dispute over the nature of practical reason. Many neo-Humeans and Kantians posit a clear distinction between theoretical and practical reason, the former leading to the formation of true beliefs and the latter to practical verdicts as to how to act given those beliefs plus an appetitive state. Proponents of virtue ethics, often influenced by Aristotle and Wittgenstein, reject this "received view" of practical reason, seeking to substitute for it a more complex picture according to which our actions reflect our seeking of the good. Emotions and desires do not figure in that seeking as (merely) appetitive states serving as matter upon which reason can work. Instead, desires are predeliberative appearances of goodness or virtue that, in a virtuous person, coincide with actual good or virtuous action. Belief as a product of perception is similarly a perception of value rather than of motivationally inert facts only. Hence neither belief nor desire can be fully isolated from one another or from normative considerations in our practical determinations (McDowell 1979; Brewer 2009, ch. 3). It is this virtue ethics view of practical reason that informs the character of medical decision-making presumed here.
9. The limits of reason qua logic in our practical judgments are an increasingly prominent theme in the psychology literature on judgment and decision-making, particularly since the widespread acceptance of dual-process accounts of practical judgment in that literature (Evans 2008). The variation of the importance of the checking and verifying function of reason in decision-making according to the actor's "eager" or "vigilant" goal orientation and the importance of message framing that matches actor orientation

are highlighted in the regulatory fit and focus theories of Cesario, Higgins, and Scholer (2008). These developments in the psychology of judgment and decision-making offer suggestive parallels with the philosophical psychology of virtue ethics.

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