

Anders Herlitz, "Comparativism and the Grounds for Person-Centered Care and Shared Decision Making," *The Journal of Clinical Ethics* 28, no. 4 (Winter 2017): 269-78.

Features

Comparativism and the Grounds for Person-Centered Care and Shared Decision Making

Anders Herlitz

ABSTRACT

This article provides a new argument and a new value-theoretical ground for person-centered care and shared decision making that ascribes to it the role of enabling rational choice in situations involving clinical choice. Rather than referring to good health outcomes and/or ethical grounds such as patient autonomy, it argues that a plausible justification and ground for person-centered care and shared decision making is preservation of rationality in the face of comparative non-determinacy in clinical settings. Often, no alternative treatment will be better than or equal to every other alternative. In the face of such comparative non-determinacy, Ruth Chang has argued that we can make rational decisions by invoking reasons that are created through acts of willing. This article transfers this view to clinical decision making and argues that shared decision making provides a solution to non-determinacy problems in clinical settings. This view of the role of shared decision making provides a new understanding of its nature, and it also allows us to better understand when caregivers should engage in shared decision making and when they should not.

Person-centered care and shared decision making are popular in medical ethics in general, and in clinical ethics in particular.¹ Typically, it is argued that person-centered care is important because it generates better medical outcomes,² and because it better meets important values in bioethics such as autonomy and consent.³ In this article I provide a different argument in favor of shared decision making in clinical settings that lays out the view that shared decision making ensures the possibility of rational choice, such as conceived by *comparativists*.⁴ Comparativism is the view that a rational choice is a choice based on the comparative merits of the alternatives. Since comparative value-theoretical non-determinacy is prevalent in evaluations of clinical options, we need to invoke shared decision making to enable rational choice. Ascribing this role to shared decision making, I suggest, brings some clarity to the complicated issue of how some disagreements between physicians and patients should be solved by prioritizing the view of patients.

The core idea of person-centered care is that, rather than applying the traditional model in which caregivers embody a paternalistic attitude toward patients and their health needs, caregivers should allow the characteristics, desires, and beliefs of patients to have a significant impact on decisions regarding what treatment to apply, by involving patients in the decision process. Advocates of person-centered care suggest that this should be done by

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the application of a series of more specific practices. Ekman and colleagues, for example, have argued that it is important to initially invite patients to express their personal views of their illnesses and symptoms, and their impact on the patients' lives, to encourage caregivers and patients to engage in shared decision making and to decide on a clinical approach to medical problems together, and to document patients' narratives in order to make the interplay of caregivers and patients transparent and to facilitate the continuity of care.⁵

In this article I focus on shared decision making. I present an argument of how to justify person-centered care and shared decision making in light of value-theoretical problems and the desire to make rational choices, and I discuss what this justification might tell us about how to understand what the practice of shared decision making ought to look like, an issue that is contested.⁶

The structure of the argument is this:

- Premise 1: *Comparativism*: A decision is rational if it tracks the comparative relation between alternatives so that an alternative that is *best* (that is, at least as good as every alternative) is chosen.
- Premise 2: There are non-determinacy problems in many situations involving clinical choice so that sometimes no alternative is best in the light of given reasons.
- Premise 3: When, and only when, no alternative is best in the light of given reasons, created reasons that are grounded in the will of individuals who are involved in the decision can determine a best alternative.
- Conclusion: In situations that are characterized by non-determinacy problems, shared decision making should be used to form created reasons, so that a best alternative can be determined and a rational decision made.

This article is structured in the following way. Throughout, I make the assumption that comparativism is a sound view. In the first section, I argue that comparative, value-theoretical non-determinacy (not to be confused with epistemic problems determining the relation between alternatives in light of what matters) is prevalent in clinical settings. That is, often, given values that apply to situations involving clinical choice fail to fully determine a course of action that is better than, or equal to, every other course of action. The argument focuses on the ideal of health promotion, and I argue that, in a large number of clinical cases, it is not determinate which course of action best promotes

health, even if we have perfect information about all of the relevant facts. This means that in so far as we accept comparativism and want clinical decisions to promote health, we face a serious problem: often, treatment alternatives cannot (even in principle) be ranked with respect to how well they promote health. In the second section, I introduce a solution to the problem of comparative, value-theoretical non-determinacy that has been suggested in recent research on practical reason, namely that we can *create* reasons in light of which a best decision can be identified when *given* reasons fail to do so. I argue that, for clinical settings in which a professional caregiver provides care to a patient, this solution is best implemented as shared decision making. In the third section, I discuss what this means for how we should understand the nature and role of shared decision making and argue that it gives us a reason to give priority to the views of the patient over the views of the caregiver when there is non-determinacy and disagreement.

COMPARATIVE NON-DETERMINACY

Consider a clinical situation in which a caregiver identifies a serious ailment in a patient; let us say a complicated type of cancer. Untreated, the patient will live for an additional five years with significant physical disabilities. The caregiver sees two distinct treatment alternatives for the ailment and is, we assume, also able to correctly predict the exact outcome of the treatments. Either (A): the patient can be provided certain medication that will not cure her or him, but radically reduce the amount of physical disability that she or he will experience. Given this treatment, the patient will be able to live the remaining five years of his or her life with a high quality of life. Or (B): the patient can be provided a different treatment that will significantly prolong her or his life, but at a significant cost in terms physical disabilities. If this treatment is chosen, the patient will live for another 10 years, but the 10 years will be spent with significantly reduced quality of life due to physical disabilities. Prolonging someone's life contributes to the goodness of a treatment in light of health promotion, and improving the quality of life by mitigation of physical disabilities contributes to the goodness of a treatment in light of health promotion. Both alternatives are alternatives that promote health, but they do this in very different ways. Is one alternative necessarily better, worse, or equal to the other alternative with respect to health promotion? Otherwise put, is health promotion an objective that is *complete* so that we, in case we have

perfect information, in all situations that require a choice, can order all alternative treatments in terms of how well they promote health? Below, I argue that this is not the case.

In this section I will use the so-called small improvement argument (which has been used to challenge completeness axioms in value theory, by pointing to how very small improvements in one of many dimensions do not change comparative relations) to argue that occasionally it is not possible to determine what a *best treatment* is, in clinical situations, in light of health promotion. Instead, I suggest that we must accept that it is possible that no treatment is at least as good as every alternative treatment in light of health promotion. That is, the trichotomy <better than, worse than, equal to> does not exhaust the set of possible relations between alternative treatments. The argument relies on a stylized situation that requires a choice, and I will start by introducing this. All of the simplifications that are needed to define the stylized situation that requires a choice are arguably unrealistic. I will, for example, discuss only physical disabilities and longevity when I discuss health promotion, and I will assume that we can fully predict the effects of alternative treatment options. In real situations that require a choice, decision makers will also need to take psychological disabilities and distress into account, and uncertainties are ubiquitous. Yet, since the simplifications enable us to identify a core aspect that is ubiquitous in clinical settings, they are warranted. We should expect that the complications that are here removed from the discussion will support the conclusion, since they introduce additional aspects that decision makers must take into account and weigh against the aspects presented below. For example, taking also psychological disabilities into account means that we also need to compare alternatives along this dimension, and this entails another possible non-determinacy.

To model well-defined clinical situations that require a choice, let us first assume that there is only one single value at stake: health promotion. In other words, let health promotion be the “covering value” in the situation.⁷ By stipulation, health promotion is what matters to the choice—the value in light of which alternatives are evaluated and compared—similar to how monetary returns might be the covering value for an investor who considers alternative investments, or to how national security might be the sole concern for individuals in the national security sector. Health is, of course a deeply complicated concept, but most of us can agree that one can promote health in at least the following two

ways. Everything else being equal, health is promoted by decreasing the amount of physical disability (for example, difficulties walking, physical incapacity to engage in intimate relations, decreased pulmonary functioning) an individual involuntarily and unavoidably experiences, and it is, everything else equal, promoted by prolonging the life expectancy of an individual (at the very least up to a normal level). We improve health by improving the mobility of someone who has difficulties walking, and we improve health by prolonging the life expectancy of someone who is expected to die very soon. That health is promoted by decreasing the amount of physical disability that an individual involuntarily and unavoidably experiences as well as by prolonging the life expectancy of an individual (at least up to a normalcy level) is not controversial.

If we, furthermore, assume that we can represent both how good an outcome is in terms of prolonging a patient’s life and how good an outcome is in terms of decreasing physical disability with numbers, we can characterize the choice between treatment A and treatment B in the following way:

Outcome A: 5 LY; 1 P

Outcome B: 10 LY; 60 P

Let LY represent life years, the more the better, and let P represent average physical disability during these years, the less the better. In light of health promotion and health promotion only, the question is: is it better to create an outcome where a patient lives for five years with very little physical disability, or an outcome in which the patient lives for 10 years with physical disability amounting to 60 on a scale of 0 to 100, or is no outcome better than the other?

A standard way of thinking about comparisons in which two alternatives are to be evaluated in terms of a defined covering value such as health promotion is to hold that the alternatives will bear one of the following three relations to each other: A is better than B, B is better than A, or A and B are equally good. This has been called the “trichotomy thesis.”⁸ Below, I will argue that the trichotomy thesis does not hold true for alternatives that are compared in terms of health promotion such as this has been defined above, and I will suggest that this is just the tip of an iceberg of comparative non-determinacy in clinical situations that require a choice.

Consider that there is an indefinitely large set of (theoretically) possible situations of the particular type introduced above, in which one alternative does relatively better in terms of LY, and the other does relatively better in terms of P. In the example

above, significantly decreasing physical disability stands against prolonging life by five years. Other possible situations will involve a conflict between decreasing physical disability and prolonging life by more than five years, and still other possible conflicts will involve decreasing physical disability and prolonging life by less than five years. If the trichotomy thesis were true for comparisons of alternatives within this set so that in light of health promotion it is true for every pairwise comparison within the set that one alternative is better than, worse than, or equal to, the other, there must be a pair of alternatives in this set that are equally good.⁹

Supposing that the trichotomy thesis holds true; let us select a pair of alternatives, X and Y, that are deemed equally good in light of health promotion, and consider whether that is plausible. X is not better than Y, and Y is not better than X. To make the exposition simpler, let us furthermore assume that this pair is the same as the pair introduced above, that is, treatments A and B. Thus: in light of health promotion, let us assume that it is not worse to provide the patient with a treatment that predictably gives the patient five years of life with almost no physical disability than to provide the patient with a treatment that predictably leads to 10 years of life with physical disability amounting to 60 on a scale 0 to 100, and vice versa. A is not better than B, and B is not better than A.

Now, imagine that a mistake was made when the caregiver assessed the options; there is a third treatment available that the caregiver had previously overlooked: A'. Implementing A' will lead to 5.0001 LY, and 1 P. Treatment A' has the same good effects as A in terms of reducing physical disability, but it will also prolong the patient's life by a tiny amount. Obviously, A' is better than A. It is not worse than A in any way, and it is clearly better than A in terms of LY ($5.0001 > 5$). But is it really reasonable to hold that A' is better than B? If A and B really are equally good, if the trichotomy thesis is true, and if A' is better than A, then A' *must* also be better than B. Treatment A' cannot be equal to B, since "equal to" is a transitive relation, and so if A' was equal to B, it would be equal to A, which it clearly is not. And A' cannot be worse than B. It is false that A is worse than B, and it is false that A' is worse than A, which again in virtue of transitivity indicates that A' cannot be worse than B. If the trichotomy thesis is true, and better than, worse than, and equal to are the only possible relations between A' and B, treatment A' must be better than treatment B. Yet, how can the additional fraction of a day that the patient will be able to live if A' is chosen make such a large differ-

ence to the comparative relation of the alternatives? Accepting that a fraction of a day makes a difference when everything else is equal is one thing; this is why A' is clearly better than A. But when two alternatives are contributing to the goodness of an outcome in such radically different ways, how can a small improvement in terms of one factor change the comparative relation? Together with Ruth Chang, I assert that it does not.¹⁰ It is true that A' is better than A, but it is not true that A' is better than B, and this is because the trichotomy thesis does not hold true in this context. Although A is not better than B, and B is not better than A, treatment A and treatment B are not equally good. The relation between a treatment that prolongs the life of a cancer patient, who is predicted to live with significant physical disabilities and to die in five years, and a treatment that significantly decreases the patient's physical disabilities but does not prolong the patient's life, is non-determinate, in the sense neither is better than the other, and they are not equally good, either.¹¹

Objections can be raised against this particular example on various grounds. It could be held that the example is poorly designed because it is unreasonable to hold A and B to be the pair that is equally good. This might be true, but it does not address the core problem. I invite readers to select whichever pair they see fit as candidates for X and Y, and make the same thought experiment. The point is not that the particular pair {A; B} is problematic, but that a small improvement in one factor cannot make a decisive difference when two alternatives contribute to the overall goodness of an outcome in such different ways. Some will question why the argument is confined to improvements in life expectancy. This is for reasons of space. The exact same point can be made by contemplating the introduction of B', for example, 10 LY; 59.9999 P. B' is better than B, but is it better than A? And finally, some might object to the selection of the factors life expectancy and involuntary, unavoidable physical disability. I contend that the exact same problem arises whichever factors we bring out. Alternative treatments often meet the overall criterion of health promotion in radically different ways (some promote health by prolonging life, some by decreasing physical disabilities), and many clinical choice situations will be such that the feasible set of choices contains alternatives that are good in different ways. By comparison, assuming that neither Michelangelo nor Mozart is better than the other with respect to artistic genius, the comparative relation would not change if we discovered that Mozart had written another sonata. The small improvement argument illustrates that we must

abandon the assumption that there will always be one alternative in the feasible set of choices that is better than or equal to every other alternative.

One can draw different conclusions from this type of problem. A radical approach that has been suggested by Larry Temkin is to conclude that the mistake lies in accepting the transitivity of the better-than relation.¹² If we accept that the standard relations are not transitive, then of course A' can be both equal to B and better than A. John Broome has argued that the problem lies in non-semantic vagueness.¹³ Ruth Chang, in turn, introduces the potential of a fourth value relation, *parity*, and Derek Parfit claims that there can be what he calls *imprecise equality*.¹⁴ I will not defend or dismiss any of these proposals, but rather suggest that from the perspective of the issue at hand, the possibility of rationality in clinical decision making, it suffices to note that there is comparative non-determinacy, and, more generally, a non-determinacy problem. Occasionally, it is impossible to establish a single course of action that is better than, or equal to, every other alternative in terms of health promotion. And this is not because we lack knowledge about the situation; it is because the trichotomy thesis does not hold true for the comparisons.

Comparative non-determinacy of the kind illustrated above poses significant problems for the very possibility of rational choice. If we are unable to identify an alternative that is either better than or equal to every other alternative, we are unable to actually make a decision that is rational, in so far as we believe it is rational to select an alternative that is best in light of given purposes and facts.¹⁵ We can, it should be noted, also, in the face of non-determinacy, identify alternatives that are *ineligible* in the face of non-determinacy. Of the options A, A', and B, it is clear that A is an ineligible alternative, because there is an alternative that is clearly equally good or better in every respect: A'. Yet, if we hold an alternative to be ineligible if and only if it is worse than some alternative in *some* respect and worse or equally good in all respects, the alternatives that remain when all of the ineligible alternatives have been removed will not necessarily be rational. The fact that both A' and B remain in the set of choices once we have removed the alternatives that are ineligible (that is, A) does not mean they are both rational choices.

CREATING REASONS

In this section I argue that the paradigm of person-centered care and, in particular, shared decision

making, provides a very good framework for dealing with the non-determinacy problem outlined in the previous section. Again following Chang, I suggest that an appropriate response to the non-determinacy problem is not simply to pick an alternative among the alternatives that are not ineligible, but to rather *create* a reason that, when applied to the situation requiring a choice, can establish an alternative that is better than the other(s). Below, I first introduce Chang's idea of how we can deal with non-determinacy when it comes to practical reasons. Thereafter, I indicate how this can be reinterpreted and applied to a clinical setting by invoking shared decision making.

Dealing with non-determinacy is easy in practice but hard in theory. Comparability problems like the ones outlined above can be addressed, and are often addressed, by superimposing a degree of comparability that is not warranted by the relevant given factors. Also, in a situation in which the relation between alternatives is non-determinate, we *can* evaluate them as if it was not.¹⁶ In the example above, one could, for example, pick a way of weighing life expectancy and physical disability that is complete in the sense that it ranks all possible alternatives in accordance with the trichotomy thesis. This is similar to what the concept of DALY (disability-adjusted life year) does at population level.¹⁷ I contend that this, in clinical settings, is a huge mistake, but it is important to accept that it is still *practically* possible. Practitioners could embrace an evaluative model of health promotion according to which A' is better than B and follow this in their practice. However, if A' is not better than B, this practice would lead to treatment decisions that are not justified. We need to settle on a treatment, and, if nothing else, this means that we at least implicitly rank the alternatives. The puzzle is, then: if we cannot simply pick an alternative that is not ineligible, which should the grounds for such a ranking be?

Chang, who first argued for the possibility of parity using the small improvement argument,¹⁸ has outlined a promising way in which to deal with situations when the comparative relation between alternatives is non-determinate. Rather than simply picking an alternative, based on the reason that none of the alternatives is determinately worse than the other, she suggests that, in situations such as these, we can rely on *created* reasons. The problem arises, according to Chang, because the reasons that are *given* sometimes fail to fully determine what we ought to do, and when we face this problem we need to turn to a kind of reason that has a different origin. In the argument above, the given reasons available

to us are: prolong the life of the patient and minimize the amount of involuntary, unavoidable physical disability. These reasons, occasionally, fail to fully determine what one ought to do, all things considered.

Relying on a rich voluntarist philosophical tradition that dates back to Duns Scotus, Thomas Hobbes, and Immanuel Kant, Chang argues that, apart from given reasons, there are reasons that agents can create through an *act of willing*.¹⁹ This largely overlooked tradition can be contrasted with the views that are more common in contemporary philosophy, regarding the nature of reasons: externalism and internalism. According to externalism, reasons are grounded in facts “outside” of us, for example, that something is painful provides reasons to avoid it.²⁰ According to internalism, reasons are grounded in facts “inside” of us, for example, that I desire to avoid pain gives me reason to avoid it.²¹ Both of these theories, Chang holds, provide explanations of *given* reasons, such as “prolong life” and “minimize physical disability.” However, since these reasons fail to fully determine what we should do, we need to accept a different kind of reason, which can be explained by the *voluntarist* theory: reasons can be grounded in our *willing* and *commitments*, for example, that I will to live a life with minimal amounts of physical disability provides reason to minimize physical disability.²² These reasons are not given; agents themselves create them.

To will something, it is important to note, is not the same as to desire something. Rather, it is to be understood as an activity constitutive of the very agency of someone, as decisive of what and who someone is. Desires, Chang suggests, are passive. They are mental states toward which we are largely passive. To will something is different from desires, in that it is an active state. Chang invites us to make a comparison to divine command theory. According to this view, God could create reasons for us not to eat hooved animals by willing it, which is different from God desiring that we do not eat hooved animals. Likewise, Kant can be seen as suggesting that rational agents can lay down laws for themselves. Again, these are not supposed to be passively desired.²³ More mundanely, there is a difference between me desiring to sleep as a result of being tired and me willing to sleep because I want to be a person who sleeps during certain regular hours.

Having recognized two different types of reasons (given reasons and created reasons), Chang suggests that the reasons should be given different importance and different roles. Since we are able to will anything, and since the very structure of rationality it-

self relies on reasons, it is imperative that we recognize that given reasons take priority; a caregiver cannot create a valid reason to purposelessly harm patients through an act of willing, and I cannot create a valid reason to believe that $2+2=5$ through an act of willing. Created reasons, grounded in acts of willing and commitments, Chang holds, only apply to situations when given reasons fail to fully determine what we ought to do.²⁴ It is only in situations when there is comparative non-determinacy, cases such as the one outlined in the previous section, that created reasons become at all relevant. However, in these situations, the role of these reasons is indispensable: they enter to settle hard cases in which we otherwise cannot establish an alternative that is better than or equal to every other alternative.

Contrary, then, to merely picking an alternative within a set of not ineligible options, choosing a rational option by first creating a reason through an act of willing involves making a commitment to a specific value. In the example above, the patient can, for example, enable a rational decision in this manner by committing to living to see her or his children grow up, and thereby create a reason in favor of selecting the alternative that gives the longest life expectancy, in the example B. Or the patient could enable a different rational decision by committing to “living life to its fullest” and maximizing life at full functioning, and thereby choose A (A’ in the expanded version), because it maximizes the time the patient has left not being impaired by physical disability.

First of all, we can see that this provides a solid ground for the general idea that healthcare should be person-centered in the quite broad sense that treatments should be decided upon based on the particular circumstances of the patient: appropriate solutions to non-determinacy are dependent on the persons who face the non-determinacy. Given reasons are universal, and whatever given reasons tell us to do in a clinical setting, they tell us to do it regardless of who the patient is. Created reasons, on the other hand, are actualized in particular situations by the individuals involved in the situations in question that require choice. Therefore, if clinical situations require that we deal with non-determinacy, and if non-determinacy is best dealt with by invoking reasons created by acts of willing, clinical practice should be person-centered at the very least to the extent that it is person-centered created reasons, and not general reasons provided, for example, by policy makers, that guide decisions when non-determinacy problems arise. Importantly, this ground for person-centered care is unrelated to ethi-

cal and medical reasons to embrace person-centered care. Such reasons might exist, but in addition we have a reason here to embrace person-centered care because it enables rational choice.

Second, it provides a ground for shared decision making that is different from other medical and ethical reasons to engage in shared decision making. Chang proposes that individuals can rationally solve situations in which they face reasons that fail to fully determine what one ought to do by creating reasons through acts of willing. It is problematic to directly transfer this to clinical settings, in the sense that we ought to simply let the patient make a commitment. Clinical decisions typically involve large amounts of highly complicated, but doubtlessly relevant, medical aspects. Furthermore, there is a large risk that patients will experience high amounts of stress in situations that require a difficult choice. Both a lack of understanding and too much stress risk undermining the validity of reasons that arise from acts of willing. A commitment that is formed either without a proper understanding of the situation, or as a result of stress, is not a valid ground for a created reason because it can be questioned whether patients really committed to what they believe they committed to. In other words, in clinical decision making, in which created reasons are invoked, it is, first, important that medical competence is involved in the decision process. This at least raises the likelihood that the commitments, the acts of willing, that generate created reasons actually are based on a good understanding of the complexities of the situation. Caregivers can play an important role in making sure that patients actually understand the specifics of a situation. Second, some medical conditions create large amounts of stress. Having a second party taking part in the decision process can prevent some of the influence that this stress might have on the final decision. If we accept that an appropriate way of dealing with comparative non-determinacy is to invoke reasons that are created through an act of willing, and if we think that (as I claim above) these situations are ubiquitous in clinical practice, we should embrace shared decision making as an appropriate solution to non-determinacy problems in clinical decision making. In the following section, I further discuss what this might entail for our understanding of what this shared decision making ought to look like.

SHARED DECISION MAKING

In the first section of this article, I argued that comparative, value-theoretical non-determinacy is

ubiquitous in clinical practice. I described comparative non-determinacy by an argument that health promotion entails non-determinacy, but I hope that readers will agree with me that similar arguments can be made almost regardless of which ideals one embraces. In the second section of this article, I suggested that the appropriate way to deal with comparative, value-theoretical non-determinacy in this area is through shared decision making. I based this on Chang's suggestion that there are essentially two different kinds of reasons. There are reasons that are given; these take priority, but sometimes lead to non-determinacy since they fail to, in every situation, fully determine what we ought to do. And there are reasons that are created through acts of willing; these reasons only apply to situations in which one faces comparative non-determinacy. In the case of clinical decision making, I suggested that we should accept that created reasons that are valid must be preceded by shared decision making, in which both caregivers and patients play a role. In this section, I discuss what this means in terms of the actual nature of the shared decision-making process.

Lars Sandman and Christian Munthe have developed a conceptual analysis of shared decision making and outlined no less than nine different versions of it, all of which appear somewhat reasonable.²⁵ Without going into too much detail of Sandman and Munthe's conclusions, their research can be summarized as illustrating that one can understand the different components of shared decision making in different ways. Is consensus desirable? If so, who has the final say when consensus cannot be reached? Is it the caregiver, the patient, or should the parties accept some kind of compromise? What is the nature of the deliberative process? Is the role of the patient merely to provide the caregiver personal information, or is the role of the caregiver merely to provide the patient medical information, or should they engage in some form of collaborative deliberation process? Different views can be defended on various grounds, and it is not entirely clear what the nature of shared decision making is supposed to be like when proponents of person-centered care advocate it.

Accepting that a fundamental reason for engaging in shared decision making is to solve non-determinacy problems gives us a clue on how to understand what shared decision making should look like. First of all, it is clear that, in so far as valid created reasons must be created through an act of willing by the patient rather than the caregiver, the will and commitments of the patient (and not only the desires) must be at the core of the shared decision-

making process. This means that as long as patients are conscious and have a sound mind, they should have the final say about the created reasons in light of which a final decision is made in face of non-determinacy. It is the patient's will and the patient's commitments that constitute the ground for created reasons that apply to situations in which non-determinacy occurs. This does not necessarily mean that patients should always have the final say about which treatment to choose, but, in face of comparative non-determinacy, it is the patient's will and the patient's commitments that provide valid grounds for which decision to make. In the case above, the following questions thus become relevant: Is the patient committed to a physically active life, or is she or he committed to living as long a life as possible? What sort of person does the patient want to be, who is she or he? Physicians can help patients think about these issues in different ways, and also to assist in ranking alternative treatments in light of what the patient is committed to, but it is the patient's will that solves the non-determinacy.

Although the theoretical risk that patients fail to see what follows from the commitments they make certainly exists, for practical purposes, this provides us with good reason to give patients final say when patients and caregivers disagree. In the vast majority of cases, we must assume that the individuals who make commitments are better at inferring what they entail than bystanders who learn about the commitments secondhand. Caregivers can, of course, still aid in this process by providing guidance concerning how different treatments match up with the commitments patients make, but patients should have the final say. This does not mean that caregivers should let patients make *any* decisions concerning treatments, but, in the face of comparative non-determinacy, patients have the final say concerning the grounds for selecting among the better alternatives (the alternatives that are not determinately worse than other alternatives). Granting patients this role is a minimum criterion for the created reasons to be valid.

Complications arise when patients are prevented from engaging in sound reasoning in different ways, but also, in such situations, it is more warranted, in light of the argument above, to search for answers to what patients *would have willed*, as expressed in recorded narratives or the patients' life history, than to leave it to caregivers to decide what matters. Past decisions and expressed commitments are not perfect sources for inferring commitments and reasons that can settle cases of comparative non-determinacy, but they still seem to be better sources than com-

mitments made by individuals who are merely providing treatment.

It is less obvious what the nature of the deliberation process ought to look like in light of the argument above. Yet, some things seem clear enough. It is, first of all, essential that caregivers provide patients with relevant medical information about their situation. Patients can make commitments to various values without understanding the medical complications they face. In so far as patients are given the final say in the decision process, they must have a good understanding of the situation at hand. This translates into two different obligations for caregivers. First, caregivers must share their knowledge, be honest about the complications, and provide information that can be relevant. Second, caregivers have an obligation to do what they can to make sure that patients actually understand the information they are provided. It is not, for example, sufficient to hand over a brochure with information about an illness, assume that patients read it, and then act in accordance with the patients' expressed will. Caregivers should do their best to assure that patients are well informed.

Shared decision making that aims at reaching a decision based on valid created reasons, in the light of which one can establish a unique course of action that is best, will consist of at least these parts:

- The patient will provide the grounds for the created reason through acts of willing, or commitments. Ideally, the patient makes a commitment in the face of the situation that requires a choice. If this is not possible, these grounds should be looked for in the patient's personal history.
- In so far as the patient is of sound mind, the patient should have the final say concerning how to apply the created reasons to the situation and concerning which treatment to select. If the patient is not of sound mind, a decision should be formed in light of the reasons the patient would have embraced.
- The caregiver has an obligation to provide information to the patient. Caregivers must be honest, and are obliged not to withhold any potentially relevant information.
- The caregiver has an obligation to ensure that the patient fully understands the information that has been conveyed.

Although these conclusions seem robust in light of the specific view of the role of shared decision making presented above, there is still room for controversy regarding the details of the shared decision making that caregivers and patients should engage

in. Cases in which patients are not of sound mind or unconscious are perhaps the most problematic. First, what counts as “of sound mind”? Second, what sources should be used to discern commitments in these situations, and how should they be selected? Two general issues that are worth exploring here are: (1) to what extent should the patient’s personal history and the often-mentioned recorded narrative that is part of the general framework of person-centered care be invoked? (2) What is the role of a spouse, children, and other family members in these kinds of situations? A different issue that becomes of utmost importance from the perspective of this argument is: What are the conditions under which comparative non-determinacy arise? One can point to non-determinacy and argue that no alternative is better than or equally good as every other alternative when one deals with radically different alternatives that both are good in very different ways. Yet, the argument above tells us that the difference between facing comparative non-determinacy and a situation in which a best option exists is massive. The existence of non-determinacy justifies shared decision making. If one treatment is determinately better than every other treatment, this particular justification for shared decision making is not there any longer; rather, it is in such situations rational to pursue the best treatment.

CONCLUSION

In this article I presented an argument in favor of person-centered care, and in particular in favor of shared decision making. I started by arguing that we must accept widespread comparative non-determinacy in clinical practice. In a large number of cases, it will, in light of the given reasons at hand, not be true that any alternative is either better than or equal to every other alternative with respect to the objectives of clinical practice, for example health promotion. In the second section, I presented Ruth Chang’s suggestion of how to deal with comparative non-determinacy, and I suggested that we should accept this suggestion, but re-interpret it so that in clinical settings it is not merely an act of willing that is required, but rather shared decision making, the purpose of which is the creation of a reason through an act of willing.

This view of the grounds for person-centered care and shared decision making enables us to pose a range of more precise questions that have been largely overlooked in the literature. In particular, although there is a widespread acceptance of person-centered care and shared decision making, little

research has been devoted to the *limits* of shared decision making. If comparative non-determinacy is the grounds for shared decision making, we can frame this question in a new and promising way: when is it, in light of given reasons, determinately true that some treatment is a best treatment? The grounds to use shared decision making track non-determinacy in this view, and this particular reason to engage in shared decision making disappears when one treatment is determinately better than all others. Furthermore, this framework allows us to develop more precise notions of what the role of patients’ narratives is in person-centered care. Much of the research mentions the importance of these narratives, but it has not been studied as systematically as shared decision making. If we accept that acts of willing and commitments provide the grounds for solving comparative non-determinacy, we can start asking important questions concerning the extent to which we can discern such commitments in recorded patients’ narratives, for example when dealing with comatose patients.

Doubtlessly, more research is needed before we have a full picture of how to apply person-centered care in clinical practice, and what the appropriate practices of shared decision making require further study. I hope that the argument presented in this article contributes to this effort, by illustrating how these practices can be grounded, and by providing a framework within which new interesting and important questions can be posed.

ACKNOWLEDGMENT

This work was funded by Forte, the Swedish Council for Health, Working Life and Welfare, grant number 2014-2724.

NOTES

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14. Chang, "The Possibility of Parity," see note 10 above; Parfit, "Can we avoid the repugnant conclusion?" see note 11 above.

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