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Manipulation and Free Will in Shared Decision Making

by

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Introduction

Healthcare is a major sector in many countries. It is usually resource-intensive, so treatment planning is an important element in any effective health care system. The traditional approach to treatment planning has often considered to be, in one sense, paternalistic, since it gives the clinician (the doctor, nurse, psychologist, etc.) the power to decide what treatment should be offered (Schramme, 2015).[1] However, in recent years there has been an increased focus on patient involvement in treatment planning and less paternalism in health care, and various methods have been employed to achieve this aim. One of these methods is Shared Decision Making (Elwyn et al., 2016).[2] Shared Decision Making is defined as '*an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences'* (Elwyn et al., 2010).[3] Thus, Shared Decision Making (SDM) is intended to give the patient the opportunity to consider treatment options in a setting where they feel free to make an informed choice in partnership with the clinician. However, potentially, SDM also has a degree of manipulation inherent in its basic premise in that, although the communication style used is supposed to be respectful and patient-centered, with the patient's interest as the central guiding point, it often also includes the presence of a person of authority (an expert) and a directive component that the person of authority controls.

Humans, in engaging in social interactions, influence one another in a variety of ways. In daily life we are influenced by family, colleagues, the media, etc. However, we seldom think of this kind of influence as manipulation. When discussing Shared Decision Making as part of clinical practice, however, we might fear that the clinician, as an authority, not only influences the patient but perhaps even manipulates him/her into making certain choices.

We might argue that an authority risks violating or at least undermining personal autonomy, and this gives rise to moral concerns. We can cast light on this topic by focusing on the core of free will and the human capability to perform actions even if some authority impedes the patient from doing so. Free will is concerned with the power to control one's choices and actions. When a patient makes choices and performs actions, he/she is exercising free will.

It is unclear what roles are played by free will, informed consent, the clinician and elements of manipulation in SDM and this raises the question of whether the patient's choice is free, or to some degree at least, manipulated. Hence, in the present paper, we will discuss how the framework of SDM might be shaped to enable it to achieve a balance between ensuring the patient a free choice, and thus remaining in control, and the facilitation of recommendations. Therefore, we take as our point of departure the topic of free will and responsibility, drawing on the Theory of Reasons-Responsiveness (TRR) and its extensions.

Shared Decision Making

Shared Decision Making (SDM) is a method that involves both patient and clinician. However, reviews suggest a need for clarity on its purpose; whether the aim is to offer the patient options recommended by the clinician or whether it is a process in which there must be joint deliberation and mutual understanding between the patient and the clinician (Woltmann and Whitley, 2010).[4] The term Shared Decision Making was used in medical reports in the 1970s. Medical ethicist Robert Veatch pointed to ethical and moral concerns related to clinical practice because of a lack of genuine sharing in decisions (Veatch, 1972).[5] Even today there is still no consensus on the best model of SDM. As a result, shared decision-making models have been applied in various formats since the 1990s. Some advocate a "shared decision-making continuum" model (Alexander, 2010),[6] accommodating a wide variety of shared decision-making formats depending on the situation. At one end of the continuum decisions are patient-driven and at the opposite end physician-driven. Between these two ends of the spectrum there will be many different approaches e.g. physician recommendations, equal decision-making or informed nondissent etc. (Alexander, 2010; Harter et al., 2011).[7] A study conducted by Mendel and colleagues found that patients are inclined to follow the healthcare professionals' advice on treatment even if the recommended treatment options go against their initial preferences (Mendel et al., 2012).[8] Others have described shared decision-making as "an interactive decision-making process conducted on an equal footing" (Quaschning et al., 2013)[9]; in this model, the healthcare professional takes part in the deliberation on treatment plans instead of directing the treatment path. On this approach, the health care professional must listen attentively and seek to understand the patient's values, preferences, cultural background, etc. when making recommendations on treatment, as well as ensuring that the patient is well informed about treatment options. The efficiency and efficacy of SDM have been tested in multiple studies (Aubree Shay et al., 2015)[10] and the method has been found to increase patients' understanding of their choices and their confidence in the decision that they had made.

The stated goal of SDM is to ensure that patients play a substantive role in their own treatment. Hence, it is a method focused on increasing patient autonomy.

Free Will

There are two widely acknowledged positions concerning free will and control: compatibilism and incompatibilism. Compatibilists maintain that free will and control are compatible with determinism[1].

[1] Determinism: all events have a cause

Incompatibilists argue that free will and control are incompatible with determinism (Kane, 2011).[11] Compatibilists contend that human beings have free will even if determinism is true.

Most philosophers espouse a compatibilistic standpoint, arguing that free will (and personal control) is reconcilable with determinism and the lack of alternative possibilities. John Martin Fischer and Mark Ravizza submit that agents may have control of their actions even in the absence of free will. Their Theory of Reasons-responsiveness (TRR) is semicompatibilistic regarding free will. They argue that to be in control and to have responsibility does not depend on free will (Fischer and Ravizza, 1998).[12]

The Theory of Reasons-responsiveness

To understand what affects free will and the factors that influence potential free choice, we need to understand how humans relate to their surroundings. Strawson[13] (1974) contends that humans are led by reactive attitudes. Reactive attitudes are unique to humans and are what make humans accountable unlike other primates. Reactive attitudes are emotions like love, gratitude, hate, etc. and are always implicit in interpersonal relations. According to Fischer and Ravizza, reactive attitudes are constitutive of moral responsibility. Only ignorance and coercion may exempt an individual from being held responsible. An individual who acts out of ignorance cannot be held responsible because she lacks knowledge pertaining to an action (Fischer and Ravizza, 1998).[12]

Fischer and Ravizza believe that control of one's actions implies regulative control and guidance control. Regulative control is something that requires that the agent has the option of performing an action, and it is a precondition of having guidance control. Further, to have regulative control, the agent must act voluntarily. Two conditions must be fulfilled to have guidance control and, hence, be in control and have moral responsibility (Fischer & Ravizza, 1998, Christiansen et al., 2019).[12,14] These are:

1. The mechanism in the relevant behaviour must be the agent's own.

    A) An individual must see him or herself as an agent. When making choices and actions, individuals must see themselves as capable of influencing the world.

    B) The individual must accept being a target of reactive attitudes because of the way he/she acts in different contexts.

    C) The individual's view of him/herself as set out above must be "caused in the right way". This

means, that when the agent makes choices and performs actions, he/she must be able to understand how this affects their immediate social world and how the immediate social world affects him/her. This kind of knowledge is obtained through what was learned from parents or in a wider social context regarding rebuke and praise. An individual must learn what is involved in social practices through participating in social practices. Through such interactions, the agent will learn what is involved in a moral conversation, independent of whether this conversation is based on good or bad moral input.

2. There must be "responsiveness to reasons" in the mechanism issuing in the behaviour.

The individual must be alert to the different motives that cause her to act in a specific way. The ability to be responsive to reasons includes being both receptive and reactive. In being "receptive to reasons", an individual must recognize reasons for acting in a specific way. He/she must then be able to translate these reasons into choices by being "reactive". When being "receptive to reasons" there must be a pattern in the way the individual recognizes reasons that can be understood by a third party in form of an understanding of the values, preferences and beliefs of the specific individual. Further, the individual must make choices that are understandable from an outside perspective (Fischer & Ravizza, 1998; Christiansen et al., 2019).[12,14]

Extending and discussing the Theory of Reasons-Responsiveness

Ignorance

It can be argued that Shared Decision Making involves degrees of manipulation because of the presence of a clinician – a person of authority – who presents information to the patient and initiates the process of Shared Decision-Making. Hence, the patient is not able to exercise control and be responsible, as described in the TRR. However, we believe that the method of Shared Decision Making can be defended in this respect, as the patient is fully informed about treatment. The clinician must provide the patient with information in terms of the fatality risk or survival rate, etc. when the pros and cons of treatment are discussed. Nevertheless, ignorance, as an epistemic condition, underlines the requirement of Shared Decision Making that the patient be provided with sufficiently advice on treatment. Hence, some doubt may be cast on whether the patient has free will in SDM if the information provided is incomplete.

It might be thought that a patient involved in shared decision-making might lack knowledge in the sense of simply

being too unfamiliar with clinical terminology. Studies have found that gaps in the patient's knowledge made it difficult for them to engage in decision-making (Renzi et al.,2008).[15] Therefore, when practicing shared decision-making, something akin to ignorance may obtain. However, if the feeling of ignorance springs from information overload, it is not strictly speaking a form of ignorance. Also, among the steps in shared decision making is that of providing the patient with substantive knowledge in order that they may gain insight into own treatment.

Another study conducted in Wales found women with breast cancer to be less involved and satisfied with the decisions made when doctors expressed uncertainty (Politi et al., 2011).[16] It is worth considering whether knowledge subject to uncertainty has the same effect on the patient as the feeling of information overload. An individual in a position to make choices where factors of risk, uncertainty of outcome, multiple choices, etc. pertain, might not react out of information overload, and yet still experience the setup on the same grounds, as not having a real choice and hence not being in control.

Reactive attitudes

In line with the study from Wales, Ishtiyaque Haji (Haji, 2000)[17] claims that Fischer and Ravizza, through their still partly subjective view, where individuals must see themselves as apt targets of reactive attitudes, effectively require individuals to take responsibility for circumstances that are out of their hands. Some patients may not be able to see themselves as apt targets of reactive attitudes during the process of treatment. Several studies have found that the values and attitudes of the patient are important factors in the success of SDM (Karel et al., 2010, Légaré et al., 2011, Charles et al., 2004).[18,19,20] The patient having negative attitudes or low self-efficacy has been shown to make SDM more difficult to conduct. One among several reasons for Haji's concern regarding the TRR is that it fails to address the situation of individuals unable to develop a balanced and stable sense of self (Haji, 2000),[17] e.g. if raised in an unhealthy environment and hence having poor personal resources to act comprehensibly. This points to the fact that to succeed in SDM, it is crucial that the values of the patient be accommodated, so that, for example, patients with poor personal resources get to engage in models of SDM where the patient-driven perspective is prominent. To underline our general concern, we again turn to Haji, who uses an example of manipulation to show the problems inherent in the TRR (Haji, 2000).[17]

Haji argues that prior to manipulation the individual does not see him/herself as an apt target of reactive attitudes. Only after being manipulated does the individual fulfil the conditions for taking responsibility. Haji argues that when Fischer and Ravizza emphasize how reactive attitudes must be situated in the right way, this can only be accepted if one relies on an internalist approach to knowledge (Haji, 2000).[17] Hence, when an individual sees him/herself as an apt target of reactive attitudes, these attitudes must be grounded in the mental

dispositions of the individual and not in some external circumstances. This is in opposition to Fischer and Ravizza's otherwise externalist approach to moral responsibility since it refers crucially to the mental states of the individual.

Haji suggests an alternative to Fischer and Ravizza's approach in the form of the following condition on responsibility:

> "*Agent, S, is responsible for an action, A, that issues from pro-attitudes like S's values, desires, beliefs, etc., only if S's attitudes are caused in the right sort of way by factors in the external world*"[17]

In this way, Haji argues, it is possible to rule out individuals who have been manipulated, instead of having to attribute full responsibility to them for their actions. Haji's argument of manipulation is illustrated by the example of the clinician suggesting various options on treatment. Before participating in Shared Decision Making, the patient may have limited insight as to which treatment to choose. When confronted with the clinician, who provides the patient with complete information about the options, the patient may become convinced that her reactive attitudes are caused in the right way and hence her reasons for choosing future treatment come from within. Yet, it could be argued that the reactive attitudes of the patient are not fully internal to the patient, but merely a result of the persuasiveness of clinical expertise.

We suggest that a patient whose situation prevents them from being an apt target of reactive attitudes can still be considered to have control and be responsible for their choice. Consider a patient with a chronic disease having some pro-attitudes, having to be involved in SDM. During the process, patient and clinician, as part of the SDM, discuss the values and preferences of the patient. Now the patient might experience some changes in her values or preferences based on the pros and cons of further treatment options. Haji's argument is illustrated in this case: the patient is responsible because the changes in their values (whether negative or positive) are caused by some external circumstance, in this case SDM, and the fact that the clinician as part of her job is expected to interact with the patient about pro-attitudes.

The above section foregrounds research that has found that patients involved in SDM are more likely to benefit from SDM over a longer time span in terms of general health and overall wellbeing compared to a short-term intervention (Van Roosmalen et al., 2004, Kaner et al., 2007).[21,22] This also points up how SDM can accommodate Condition 1C (the individuals view of herself caused in the right way) regarding guidance control in the TRR,

because long term commitment in SDM for a patient without enabling resources could have the effect of the patient gaining more confidence about herself through interactions with the clinician.

Nonetheless, the critique set out by Haji raises some fundamental questions. We might consider whether it is at all possible to provide the patient with full information without leaning towards manipulation of the patient's decision-making. On Haji's condition involving agent S and action A cited above, we find a possible solution. The clinician offers the patient her professionalism and professional opinion based on the needs, values, desires, beliefs, etc. of the patient. Thus, what defines the 'right sort of way' is characterized by the needs, values, desires, etc. of the patient herself and the clinician's ability to support the patient. Only then does the role of the clinician become that of an ally rather than of a manipulator. The reactive attitudes perspective gives insight to the emotional dynamics involved where decisions about responsibility occur. That a patient is appropriately subject to certain attitudes and practices gives us reason to consider patient's as free, responsible, and not manipulated into decisions.

Also judging a patient responsible, we may argue that a patient is accountable for their behavior, in the sense that the patient offers explanation of their beliefs about their behavior in SDM.

Self-identification and responsiveness

In line with above proposal, theories of self-control suggest that individuals may develop self-control by framing choices in relation to what they consider may, or may not, cause problems for themselves over time (Ainslie, 2001, 2010).[23,24] If the patient manages to be actively involved in this process and exhibit control, Ainsle would suggest that an individual does not lack self-identification and, hence, acts as a free individual; the charge of manipulation could then be refuted.

Nevertheless, developing self-control by framing choices in relation to SDM requires great effort as well as knowledge. Often treatment prospects are unavailable to both patient and clinician, regardless of the expertise in the specific field – so framing choices might not be possible. Even if a patient exhibits control, which might indicate that they do not lack self-identification and, hence, have free agency, the self-identification could be affected by the clinician's values or preferences, so that it's not free agency after all. This would have the consequence of the patient being unable to exhibit responsiveness to reasons as specified in the TRR. Further, research on SDM also seems to indicate that patients engaged in SDM are sometimes pulled away from their initial treatment preferences when confronted with the clinician's recommendations; the result was less satisfaction with their choices (Mendel et al., 2012).[8] The patient might be receptive towards reasons in the sense of being aware of initial values and preferences as the basis for having reasons for acting in one way or the other.

However, the patient fails to be reactive, because as research indicates, the clinician's "interfering" results in the patient not being able to translate reasons based on values and preferences into choices. Another way to shed light on this problematic aspect of SDM is to consider cultural background, age, gender, etc. as potentially limiting the patient's basic ability to be responsive to reasons as required in the TRR. When comparing young patients to older patients, we find that older people more often prefer a paternalistic style when interacting with a doctor, while younger people tend to be more involved, participating in decision making (Clark et al., 2009, Mazur et al., 2005).[25,26] We argue that both patient groups, young as well as old, are capable of being receptive towards reasons because both recognize reasons, even if their reasons may be different or even only tangential to the clinical encounter. Likewise, both groups are reactive because, with a focus on their initial reasons, they translate these reasons into choices; even if their choices are fundamentally different. However, if we consider demographic aspects and the possibility of satisfying Condition 1 for guidance control in TRR (the mechanism that issues in the relevant behaviour must be the agent's own), some profound difficulties might be found. Young people may not have difficulty in seeing themselves as agents whose choices and actions influence the world (condition 1A in TRR). They are raised under social norms where participation in society is expected of them, whereas older adults might be more restrained, in part due to being raised in a less individualized society. However, we would still expect older people to see themselves as agents as well. Nonetheless, we argue that being raised under two different codes of conduct can have a huge effect on the patient's way of handling being a target of reactive attitudes (condition 1B in TRR) in SDM because of the way reactive attitudes are situated in the agent (Condition 1C in TRR). Young people, being better educated and having a more individualized mindset, are caused greater discomfort by reactive attitudes (Briel et al., 2007).[27] This shows that the younger patient group have a lot of 'expertise' in involvement and participation and are hence an apt patient group for SDM, but they tend to be insufficiently aware of their own reactive attitudes and those of the clinician. Research indicates that this patient group is also more inclined to have a troubled relationship with the clinician and be less willing to take part in decisions, as opposed to older people who are happier with a paternalistic approach to treatment (Adams et al., 2012).[28] This indicates that even if control and responsibility are present in the patient group, the outcome of SDM is different.

Preferences and values

One reason for different outcomes of SDM may also be found in the preferences and values of the patient. The philosopher Nomy Arpaly describes how the will of an individual may be "weak" if she has an intrinsic desire for something which is considered bad for her (Arpaly, 2003).[29] This may partly be the result of upbringing, general

life circumstances, opinions, life experience, etc. (as in condition 1C in TRR). Arpaly argues that individuals show moral indifference by failing to have an intrinsic desire for what is right or good. (Arpaly, 2003; Levy, 2013).[30,30] Young people may have difficulty in realizing their intrinsic desires because of less life experience and, to some extent, through having too many choices in their daily life. This could cause younger patients to act independently of appropriate beliefs or expectations, which might lead to actions that diverge from the immediate intent or desires of the individual

Consider a case where a patient has an intrinsic desire for something which has a negative effect on the individual's capability of exhibiting control and, hence, consequences for the patient's choice; the desire to drink alcohol while being in treatment for liver cancer, which would diminish the prospects of effective treatment. Arpaly considers this as having an intrinsic desire for inappropriate things, e.g. to drink while in treatment for liver cancer, as manifesting a flawed will. The intended desire of the individual may not be compatible with their choice and actions.

Even the most profound expertise may have difficulty in providing sufficiently reasoning in such a case. In the light of the TRR, we argue that the clinician would have to be capable of evaluating the patient's life in general and not only the patient's immediate values or preferences. We wish to highlight the need for specific tools to assist the patient in exploring his/her values and preferences. Tools of this kind may help the patients in framing their choices in view of the consequences for treatment such as risk to health etc. and, hence, to deliberate on the quality of their choice.

Conclusion

Drawing on the Theory of Reasons-Responsiveness (TRR) perspective on free will and control, we have investigated how control and responsibility may be perceived in the light of that theory. We found that individuals involved in Shared Decision Making do have control and responsibility and hence not being manipulated. However, we suggest that some individuals may have difficulty in experiencing appropriate reactive attitudes when confronted with the clinician and hence differences in the way of being receptive towards the reasons involved. This is in line with research on SDM, which indicates that values and preferences play a huge role in the experience of SDM. Analysis by demographics indicates differences in ability to involve in SDM. Unsettled reactive attitudes experienced by the patient affect the patient's ability to act in accordance with what would be most advantageous to her, causing the outcome of SDM to diverge significantly depending on the individual. This may be due to upbringing, life circumstances or other features and has consequences for the patient's overall prospects of treatment. Therefore, the clinician needs to be an ally as to assure compliance with

the patient's life in general. Tools that can assist clinicians in gaining knowledge of reactive attitudes and the patient's ability to act receptive would be an advantage of SDM.

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