Opinion

CATHOLIC
MEDICAL
ASSOCIATION

The Linacre Quarterly
2019, Vol. 86(2-3) 168-171

DOI: 10.1177/0024363919841775
journals.sagepub.com/home/lqr
SAGE

Dialogic Consensus as the Moral Philosophical Basis for Shared Decision-making

Paul Walker, MBBS, PHD, FRACS, FACS[1]

Abstract

Shared decision-making is important and beneficial for patients. Practically, this requires that we explore the values of the patient and the clinician and then consider available treatment options. The aim is to maximize the good of the patient in the context of their illness. Hence, clinical consultations are situations in which we can, and should, draw upon moral philosophical precepts. One such precept, which can fortify the foundations of shared decision-making, is a process of inclusive, noncoercive, and reflective dialogue, which aims at reaching a consensual decision as to what is best for the patient in their situation.

Summary: Shared decision making is important and helpful for patients. This is based upon having a conversation about values and what is important. We can base that conversation on principles of moral philosophy, via a process termed "dialogic consensus".

Keywords

Dialogic consensus, Medical ethics, Moral philosophy, Shared decision-making,

Shared decision-making has been described as a process wherein clinicians and patients "jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the patient's values, preferences and circumstances" (Hoffman et al. 2014, 35). Outside of emergency situations, shared decision-making has been shown to reduce patient mortality, reduce readmission rates, reduce healthcare-acquired infections, reduce length of stay, enhance compliance, and improve functional status (Australian Commission on Safety and Quality in Health Care 2011). To put shared decision-making into practice in clinical consultations requires a conversation, a dialogue, or a discourse among all the stakeholders. There is no other way to explore and understand "what matters most" to the individual patient and their family or others whom they see as significant.

Clinicians are well aware that we need to have a conversation with our patients, in order to determine what their values are, so that, jointly, patients and clinicians can determine what treatment course will maximize their values, in the situation of their illness. What I aim to do here is to place that conversation on a more robust moral philosophical footing. Since all clinical decisions involve other human beings, the doctor–patient relationship has, by its nature, an essential intersubjectivity. The role of clinicians has been intimately associated with moral responsibilities since antiquity. The Hippocratic Oath (and similar Commitments) is grounded in a classical-era virtue ethic framework. Hence, we can, and arguably, we should, call upon moral

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[1] Faculty of Health and Medicine, University of Newcastle, Callaghan, New South Wales, Australia

Corresponding Author:
Paul Walker, MBBS, PHD, FRACS, FACS, Faculty of Health and Medicine, University of Newcastle, PO Box 293, New Lambton, New South Wales 2305, Australia.
Email: walkerp@tpg.com.au

philosophical understandings to underpin clinical consultations that aim for shared decision-making.

The philosophical precept can be used to fortify the foundation of shared decision-making in clinical settings and is a process of inclusive, noncoercive, and reflective dialogue aimed at reaching a consensual decision as to how to maximize the good of the patient (Walker and Lovat 2016, 2019). This process of dialogic consensus seeks mutual understanding of the values held by the patient and others whom they see as significant, set against the actual reality of the situation at hand. The "situation" includes their clinical illness itself, the supports they may have, and the values that are important to them.

First, an important clarification. More useful than speaking of "the best interests" of the patient, under a virtue ethics framework, the end goal of the clinician-as-agent is to maximize the *good* of the patient in the sense of health in all its dimensions—physical, psychological, social, and spiritual. Pellegrino (1985) identified a hierarchy of four Goods of the patient (pp. 117-38). The highest Good is the ultimate good or *summum bonum*, in its ill-defined but generally understood sense. The least Good is the Biomedical Good—an instrumental good in the technomedical sense (e.g., the correct drug in the correct dose given to the correct patient). From a dialogic point of view, providing sufficient factual information, in a way that the patient can understand, is a significant contributor to patient autonomy. That is, if autonomy is to have real meaning, it must be founded upon an understanding of the true facts of the situation. Next in the hierarchy is the Perceptual Good of the patient—how she understands the situation and values the treatment options from her perspective. This good is necessarily subjective and reflects conceptions of the quality or the meaningfulness of life. For example, consider two of the risks of radical prostatectomy for prostatic cancer—incontinence of urine and erectile dysfunction. Individual patients will place differing values on these risks. The dialogue must explore these values to this patient, should include potential options (e.g., adult incontinence pads), and since sexuality is a shared activity, it is important in a properly constituted dialogue that the partner be engaged about the potential need for additional effort in this area. Properly valuing this risk requires the patient and relevant family be involved in the dialogue. Next is the Good of the patient as a Human Person, which in Pellegrino's understanding is grounded in patient autonomy. The process of dialogic consensus, to the extent that it is successful in fostering the conditions for the ideal speech situation, engenders respect for the patient and their values in the context of the medical illness at hand and so strengthens the patient's autonomy in the situation they find themselves in. This approach of the four goods of the patient usefully specifies the otherwise-unspecified concept of "best interests."

Second, it is clear that our contemporary era is characterized by a much wider awareness of different cultures, faiths, and ways of living than in previous eras. Profound cultural, religious, social, and ethno-political diversity follows. There are equally viable concepts of the "good life," and how it should be lived, which are not able to be directly compared in terms of what we might term their "goodness quotient."

This grounding precept of dialogic consensus, which can underpin or fortify the foundations of shared decision-making, draws upon the writings of the continental philosopher, political scientist, and sociologist Jürgen Habermas's (1993) concepts of discourse theory of morality and his principle of communicative action (Habermas 1990).

Habermas's discourse theory of morality derives from the categorical imperative of Immanuel Kant. Namely, that we should act only on rules that can be applied to all persons in a similar situation. That is, philosophically speaking, this ethical rule can be *universalized*. For example, torturing a terrorist is always wrong, and this applies to all terrorists, regardless of the consequences. The discourse theory of morality allows us to widen Kant's imperative from what may traditionally have been a monological contemplation on the part of the clinician as to what is best for the patient, to an active dialogue within the community of those affected by the decision, that is, the patient, the clinician, and relevant others. Then, all participants accept that the decision reached and is able to be universalized as being in the best interests of everyone in the discourse.

Habermas's theory of communicative action allows us to set out the criteria for (philosophical) truth and validity in a discourse. Communicative action involves an ideal dialogue, which uses language (verbal and nonverbal) in a noncoercive way, with meanings that all understand or agree upon. More formally, no affected party should be excluded from the discourse, participants have equal possibility to present and criticize claims, participants are willing and able to empathize with each other, power differences between participants are neutralized so they have no detrimental impact upon consensus, participants openly explain their goals and intentions and avoid deliberate manipulation of the argument (Flyvbjerg 2000, 3, 4), and sufficient time is made available. As well as explaining the facts of the medical condition, including uncertainty about the diagnosis and prognosis, each participant aims to speak truthfully and noncoercively rather than in a way which is aimed at dominating, influencing, or coercing other participants in the dialogue. The facilitator of such a dialogue, in a clinical setting, may be the family doctor, a specialist clinician, or in hospital, a social worker, clinical ethicist, senior member of the nursing staff, or a chaplain. Traditionally, a medical ethics approach may seek to group the ethical considerations under the traditional frameworks of rules-based or consequential frameworks, or principles distilled from these frameworks (autonomy, beneficence, nonmaleficence, and justice), or may appeal to principles of double effect, doing versus allowing, or benefit versus burden assessments. However, from a moral philosophical perspective, recourse to these frameworks in isolation has the potential to overlook the individual patient's value set that gives meaning to their lives. This is especially likely in our contemporary era, characterized as it is by significant value and moral pluralism. Shared decision-making may usefully, especially contemporaneously, be based upon a *process* of decision-making together.

The word *consensus* is general agreement, following argumentation, in reaching a decision about what is best for the group or the community which is making the decision. Hence, from a philosophical and a pragmatic perspective, individual members can legitimately disagree with the decision itself but still agree that it is the best decision for the group. Individuals may need to withdraw some way from their preferred position, tolerant of conflicting values, in order to achieve consensus. It may be possible for participants to accept a position which is not reasonable for them to reject and so reach consensus. Consensus is different to a majority vote, to unanimous agreement (necessarily both publicly and privately), and to mere acquiescence (agreement out of a sense of good nature, altruism, coercion, or another reason that denies true argumentation).

This article holds that reaching unforced consensus among the stakeholders of clinician, patient, family, and relevant others, following inclusive, noncoercive, and reflective dialogue, vests the decision with moral authority in the situation at hand. That is, the decision has a sense of "oughtness" or "shouldness" associated with it. This is a contentious position (Parker 2019), but it is possible to argue on both epistemic grounds and normative grounds that in dialogic consensus, "[t]he moral discourse is properly relocated away from a first-person monologue and [also] a third-person abstraction into the second-person perspective grounded in inter-subjectivity" (Walker and Lovat 2019, 82). The proposition that consensus has moral authority demands further analysis, but it seems more likely an arguable contention in clinical encounters, where clinicians, patients, and their families dialogue about how best to maximize the good of the patient who is suffering. Additionally, if this process of dialogic consensus is understood and reflected upon, the patient, family, and others are less likely to have lingering doubts about whether the normatively right or best-in-the-actual-circumstances decision is being made.

Notwithstanding the practical difficulties with shared decision-making in time-poor consultation spaces, especially given our increasingly multicultural and multifaith communities in a postmodern philosophical framework, there is a need to underpin shared decision-making with principles of conduct toward other persons. Principles that apply no matter how one's own ethical values, conceptions of the good, or life choices differ. This is more than pragmatic (or strategic) "we agree to disagree" and is much more than ethics-by-committee. It understands that this moral philosophical framework must encompass "a degree of generality and a binding character that transcends the competing value conceptions" (Forst 2014, 63, 64). That is, the decision is consensually agreed to by all the participants, is action-guiding, and the process has taken into account the values of the participants.

In summary, shared decision-making in clinical consultations is especially relevant in our contemporary era, and dialogic consensus is one way to provide a robust moral philosophical underpinning to fortify its moral philosophical foundations.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Paul Walker, MBBS, PHD, FRACS, FACS https://orcid.org/0000-0003-4947-7718

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Biographical Note

Paul Walker, MBBS, PHD, FRACS, FACS, is in the Clinical Unit in Ethics and Health Law, Faculty of Medicine, University of Newcastle, Australia. He is member of the Royal Australasian College of Surgeons Ethics Committee and is a pediatric otolaryngology surgeon.