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Value Theory, Beneficence, and Medical Decision-Making

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Johan Bester's target article (2020) explores conceptions of well-being before proposing a hybrid objective-subjective approach in an effort to illuminate beneficence in medicine. Bester is entirely correct that understanding the nature of individual well-being—the study of which philosophers call *prudential value theory* (or *value theory* for short)—is central to in-depth understanding of beneficence, best interests, and related concepts (see also Brock 1993; DeGrazia 1995). Moreover, the vast majority of specific ethical and prudential judgments his essay advances are sensible. But I find the theoretical investigation unsatisfactory. Because the thrust of his essay is theoretical—engaging value theory as it pertains to medicine—this commentary will focus on concerns about his foray into value theory.

Readers well-versed in the value theory literature will note that Bester engages little of it. He relies heavily on an encyclopedia article about well-being (Crisp 2017), a very good article, but that is no substitute for being conversant with the primary literature. To be clear, I am not valorizing scholarship for the sake of scholarship. Rather, I believe that limitations of the discussion are related to a superficial acquaintance with relevant literature and the issues and theoretical options that it brings to life.



For example, in characterizing general types of value theory, he distinguishes subjective and objective-list theories but says little in describing the latter. He does not identify any of the items that would appear on a plausible objective list (though later he mentions health and functioning, which are relevant to medicine). Instead, by way of summary, he states that on this approach “interests are objective and not determined by the individual” (54). The last five words misleadingly overreach insofar as plausible objective

lists make some concessions to subjective accounts—in particular, treating self-determination and enjoyments as constituents of human well-being. (One of the few works in value theory Bester engages is Powers and Faden (2006). I find it odd that this mostly excellent work finds no place for enjoyments, satisfaction, or the like—no concession whatsoever to hedonism—in the objective list view it defends. It does, however, include self-determination.)

As the discussion proceeds in the section entitled “A Dilemma,” the question of what constitutes a patient's well-being becomes conflated with the question of what constitutes the patient's *health*. But value theory is not just about the nature of health, and patients' well-being is not reducible to their health. Bester asserts that the subjective conception of well-being (or health?) seems to prioritize respect for persons whereas the objective-list conception protects equality of opportunity. But this seems muddled. The nature of individual well-being is one thing, an issue in prudential value theory. Ethical principles are another matter, an issue in ethical theory. Two people could coherently agree on accounts of well-being and disagree about ethical principles—or vice versa.

Insufficient familiarity with theoretical options is apparent in the discussion of a case in which a patient asks a doctor to amputate an arm because it is “filled with evil” and causes her severe distress. He stipulates that the patient is found to have decision-making capacity and “no delusion.” According to Bester, a subjective approach would judge that amputation would promote the patient's well-being.

Bester is right to find this result counterintuitive but mistaken in eliciting this implication from a subjective approach, assuming the latter is reasonably nuanced

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and plausible. First, to believe that one's arm is filled with evil is delusional. Appendages cannot be filled with evil. Second, if the mere presence of a healthy, functioning arm is causing the patient distress, then a psychiatric problem is almost certainly what is driving her preference, undercutting the stipulation that she has decision-making capacity with respect to this particular decision. Third, loss of the arm would entail a severe loss of functioning, pain and discomfort, and possibly infections. Although it is conceivable that the losses associated with the amputation would be outweighed by whatever might be gained from removing a bodily source of distress, this seems somewhat unlikely. What seems likely is that psychiatric treatment would be more conducive than amputation to the patient's health and overall well-being.

Bester also underestimates the ability of a subjective account to judge plausibly in the case of a patient who insists on smoking. He suggests that physicians who are adamant that smoking is bad for patients, even patients who maintain that smoking fits their conception of a good life, are relying on an objective conception of well-being. Not necessarily. In assessing whether something (e.g. smoking) is good for an individual, a plausible subjective account will factor in not only whether an individual likes or prefers the activity or product, or finds it satisfying, but also how that something will affect the individual, in terms of her own values and priorities, down the temporal road. 20-year-old Sarah may enjoy smoking, may value being contrarian, and may appreciate the opportunity to act contrary to prevailing middle-class norms of sensible, healthful behavior. But Sarah will also surely dislike any downstream painful, debilitating effects of smoking such as shortness of breath and, if she is unlucky, lung cancer; and, unless she has money to burn and doesn't care about charitable giving, it would be rational for her to dislike the opportunity costs associated with spending thousands of dollars on cigarettes. Now, if Sarah, despite her actual preference to smoke, would prefer to quit (assuming she could muster the will-power) if she understood the longer-term implications and took them fully into account, then a subjective value theory will judge that smoking is bad for her. In that rare case, however, where an individual's relevantly informed, autonomous preference would be to smoke, then a subjective view would judge that smoking is not bad for her *all things considered* (even if it is bad for her health). These cases, I assume, are very rare or nonexistent.

One more concern about the author's foray into value theory. The section entitled "A Proposed

Solution: A Hybrid Conception of Wellbeing for Medical Practice" appears to feature a conflation between two issues: (1) "What are the ultimate constituents of an individual's well-being?" and (2) "What general conditions reliably promote well-being?" The first question is what divides value theorists and is presumably the issue the paper had been discussing in earlier sections. Yet, notwithstanding the section title, the proposal Bester offers is not a solution to that issue because it features a discussion of all-purpose means—conditions that anyone could value as means to their ends, whatever they might be—the topic of the second question. Accordingly, the "solution" instructs clinicians to attend to such factors as patients' freedom from pain and suffering, prolongation of their lives, their physiological functioning, and their capacities for self-determination—with a recognition that sometimes such goods will conflict with each other. But we didn't need value theory to know that these goods are all-purpose needs. And both objective-list and subjective theorists agree that such goods promote one's well-being.

Let me close by very briefly sketching what I believe to be the most promising account of individual well-being (DeGrazia and Millum under review). According to this account, both enjoyment/contentment and the satisfaction of narrative-relevant desires (that is, desires whose satisfaction makes a difference to one's life-story) are prudentially good for an individual; suffering and the frustration of narrative-relevant desires are prudentially bad for an individual. This subjective account features two fundamental sources of well-being: positively experienced mental states and a type of desire-satisfaction. Critically, in this view, contact with reality—as contrasted with illusion or delusion—plays an amplifying role. Enjoyment/contentment is prudentially better when it responds to an actual state of affairs—as opposed to an imagined one. Likewise, the fulfillment of desires is prudentially better when those desires are informed and rational. Enjoyment/contentment and narrative-relevant desire-satisfaction are unified in a single coherent account of well-being insofar as both reflect the lived, self-caring perspective of a conscious subject. What the best objective-list views get right is that the items on their lists are almost always prudentially valuable for human beings. Where they go wrong is in asserting that most of the items on the list are ultimate constituents of well-being rather than all-purpose means.

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Virtues and *Phronesis*: Making Decisions in the Clinical Context

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We are broadly in agreement with Bester (2020). When approaching medical decisions many tensions need to be balanced before a decision is made that is in the patient's best interest, including but not restricted to their physical wellbeing. Clinicians encounter uncertainty in making decisions for their patients (Jonsen et al. 2010) that is further compounded by patient's (sometimes family's) values and beliefs and the circumstances in which decisions have to be made. Patients are not just bodies with altered biochemistry that needs putting right; they are persons with attendant psychological, emotional and relational facets (Malik 2011). Each patient is unique in their lived experiences (Bain 2018). Within this context doctors are urged to make ethical decisions- decisions in their patient's best interest.

Acting in the best interest of the patient and the wider society can be achieved through a duty- based/ principlist approach, the approach taken by Bester (2019). We argue for an alternative, albeit complementary, approach to the duty-based beneficence-related decisions. Our approach borrows the concept of *phronesis* (practical wisdom) from virtue ethics. *Phronesis* is considered medicine's "indispensable virtue" by Pellegrino and Thomasma (1993).

Based on data from a 3-year ethnographic study of doctors and GPs (Conroy et al. 2018), we argue for a non-prescriptive approach to help healthcare professionals take account of virtues relevant to the dilemma under consideration and make a practically-wise decision that brings about the best outcome for their patient, and wider society. The dilemmas raised by Bester (2020) show tensions that exists when two theories of wellbeing clash: View A is the individual's (i.e. patients') own view of the good, derived from their concept of flourishing (in this regard the goal of their treatment). In contrast, View B is an objective list of things that are important in every person's life. These are the things that are considered good and is decided by an objective criterion guided by evidence-based practice. We consider both these as two sides of the same coin and a balance between the two can be achieved, through *phronesis*. By keeping the stakeholders central to the decision-making process, *phronesis* acts as an executive virtue in providing a way forward to solve the dilemmas encountered in clinical setting and promote the good in morally difficult situations.

Bester (2020) proposes a solution that comprises two criteria of wellbeing: First, objective functioning i.e. a list of requirements that are necessary to