The philosophical moment of the medical decision: revisiting emotions felt, to improve ethics of future decisions

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The present investigation looks for a solution to the problem of the influence of feelings and emotions on our ethical decisions. This problem can be formulated in the following way. On the one hand, emotions (fear, pity and so on) can alter our sense of discrimination and lead us to make our wrong decisions. On the other hand, it is known that lack of sensitivity can alter our judgment and lead us to sacrifice basic ethical principles such as autonomy, beneficence, non-maleficence and justice. Only emotions can turn a decision into an ethical one, but they can also turn it into an unreasonable one. To avoid this contradiction, suggest integrating emotions with the decisional factors of the process of “retrospective thinking”. During this thinking, doctors usually try to identify the nature and impact of feelings on the decision they have just made. In this retrospective moment of analysis of the decision, doctors also question themselves on the feelings they did not experience. They do this to estimate the consequences of this lack of feeling on the way they behaved with the patient.

There exist, in the works and writings about the medical decision, many investigations on decision-support techniques. The standard protocols and other published decision trees all have one common point. They only ask the question on how they can rationalise the deliberation that precedes the moment of therapeutic choice and never the one of the moment that follows the decision.

THE PHILOSOPHICAL MOMENT OF THE MEDICAL DECISION

The protocols and formalisations of the decision maker’s mental process are essential instruments. We think about evidence-based medicine, which answers to a scientific rational rigour that is completely necessary and legitimate.^{3 4}

However, that scientific and rational preoccupation cannot be sufficient to guarantee the ethical quality of the decision. For example, decisions about neonatal resuscitation or amputation in older people are not only scientific decisions. They are decisions that do not depend exclusively on evidence-based medicine. We could say that the pre-decision making of evidence-based medicine is a thought that calculates. It is not a thought that meditates.⁵ Obviously, we need a thought to calculate the best treatment and its medical consequences. But a thought that meditates on the feeling experienced during the meeting with the patient is essential to give ethical substance to the decision.

If we estimate that treatment cannot be separated from ethics, then ethical thought can complete the scientific thinking. This post-decisional moment can be called the philosophical moment of the medical decision. This is about a time that is not connected to any emergency context, and dedicated to a consideration in retrospect. It is proper that philosophical meditation always comes after the fact.⁶ Once the time of action has passed, it is possible to calmly review the logic of the decision process so that we can understand its mechanism. Under the effect of passion, we can never think clearly about it. The power of emotion is lethal to reflection. It is too difficult to meditate when emotions control us.⁷

Hence, the post-decisional moment is a moment of considering a posteriori. The philosophical moment of the medical decision consists of removing the decision from the technical and administrative considerations. These considerations are generally entangled at the time of the action. This moment analyses the decision and isolates the ethical component supporting four

Doctors are constantly driven to ask themselves ethical questions about their past behaviour.¹ Their decisions are frequently followed by a moment of personal reflection that awakens a form of thought of a different nature from the one immediately preceding the medical decision.²

The ideas that come into the doctor’s mind after a decision probably influence his subsequent decisions. However, these are neither organised nor consigned to documents that can be read or consulted. The contents of thought produced by that moment of post-decisional meditation remain unspecified and confused.

The doctor thinks again about what he has said to the patient or left unsaid. He also thinks about his own hesitations and the risks he took. He wonders if his decision is fair. Is this decision adjusted to the existential context of the patient? And yet, those reflective moments, often tainted with regrets, sometimes with remorse, are never spoken, at least, at the hospital. Everything happens as if the ideas that come to the doctor’s mind after a serious decision had no more importance than sighs. The moment of post-decisional meditation on goodness and badness, the fair and the unfair, seems not to be an important moment, a moment without great consequence, a time with not enough interest to be taken back in a work of clearness.

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coordinating concepts: the principle of autonomy, the principle of beneficence, the principle of non-maleficence and the principle of justice.

EMOTION AND DECISION MAKING

An emotion, be it happiness or sadness, embarrassment or pride, is a patterned collection of chemical and neural responses produced by the brain when it detects the presence of an emotionally competent stimulus.⁸ The processing of emotionally salient stimuli need not be conscious to be efficient. They automatically engender responses to optimise reaction time and the decision-making process to cope successfully with objects and situations in a hostile environment. Emotional responses are a mode of reaction of brains that are prepared by evolution to respond to certain classes of objects and events with certain repertoires of action.

Furthermore, feelings are a different matter.⁹ According to Damasio,¹⁰ feelings are the mental representation of the physiological changes that characterise emotions and that keep going on in our minds after the happening of physiological changes.

Emotions enter decision making in two different ways.¹¹

- The first way is the influence of expected emotions. They consist of predictions about the emotional consequences of decision outcomes. An individual facing a decision might attempt to predict the probability of different outcomes and how he/she would feel in different scenarios that he/she envisages. The desire to avoid experiencing aversive feelings therefore guides his/her choice. However, the expected emotions are not emotions per se at the time of the decision making. This model is very close to the canonical economic model of expected utility.
- The second kind of influence consists of immediate emotions that are experienced at the time of decision making. Such emotions have a direct impact on behaviour. It depends on their characteristics. Specific emotions carry specific action tendencies.¹² Moreover, as emotions intensify, they exert an ever-increasing influence on the doctor's behaviour. At the least, immediate emotions modify the decision maker's expectation of future outcomes and consequences.

The influence of emotions explains why, in philosophy, emotions are traditionally set in direct opposition to reason. Such opposition has been questioned because, under certain circumstances, emotion-related processes can advantageously bias judgment and reason. An emotional contribution to high-level decision making is evident after prefrontal cortex damage, even if it may have no consequence on intellectual function. It results in patients making personally disadvantageous decisions.¹³ The proposal is that these subjects fail to evoke appropriate feeling states associated with the contemplation of possible scenarios that constitute options for action. As formulated in the somatic marker hypothesis, this region provides access to feeling states in relation to past decisions during contemplation of future decisions of a similar nature.¹⁴ Thus, evocation of past feeling states biases the decision-making process toward or away from a particular behavioural option.

ARTICULATING ETHICAL PRINCIPLES AND EMOTIONS

The value that we attribute to the four great principles of ethics is revealed to us across privileged emotions or feelings.^{15 16} Emotions and feelings reveal principles and rules indispensable to social organisation.¹⁷ Emotions such as compassion or fear and feelings such as respect or justice are affective experiences, which inform the agent about the value of the ethical principles (autonomy, beneficence and so on).

They reactivate the doctor's commitment to implement the fundamental ethical principles to which their vocation has attached them. The compassion they feel in front of the suffering of a patient awakens (in doctors) their attachment to the principle of beneficence.¹⁸ Fear makes them sensitive to the principle of non-maleficence. The affective experience of respect revives in them faithfulness to the principle of the patient's autonomy.¹⁹

AMBIVALENCE OF THE EMOTIONS

Emotions and feelings are necessary to ethics.²⁰ But it is not enough for a doctor to be sensitive to and affected by the suffering of a person to make his decision a good one. Emotional experiences only reveal to us the values to which we are attached.²¹ Emotions are the indicators of the ethical values to which we are attached but they are not values in themselves.²² Emotions are a condition necessary but not sufficient for the ethical quality of the decision.²³ There are no ethics without emotions. But, by itself, an emotion is not ethical. We always have to keep in mind that emotions have no intrinsic factor of moral value and consider them for what they are: affective facts, and nothing more.²⁴

Nothing is more indispensable to ethics and, at the same time, more detrimental to the ethical quality of a decision than an emotion.²⁵ This negative effect depends on how intense emotions are.²⁶

This is how compassion can reactivate in us the value we attach to the ethical principle of beneficence, and make us forget other principles the values of which are nonetheless legitimate. For example, when professionals pretend to have acted out of compassion after unjustified euthanasia (they can be reproached with justice), we can still credit them with the sincerity of their compassionate emotion. But an emotion is nothing but an affective reaction devoid of any ethical value. What cannot be justified in the name of compassion? Even reproductive cloning has found its subscribers acting out of compassion. Why should an emotion such as fear be harmful to the feelings of others? Why should it be a less-reliable guide than compassion in decision making?²⁷ Hence compassion, which awakens in us the importance that we credit to the principle of beneficence, cannot legitimise the emotional monopoly that we so often tend to grant it.^{28 29} Compassion reveals one value but not all values.

EMOTIONAL REVISION

Emotions are essential to doctors so that they remain sensitive to great ethical principles, such as respect for autonomy, beneficence, non-maleficence and justice.³⁰ But, if those emotions become obstacles to their objectivity, how can we be sure of the ethical validity of a decision? How can doctors be aware of the fact that an emotion leads them astray or drives them in the good way?

We can formulate our position thus: a decision is justified, ethically speaking, when it is the fruit of an emotional revision. It is a sort of spiritual exercise when we play an emotion against an emotion.³¹ The emotional revision consists of creating new emotions by using imagination, memory or reasoning.³² The deliberated re-evaluation of a spontaneous emotion by using other emotions constitutes a mental proof of truth. It's checking that an emotion is pointing in the right direction. This test of reliability of immediate emotion will be as relevant, as we will have made the effort to search for new emotions.

As an example, if we have felt the emotion, compassion, and we have let it drive us from our decision (for instance, hiding the truth from a patient), we must seek what could have been the other emotions capable of countering that spontaneous affective experience. In the example of the compassionate lie,

we can imagine, after the fact, which principles of other emotions could have made us receptive: respect for the patient's will and fear of letting him/her have illusions about his/her chances of recovery. This is what we call the philosophical moment of decision: time for an emotional revision.

Fantasies and memories play leading roles in this process of emotional revision.³³ They make us responsive to other values that we may have obscured because of the intensity of our emotional background while deciding. But it is, in fact, dialogue that is the most important element in accomplishing this exercise of emotional revision.

When we participate in a discussion, we can revise the emotions that have dictated our spontaneous judgments. Our interviewer's arguments manage to awake new emotions that can make us sensitive to other values.³⁴

The exchange of ideas is the most suitable method for any emotional revision. However, it is not enough to gather around a table to make the proper decision. The fact of being collective will never prevent a decision from being wrong. Even if we are gathered in groups, we still speak under the effect of emotions. (These emotions are sometimes even stronger than the emotion that accompanies our meeting with the patient!)

There is a moment when the emotions are weaker and more accessible to revision, once the decision has become irreversible. When the decision has been taken and it is no longer possible to retreat, we can return to the process that has presided over the decision because we do not experience those emotions anymore. It is the philosophical moment of the medical decision—that moment designed precisely for retrospective thinking on the processing of decisional maturation in which the medical actors have participated. It is a profitable experience, making us modulate future decisions.

CONCLUSION

The medical decision must remain the medical staff's concern in agreement with the patient and/or his/her relatives. Philosophical reflection on the decision is open to all other actors (such as philosophers or psychologists). It comes after, with retrospective thinking about the decisional factors. We propose to base the retrospective moment of the decision on the following concerns:

- What was the background?
- Which emotions were involved?
- To which principles (or which values) did those emotions make us sensitive?
- What were the emotions we did not feel?
- What are the values to which we are attached but that we have avoided because of the lack of feeling?
- Through which behaviour have we concretised the ethical principles that are necessary for a fair decision?

One condition for a hospital to be a place of hospitality is that the decisions taken there, every day, can be lived with as ethically sound. Yet, the habit of periodically re-thinking some medical decisions must be instituted so that we can rid ourselves of the sour taste of failure and regret.

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