Review article

The role of values and emotions in patients’ health care decision-making

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Abstract

Aim: As the decision-making science progresses, in recent years, there has been an increasing discussion about non-cognitive components involved in decision-making process. This paper aims to provide an inclusive overview of current knowledge on the state of the science related to the role of values and emotions in decision making. In an effort to provide the most inclusive review possible, internal rationality, awareness of values, and practical wisdom will be considered.

Method: It was conducted a comprehensive narrative review of literature on the topic of interest.

Results: Sharp distinction between rational and emotional decisions would be a false dichotomy. Both values and emotions underpin every aspect of a decision-making process. Interpersonal comparisons of value judgments are thought of as being inherent in the very activity of interpretation. This is important when considering reasonableness of another’s decision. Moreover, as decision-makers has to be aware of and then navigate their own, feelings and values, it is noticeable that emotions may not only affect the development of the values of an individual, but also affect an individual’s introspective awareness of her values, beliefs and preferences. Finally, it is interesting to note that it has been suggested an alternative approach to decision-making competence based on decision-maker’s practical wisdom.

Conclusion: The ways by which beliefs, values, and emotions affect decision-making processes seem to be unclear and overlapping, thus giving a boost to uncertainties. Further research into complexities related to the role of values and emotions in decision making seems to be necessary.

Keywords: Values; emotions; decision-making process; practical wisdom; narrative identity.

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**Introduction**

Decision-making process is a dynamic, rigorous and complex process. Less than perfect cognitive functions do not necessarily mean incompetence to make treatment decisions. Furthermore, perfect cognitive functions do not always suffice to make autonomous treatment decisions. Modern theory shifts the focus from providing as much information as possible towards obtaining better communication between physician and patient. Patients should be actively involved in the treatment (shared) decision making. They should be empowered and ‘fully’ engaged in the treatment decision making process with their own core values (strictly and stably related to their narrative identity), preferences and emotions. As the decision-making science progresses, in recent years, there has been an increasing discussion about non-cognitive components involved in decision-making process. Great emphasis is placed on values and emotions rather than on cognitive functions. This paper provides a narrative review of the currently available literature related to values and emotions attempting a comprehensive approach. In an effort to provide the most inclusive review possible, internal rationality, awareness of values, and practical wisdom will be considered in the discussion of the role of values and emotions in patient treatment decision making.

**Values and emotions play crucial role in decision-making process**

There is much and longstanding controversy surrounding the components and the criteria of decision-making process, especially those related to mental skills and abilities. The traditional criteria for decision-making competence assessment are mainly based on assessment of the following cognitive functions: understanding, appreciation, reasoning, and evidencing/expressing a choice (Grisso and Appelbaum, 1998). Fields and Calvert (2015), after having conducted a review regarding informed consent procedures with cognitively impaired patients, they concluded that ‘evaluating the capacity of patients with cognitive impairment to understand treatment options is vital for valid informed consent and should be guided by best practices.’ However, the cognitive criteria of decision-making competence have been widely and strongly criticized for underemphasizing the role of emotions and values. Already Benaroyo and Widdershoven (2004) had emphasized the role of the overall context of a decision-maker and the meaning of the decisions to her in the assessment of her decision-making competence, thus involving consideration of values. Although emotions and values are peripheral to decision-making process, they are strongly thought of (at both theoretical and empirical level) as playing significant role in decision-making. Although the cognitive-focused approach of the decision-making competence has found support in scholarship (Crisp, 2017), there are scholars who raise a number of considerations in favor of the emotion-focused (Sullivan-Bissett, 2017; Charland, 1998b) or the value-focused approach (Tan et al., 2006; Karel et al., 2010) of the decision-making competence. Hyper-cognitive functions, namely, perfect understanding and appreciation of the information provided are not necessarily requirements for decision-making capacity. According Friedman ‘autonomous choice…does not need to be highly deliberate or deliberated’ (Friedman 2003, p. 8). Irrationality does not mean lack of decision-making competence. Evaluative and emotive
capacity as well as other skills e.g. imagination and retrospection are thought of as being able to compensate the cognitive functions deficit. Friedman states that ‘emotions and desires, as well as imagination, can constitute a kind of reflection or attention to objection or values of concern’ (Friedman 2003, p. 10). Not surprisingly, in assessment of decisional capacity, the shifting of focus from cognitive capacity towards emotive and/or evaluative capacity is facilitated when considering autonomy on the relational account of the notion. Indeed, the cognitive-focused approach of decision-making competence is a matter of ‘self-made man’, this is to say, a matter of ‘substantive independence and self-reliance, social isolation and hyper-rationality’ (Stoljar, 2015). Given that the model of ‘self-made man’ is related to the ‘‘masculinist’ ideals of personhood” (Stoljar, 2015), the cognitive-focused approach of decisional capacity is not endorsed by feminist moral philosophers.

The approaches of decision-making procedure that are not cognitive-focused open doors to appropriate alternative consent procedures. This is of considerable importance in case of questionable decision-making capacity (Fields and Calvert, 2015) as is the cases with mental disorder. Mentally ill persons do no way lack decision-making competence for the only reason they are mentally disordered (Radoilska, 2012). Mental disorder does not necessarily involve a loss of personal autonomy. This consideration, among other things serves the purposes of the principle of justice. Given that biases (based on prejudice, discrimination or other use of asymmetry) against patients may be caused by simple disagreement with proposed medical treatment, it is much more likely the bias against mentally ill decision-makers. For instance, by focusing on an agent’s capacity to value we might show respect to marginal agency as in the case of (not advanced) dementia, in light of the assumption that a person is not only memory but also wills, emotions, beliefs, and values that may remain stable before, during and after a decision-making process and hence should be thought of as having crucial role in assessment of decision-making competence (Jaworska, 1999). Nonetheless, it is crucial to bear in mind that the specific way in which values and emotions affect decision-making process remain by and large unknown. They may affect decision-making in substantive or procedural way (Hermann et al., 2016). Note, however, that these two ways are overlapping and the distinction between them remains blurred (Hermann et al., 2016). Further, there is a conceptual overlap between values and emotions and interplay between cognition and emotion (Hermann et al., 2016; Pessoa, 2010; Balconi et al., 2017). Besides, it is also crucial to bear in mind that the cognitive, emotive and evaluative capacity of a patient may fluctuate over time, especially in the presence of mental illness (Fields and Calvert, 2015).

Below, some more details are provided about the role of values and emotions in decision-making process.

First. Emotions and cognitive procedure of decision-making are strictly interwoven. Interestingly, it is arguably stated that ‘emotions are no longer considered structurally opposed to reason’ (de Sousa, 2017).

Emotions are complex and contextualized continuous interaction between conscious, unconscious and fringe conscious processes (Baars, 1993). Interestingly, there are peripheral ‘fringe’ experiences that may occur while we are focused on something else (Baars, 1993). These experiences may involve signals such as
feelings and contents which are pre-conscious, namely, ‘momentarily inaccessible’ (Balconi et al., 2017).

A person may feel various kinds of emotions in varying degrees. Emotions are positive contributing components in decision-making capacity (Charland, 1998a; Charland 1998b). A certain degree (not lack or excess) of emotional involvement seems to be essential for a person to appreciate (understand in more experiential sense) the external and internal to her world including her current situation as well as personal values, and then to set goals of a meaningful and engaged life, thus promoting their well-being (Charland, 1998a). Cognitive empathy and emotion are associated with increased decisional capacity (Supady et al., 2011). A decision-maker should pay attention to emotions to decide whether a certain decision effectively promotes her well-being (Silverman, 1997).

Importantly, cognition inherently involves emotion. Decision-making competence in (complex, intertwined, “unpredictable and idiosyncratic”) real life could be viewed as practical thought that involves appreciation. As such it requires emotional involvement (Damasio, 1994, pp: 3-83; de Sousa, 1990, p: 330; Pepper-Smith et al., 1996). Without emotional involvement practical thought (judgment) may be at a loss as to how to proceed, as it ‘knows neither when to start nor when to stop evaluating costs and benefits’ (de Sousa 1990, p: 330). In practical thought emotions are said to be probably bodily felt because they are ‘on-line’ (Charland, 1998b). However, a spontaneous emotion-driven decision may be considered problematic from the viewpoint of the agent who therefore adapts it both consciously and unconsciously (den Hartogh, 2016).

Second. Reasoning is considered as including value-based reasoning. Some philosophers place great weigh on values in practical reasoning (Atkinson and Bench-Capon, 2008). Appreciation is one of the four stages an individual has to go through to convey an optimal decision-making process (Grisso, Appelbaum, 1998). It is a versatile concept (Hermann et al., 2016). However, it should rather be regarded as including emotional and valuational processing (Hermann et al. 2016). Besides, it may be necessary for value-based reasoning (Karel et al., 2010). A ‘relatively stable set of values’ which is at least minimally consistent is a requirement for decision-making competence (Buchanan and Brock, 1989, p: 84). Two concepts are required: a developed set of values and their stability (which, however, is difficult to be established over time). The values of a person are said to derive from their emotions (emotion-driven values). Presumably, the values proceed directly from same mechanisms that generate or sustain the emotions (Charland, 1998b). Note, however, that pathogenic values may be less problematic for decision-making process than other not considered pathogenic but eccentric values. At any rate, it is crucial to bear in mind that both emotions and values may not only facilitate but also impede a decision-making process. Whilst emotions facilitate smooth-running autonomous decision-making processes, they may impede them by affecting the internal consistency between first and second order desires / choices (e.g. in states of phobias or addiction) (Hermann et al., 2016).

However, a patient may be decision-making competent even if their first-order desires / choices are not in consistency with their second-order ones, namely, has not autonomy. It should be highlighted that decision-making competence is not identical to personal autonomy. Besides, emotions may negatively affect the perception of
reality or the epistemic beliefs (i.e. about the future) (Hermann et al., 2016). It is noteworthy that we may be self-deceived in our emotional responses. De Sousa (2017) provides three sources of emotional self-deception. In ‘pathogenic affective states’ (Charland, 2013) (although such states are mostly ill-defined) the emotions may be problematic, thus making also problematic the role of the values derived from or based on them. As to values, they may be inauthentic or pathological (Tan et al., 2006), even though the line of distinction between normal and pathological values may often be blurred. Importantly, it is no clear whether pathological values are these closely allied to illness or these considered “unreasonable” from a third party’s standpoint.

Importantly, as Hermann et al. (2016) argue, it is difficult to formulate universally applicable criteria regarding the accurate role of values and emotions in decision-making capacity assessment. Hermann et al. (2016) state that ‘substantive account of emotions and values appears particularly case-sensitive...’ and that emotions and values ‘cannot be judged in isolation but only in light of their interaction with each other and with other factors’.

Summing up: Emotions are not separate from cognition. Sharp distinction between rational and emotional decisions would be a false dichotomy. Both values and emotions underpin every aspect of a decision-making process (Charland, 1998; Hermann et al., 2016). Without values and emotions decision-makers are at a loss due to the fact that they are in the face of an endless number of potential alternative options. Lack of emotions or adequately elaborated pattern of values constitutes apparently inherent obstacles to obtaining a decision-making process that effectively serves the purpose of protecting or promoting decider’s autonomy. Decision-making process is a dynamic process and as such the values that are assigned and the emotions that are implicated in every aspect of it may considerably vary. Current scholarship lacks a nuanced and comprehensive understanding of the accurate role of emotions and values in decision-making capacity as well as the accurate mechanisms by which they contribute to it. It would be highly interesting to further explore the mechanism by which values affect decision-making process as well as the dynamic of values and emotions in regard to the various aspects of a decision-making process. Particularly, when it comes to multi-phase and multi-dimensional decision-making processes, i.e. young women’s fertility preservation decision-making process following cancer diagnosis. (Hershberger, 2013).

Elaborating on the role of emotions in decision making

A certain degree (not lack or excess) of emotional involvement seems to be essential for a person to appreciate (understand in more experiential sense) the external and internal to her world (Charland, 1998). Emotions often reflect a decider’s important underlying values that are strictly and stably allied to their narrative identity and hence, are keys to decision making. Without emotional involvement practical thought (judgment) may be at a loss as to how to proceed, as it ‘knows neither when to start nor when to stop evaluating costs and benefits’ (de Sousa 1990, 330). In that connection, it must be noted that the Aristotelean notion of ‘phronesis’ (practical wisdom) that may play a crucial role in making certain clinical decisions includes finding a balance between extreme emotions (Widdershoven et al., 2017). Different theories have been proposed to explain the role of emotions in
decision making (Bandyopadhyay et al., 2013). Interestingly, emotional influences may affect not only the decision process but also post-decision experience ‘as a function of uncertainty’ (Bandyopadhyay et al., 2013). Emotions seem to influence the way that options and the surrounding information are interpreted and used (Mazzocco et al., 2019). Emotions may interact with situational factors to improve or degrade health-related decisions (Ferrer et al., 2016). Emotions can interfere with decision-making (Paulus and Yu, 2012). Lerner et al. (2015) concluded from their research that ‘emotions constitute potent, pervasive, predictable, sometimes harmful and sometimes beneficial drivers of decision making.’ Mazzocco et al. (2019) found that ‘emotion's intensity level' and ‘cognitive appraisal’ interact in shaping the decision. Ferrer et al. (2016) write that emotion also influences perspective-taking; shame decreases perspective-taking ability compared to guilt, perhaps because shame is more self-focused (Yang, Yang, & Chiou, 2010). Potential moderating factors affecting the effect of emotions on the complex non-linear decision-making processes should be further investigated (Mazzocco et al., 2019). At any rate, Ferrer and Mendes (2018) put it best in saying that ‘the relative dearth of research focused on how affective states contribute to and influence health decision-making and behaviour is an important gap in the literature.’

Emotions are complex and contextualized continuous interaction between conscious, unconscious and fringe conscious processes (Baars, 1993). Lufityanto et al. (2016) argue that non-conscious emotional information can boost accuracy and confidence in a concurrent non-emotional decision task. Fuzzy-trace Theory is a dual-process approach that distinguishes two kinds of mental representations of information: verbatim and gist. Reyna et al. (2015) state that verbatim representations are encoded in parallel with gist (including emotional gist) representations support the fuzzy, parallel, usually unconscious processes of intuition.’ In the clinical context, perceived emotional threats affect physician cognition and may lead to responses such as rumination or thought looping in unknown ways (Childers and Arnold, 2019). Emotions may affect physician’s clinical decisions on a level that is not entirely conscious (Kligyte et al., 2013; Kozlowski et al., 2017). Further research is needed to shed more light on the topic about the role of emotions in decision making.

The awareness of values and emotions

Before jumping into making autonomous decisions and then acting according to them, a decision-maker has to be merely aware of and then navigate his/her own experiences, feelings and values as well as those of their environment, which subsequently will affect their decision-making process in both conscious and unconscious ways (Berg et al., 2001; Sweeney, 2008, Hermann et al., 2016). An important stepping stone for decision-making is the use of self-exploration (involving introspective attention) to become merely aware of one’s own situation, previous experiences, emotions and set of values (located in one’s inner context, which are stable over time and closely allied to her narrative identity) and then to connect them with external to them information. The awareness of one’s cognitive, emotional and motivational limitations in literature is referred to as ‘meta-cognition’ and allows her to determine her impaired decision-making competence (Ryan-Durby and
Dickerson, 2018). Individuals may need to reflect, meta-reflect on their inner storyline (experiences, turning points etc), thereby reconstructing their narrative identity against a context of a rather relativist and dynamic world. Narrative identity shows how a person understands her own autobiography, including her dispositional characteristics also referred to as personality, as well as a collection of experiences and values (and hence propositional attitudes like preferences, beliefs and desires), especially those that mostly matter to her (Glannon, 2009; Jecker, Ko, 2017). Narrative identity is a changeable and dynamic matter of degree since it ‘requires cognitive capabilities that can be present to a greater or a lesser extent’ (Jecker, Ko, 2017). Moreover, narrative identity is dynamic and changeable. It may change over time. It is to be highlighted that patients may refuse medical treatment due to unauthentic belief that certain values are closely allied to their identity (e.g. in anorexia nervosa). Since narrative identity is a changeable matter, it would be an additional difficult task to assess whether a certain patient has a developed and coherent pattern of values that are (at least to a small extent) constantly related to her (narrative) identity at least over a certain period of her life. Given the truth of the assumption that values are inherent in the decision-making process the assessment of decision-making competence necessarily involves consideration of values (Breden and Vollmann, 2004). A decision-maker has to be aware of and then navigate his/her own experiences, feelings and values as well as those of their environment, which subsequently will affect their decision-making process in both conscious and unconscious ways (Berg et al., 2001, p:105; Sweeney, 2008). An important stepping stone for decision-making is the use of self-exploration (involving introspective attention) to become aware of one’s own situation, previous experiences and values (located in the inner context), and then to connect them with external to them information, thus becoming (as much as possible) ‘fully’ engaged in a decision-making procedure that leads them to achieve health-enhancing goals / outcomes in full congruence with their values, previous experiences and actual situation. Interestingly, when it comes to higher cognitive functions the relationship between attention and awareness is a topic that matters. More particularly, when it comes to the awareness of one’s own values and emotions, what matters is the relationship between one’s awareness and introspective attention. This relationship involves automatic procedures where cognitive or automatic biases may be involved to a lesser or greater extent. Indeed, attention normally accompanies a procedure of awareness and participates in the mechanism of binding awareness to a stimulus representation. Graziano and Kastner (2011a) view a complex relationship between attention and awareness. Graziano and Kastner (2011a) suggest that the consciousness of information passing through one’s neuronal networks can be constructed by specialized neuronal ‘social perceptual machinery’ that serves the social intelligence as well as the perception of awareness in ourselves. They consider that awareness is a ‘perceptual model of the process of attention’ (Graziano and Kastner, 2011b). They argue for a similarity between perceiving someone else’s awareness and perceiving one’s own awareness. They consider that awareness is a ‘product of social perception’.
The authors state that it is possible to attend to an object without awareness of it whereas it is difficult to obtain robust and consistent awareness of an object without attention to it. Attention is something the brain does (procedural), not something it knows (as awareness is). Indeed, attention seems to be active though rather automatic procedure whereas awareness seems to be passive though subjectively conscious procedure.

The examination (subjective description) of one's own conscious thoughts, values and preferences, experiences and feelings is a product of introspective consciousness, which however, may be a matter of bias due to the fact that introspective illusion may occur as a form of cognitive bias (Pronin, Gilovich and Ross, 2004; Pronin, 2009, pp: 1-67). Besides, the construction of social reality by one’s brain may be negatively affected by cognitive biases that may influence one’s perceptions, judgments and interpretations. Attention and development of ‘social perceptional machinery’ (which according to Graziano and Kastner (2011b) ‘constructs awareness’) is likely to be a matter of degree. Underlying attentional biases (predisposition towards paying more attention to process certain types of information) may result in awareness deficit (neglect). The accurate mechanism by which attention influences the obtaining of robust and consistent awareness remains to be further explored.

In short, emotions may not only affect the development of the values of an individual, but also affect an individual’s introspective awareness of her values, beliefs and preferences. Moreover, it is crucial to bear in mind that a) it is most likely that awareness is a ‘perceptual property’ (Graziano and Kastner, 2011a). Furthermore, b) it has been argued that there is a quasi-perceptual account of the nature of emotions (de Sousa, 1990) and emotions may negatively affect the perception of reality. Moreover, c) introspective awareness may have a crucial role in decision-making process (Pronin, 2009).

Below, I go into topics strictly related to the role of values and emotions in decision-making process and assessment of decision-making competence.

The ‘internal rationality’
Charland (2001) regards ‘internal rationality’ as a requirement for decision-making competence. Internal rationality means that a decision intellectually coheres with the set of one’s personal value system, is justified as being based on them and can be considered reasonable from the standpoint of an assessor who has not to share that personal value system built on the patient’s own terms. Patients can fit her decision into her personal (intelligible from their own standpoint) concept of the human good. Irrational decisions may be judged internally reasonable decisions. However, it cannot always be established with reliable accuracy the internal reasonableness of another’s decision. Interestingly, Davidson (2004, p: 67) who focuses upon problems such as the nature and our understanding of value judgments, plausibly argues that intrapersonal comparisons involving the assessor's own values are rather inevitable when considering reasonableness of another's decision. Interestingly, Davidson (2004, p: 67) who focuses upon problems such as the nature and our understanding of value judgments, plausibly argues that intrapersonal comparisons involving the assessor's own values are rather inevitable when considering reasonableness of another's decision. Interpersonal comparisons of value judgments are thought of as being inherent in the very activity of interpretation.

In addition, a deeper consideration of the decision-making processing reveals that the difficulty in establishing with reliable accuracy the internal reasonableness of another’s decision
may in reality be much greater than the at first look anticipated one. De Sousa (1990) has sketched an account of the rationality conditions for an emotion (thus defending the so-called emotional rationality), and therefore, he provides a quasi-perceptual account of the nature of emotion. Given the truth of the assumption that emotions can be subjected to assessment of rationality (and if so, in what sense and to what extend?) and provided that emotions underpin every aspect of a decision-making process, the internal reasonableness of another’s decision can be established with much less accuracy. The intrapersonal comparison may be to a greater extent unavoidable due to the fact that it cannot always be established with reliable accuracy the rationality of another’s emotional reaction which influences her decision-making process.

The role of practical wisdom

Practical thought is so-called because it aims at action (praxis). The excellence of practical thought is practical wisdom or prudence (phronesis), which issues in true judgments about actions that are good or bad for a human-being (Lobban, 2010). The Aristotelian notion of practical wisdom means to be able to do the right thing at the right time under the concrete circumstances. (Schwartz and Sharpe, 2010) Practical wisdom means to be able to choose the right way among different ways. For doing so, it is necessary the knowledge of what is good and the capacity to act accordingly. Practical wisdom is a product of experience which, however, is a mainly intellectual virtue. It includes the ability to be practically intelligent, or conscious of your values. However, practical wisdom is not all rational. Emotions may also be central to practical wisdom (Roberts, 2017). The capacity for practical wisdom encompasses the ability to generally conceive what is good, as well as to perceive, feel, deliberate, discern, and then make choices and act accordingly. Emotive and evaluative abilities may have a significant impact on the effectiveness of this procedure. Swartwood (2013a) argues that practical wisdom is expert decision-making skill which includes ‘substantial intuitive and deliberative and reflective abilities’. The author states that this skill is comprised of three component abilities: The intuitive ability (involving the use of effortless processes), the deliberative ability (involving the use of effortful processes) and the meta-cognitive ability ‘to decide when and how to rely on intuition and deliberation’ (Swartwood, 2013a). Besides, Swartwood (2013a) considers two other abilities in addition to the aforementioned: Self-regulative ability (namely, ability to identify how to affect her environment, behavior, affect and motivations in order to achieve her goals) and self-cultivation ability (namely, ability to make her aforementioned abilities ‘even more reliable over the long-run’).

Interestingly, Nussbaum states that wisdom involves ‘a quasi-perceptual capacity to see what to do’ (2001, p: 300). Quasi-perceptual experience is the one that resembles perceptual experience but occurs in the absence of the appropriate external stimuli. In my opinion, this perceptual experience may involve spontaneous intuitions and/or products of deliberation.

Practical wisdom is a matter of degree. It is developed through experience and can be cultivated more or less successfully (Swartwood, 2013b). Interestingly, it can actually be developed as expert skill, through ‘deliberate practice that gives a person feedback on the quality of their decisions’ (Swartwood 2013b).
Swartwood consider available this kind of feedback. Practical wisdom is highly valuable for sound decision-making, not only because it is the excellence of practical thought but also because it is essential for orchestrizing the values of a person into an effective and happy life. That is to say, into a meaningful, fully engaged, successful and balanced life, not simply as positive emotion. Swartwood (2013a) states that practical wisdom is a ‘high-level achievement’ that ‘enables a person to make reliably good decisions about how, all-things-considered, to live.’ Positive emotion might be obtained by only cultivating just one ‘signature strength’. However, as Schwartz and Sharpe (2006) argue this would produce neither Aristotelian ‘eudemonia’ nor ‘authentic happiness’ of Seligman’s (2002), a pioneer of positive psychology who scientifically explores why people are happy. Practical wisdom is to find a right and context-specific balance among interdependent virtues which are necessary to exist only to an appropriate extent. More of a virtue would not always be better.

Patients may have to process the provided information to reach medical decisions making choices within a spectrum of scenarios. This is a highly demanding and complex task, that involves processes such as the following: to appreciate, deliberate, interpret, weigh, balance, and perhaps to weave (perhaps unpredictable) events or make choices in light of their idiosyncrasy and in congruence with their more or less stable and coherent set of values. For doing so, they have to find a balance between their extreme emotions and values and engage themselves in decision-making procedures leading to achieving intelligible life goals that are meaningful and fully-engaged from their own point of view. In other words, practical wisdom seems essential for decision-making competence of patients who consider medically indicated treatment. More in particular, in case of serious mental illness such as severe dementia or paranoid delusions, the line between decision-making competence and incompetence is less difficult to draw as compared to other cases of less serious mental illness such as anorexia nervosa or obsessive-compulsive disorder (OCD) where matters may be less clear. Indeed, practical insight is of paramount importance in decision-making regarding a medical treatment and as such should be facilitated by the physician, provided that medical responsibility is thought of as being enhanced and having a prevalent role in the context of clinical practice. Patients’ abilities to gain practical insight and engage themselves in decision-making procedures leading to achieving intelligible goals of (meaningful from their own perspective) personal life may be viewed as elements that might compensate the deficit of cognitive (reasoning) capacity, which, as it has already anticipated above, does not necessarily deprive a person from her decision-making capacity.

Furthermore, a patient decision-maker has to balance all the relevant considerations before making any final decision on treatment acceptance or refusal. As den Hartogh (2016) puts it, decision-making is a multi-dimensional process that should be assessed “on several relevant dimensions at the same time”. For instance, in the realm of health care decisions, a patient may be at a loss as to what to decide when balancing risks and benefits of a treatment, with tradeoffs between quantity and quality of life. Note, however, that decision-making capacity is neither a permanent condition nor an ‘all or nothing’ concept, namely, a patient may be competent to make
certain decisions but not others (Ganzini et al., 2005). The decision-making mental abilities constitute only a part of multi-dimensional judgment involving considerations to be balanced, such as the harmfulness and invasiveness of an intervention, the infringement of patient’s autonomy, the centrality of the decision (and the values that it concerns) to the way patients lead their own life and have their own sense of their narrative identity. den Hartogh (2016) considers that these important considerations and decision-making mental abilities bear equal weights, thus considering that the line of distinction between soft and hard paternalism is blurred. Besides, given the truth of this assumption, the threshold of decision-making competence becomes blurred and shifting because of the multifactorial (almost chaotic) ontology of decision-making process. Therefore, in author’s opinion, decision-making science advance can make the decision-making threshold less cloudy though not well-defined.

At any rate, the balancing of different though relevant considerations is a difficult and complex task that seems too subtle to be dictated by rules. Practical wisdom seems necessary to address such a balancing and so to convey an optimal decision-making process.

Widdershoven et al. (2017) offer an alternative approach to decision-making competence which is alternative to both the standard (focusing on cognitive abilities) and the challenging it (focusing on the role of emotions and values) approach to decision-making competence. They appeal to the Aristotelean notion of ‘phronesis’ (practical wisdom) that – according to the authors-combines a) knowing (argumentative or not) the ‘right thing to do’, b) having adequate emotions and finding a balance between extreme emotions, and c) finding a balance between various values and enacting them in meaningful and successful personal life.

The approach of decision-making competence that focuses on practical wisdom seems ‘intuitively attractive and practically helpful’ (Boyd, 2017), particularly when the line of distinction between competence and incompetence is blurred. Further research is needed to be conducted with a much larger number of participants compared to the earlier study of Widderhoven et al. (2017) suffering from a broader spectrum of chronic mental disorders, to confirm the validity of practical wisdom as criteria for decision-making competence.

Conclusion

Sharp distinction between rational and emotional decisions would be a false dichotomy. Both values and emotions underpin every aspect of a decision-making process. Decision-making process is a dynamic process and as such the values that are assigned and the emotions that are implicated in every aspect of it may considerably vary. The ways by which beliefs, values, and emotions affect decision-making processes seem to be unclear and overlapping, thus giving a boost to uncertainties. It is important to bear in mind that intrapersonal comparisons involving the assessor’s own values are rather inevitable when considering reasonableness of another’s decision. Moreover, as decision-makers has to be aware of and then navigate their own, feelings and values, it is noticeable that the relationship between introspective attention and awareness is a topic that matters. Emotions may not only affect the development of the values of an individual, but also affect an individual’s introspective awareness of her values, beliefs and preferences. Finally, it is interesting to note that it
has been suggested an alternative approach to decision-making competence, which is alternative to both the standard approach (focusing on cognitive abilities) and the challenging it one (focusing on the role of emotions and values). This approach is based on decision-maker’s practical wisdom. Further research into complexities such as continuums, blurry distinctions, and uncertainties related to the role of values and emotions in decision making seems to be necessary.

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