令和６年度　　兵庫県立大学看護学部学校推薦型選抜試験問題

小　論　文（１２０分）

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医療現場における意思決定について論じた次の英文を読んで設問に答えなさい。

The Flight From Practical Wisdom

There are many reasons for the (1)shift from the physician paternalist to the patient autonomy model. The most obvious is the belief that individuals have a moral right to run their own lives–the patient's right to decide is merely an instance of this broader moral right. But there is another reason, namely, skepticism* that physicians are wiser than others in their normative judgments at the bedside. The phrase from back in the day, "Doctor knows best," was not a claim solely about technical knowledge. It also expressed the belief that the physician's overall bedside judgment–including both technical and normative content–was better than that of anyone else on the scene. The physician was thought to be "wise."

A quick argument for medical paternalism goes as follows:

Premise 1: One's goal is the best overall outcome for the patient.
Premise 2: Determining what is likely to be the best overall outcome for the patient requires the exercise of practical wisdom; that is, it requires the excellent exercise of practical reason.
Premise 3: The exercise of practical wisdom requires a person who possesses practical wisdom.
Premise 4: Among those at the bedside, with regard to the decision at hand, the person most likely to be a person of practical wisdom is the physician.
Conclusion: The physician should make the bedside decision.

I think the demise of (2)paternalism was due in part to increasing skepticism about Premise 4. Call this "doctor-knows-best skepticism."

To see where such skepticism fits into clinical practice, let's examine the current algorithm for bedside decision making. At step 1, there is a patient-doctor conversation, and then the patient decides to accept or to refuse this or that recommended treatment option. The criterion for whether to accept the patient's decision is not whether their decision is wise or foolish but whether they have decisional capacity. We hope that the patient has good judgment, although we know this is often not the case.

If the patient does not have decisional capacity, a surrogate decides. (3)The first thing the surrogate is supposed to do (step 2) is to determine whether the patient has ever indicated their decision with regard to the treatment at issue, through an advance directive or in some

other way. At step 2, the surrogate is functioning as a (A). They are not being asked to make a normative judgment but only a factual judgment. They are not required to possess practical wisdom.

If the patient did not indicate their decision about the treatment at issue, we get to step 3. Here, the surrogate is supposed to answer a different question, the “What would the patient choose in this situation?” question. Here too at stake is something factual, namely, the surrogate’s knowledge of the patient’s beliefs and values. The surrogate is not asked to judge whether they are wise or foolish. They are asked only to use their knowledge of the patient to determine what the patient would have decided. Again, practical wisdom is not required.

It is only if there is no answer to the “What would the patient choose?” question that we get to step 4, and the surrogate is asked to determine which option is in the patient’s best interests. This does seem to require good judgment, that is, practical wisdom. Even here, however, the scope for such judgment is restricted. The surrogate is supposed to judge only which option is best for the patient. Other considerations are not supposed to intrude. Moreover, and crucially, there seems to be no role for the exercise of the physician’s practical wisdom.

General Rules and Particular Judgments

Skepticism about the physician’s special possession of practical wisdom seems to restrict the physician from engaging in any serious moral deliberation about what is best for the patient. One source of this restriction on physician practical wisdom might be what Paul Ricoeur* calls “the hermeneutics* of suspicion”–the thought that any claim to be wise is a cover for class prejudice or race prejudice or some other form of individual or group interest. Moreover, there might be skepticism about the practical wisdom specifically of institutionally assigned decision makers such as doctors. They might be thought to be subject to a range of pressures likely either to distort their judgment or to undermine their willingness to exercise it properly.

Putting such speculation aside, what needs to be stressed is that a lack of confidence in the wisdom of a particular group of decision makers does not entail a lack of confidence in every decision maker of the relevant kind. The lack of confidence is usually in the average decision maker. Consider a rule that prohibits any surgeon from operating the morning after a night in which they have been on call. Assume the justification for the rule is compelling data that shows that, after having been up all night, the average surgeon is not able to judge their own surgical competence. (For our purposes, it is not relevant whether the data actually shows this.) Given the stipulated data, and given that avoiding bad surgical outcomes is more important than the inconvenience to patients of rescheduling surgery, it might make sense to impose this rule. Yet there need be no assumption that every surgeon is unable to make a

good judgment. When Dr. Smith says that she does not need such a rule because she knows when she is unfit to operate, she might be correct, but the rule was not made with her in mind. It was made for the many surgeons who are not to be relied on to judge correctly when they are unfit to operate. The inconvenience the rule imposes on Dr. Smith and her patients is collateral damage. There is simply no viable mechanism to protect the patients of surgeons who are not as selfaware as Dr. Smith without inconveniencing the patients of surgeons who are.

Philosophers call this "rule consequentialism*." That doctrine holds that one should do the action such that, if the action were made into a rule with widespread compliance, better consequences would result than would result from compliance with any other relevant and feasible rule.

Philosophers have long known that the rule that yields the best overall consequences might yield suboptimal consequences in individual cases. Consider the rule that mandates rigid confidentiality about the results of HIV* tests. At the beginning of the AIDS* epidemic, (4)<u>public health officials believed that the most important thing to do was to get people tested, and that only the promise of confidentiality would induce people to come in for testing. That the confidentiality rule was the right rule at the time is consistent with conceding that in some cases it might have had problematic consequences.</u> In some cases, a doctor might have known that a patient was HIV positive but was not permitted to inform the patient's sexual partner, who might have been in the waiting room. This might have led to avoidable infection and, in those days, even avoidable death. Endorsing the propriety of the rigid confidentiality rule is consistent with conceding that it did not produce the best outcome in every case.

It often makes sense to use a rule even if it doesn't produce the best outcome in every case. This can create a puzzle. In thinking about doctor-knows-best skepticism, it can seem a good rule to assume that, in the clinical (5)<u>setting</u>, the doctor is not the wisest person at the bedside and that, therefore, they ought to defer to the judgment of the patient, surrogate, or parent. Yet one could simultaneously accept that, at times, the doctor might be the wisest person there and would make the best decision. The puzzle is that it might sometimes be right to violate the rule, but there is no reliable way to know when.

Daniel Brudney, Practical Wisdom, Rules, and the Patient-Doctor Conversation, in *The Ethics of Shared Decision Making*, Oxford University Press, 2021より引用・一部改変

*注

skepticism：懐疑論、ある事柄について疑いを持つ考え

Paul Ricoeur：ポール･リクール、20世紀フランスの哲学者

hermeneutics：解釈学、哲学のひとつの学説

rule consequentialism：規則帰結主義
HIV：human immunodeficiency virusの略、ヒト免疫不全ウイルスのこと
AIDS：acquired immunodeficiency syndromeの略、後天性免疫不全症候群のこと

問１．　下線部(1)のphysician paternalist modelからpatient autonomy modelへのシフトがおこった理由を日本語で２つあげなさい。

問２．　下線部(2)のpaternalismが成立する要因を本文を参考にして説明し、paternalismの具体例を医療以外から１つあげ、ともに日本語で解答しなさい。

問３．　下線部(3)の文章を日本語に訳しなさい。

問４．　(A)に入る最も適切な語句を下から１つ選びなさい。
ア．witness　イ．teacher　ウ．doctor　エ．counselor　オ．advisor

問５．　下線部(4)の文章を日本語に訳しなさい。

問６．　下線部(5)の語を言い換えるならどの語が適切か、下から１つ選びなさい。
ア．aspiration　イ．rule　ウ．situation　エ．hierarchy

問７．　本文を読んで、bedside decisionを医師のみが行った場合の問題点と患者やその家族のみで行った場合の問題点を示した上で、医療におけるよりよい意思決定について、あなたの考えを日本語600字以内で述べなさい（句読点を含む）。