原　著

チーム医療における意思決定モデル
——インフォームド・コンセントからコンフリクト・レゾリューションへ——

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【要　旨】インフォームド・コンセントは患者の自律性と権利を尊重するために導入された．しかし意思決定が根本的に困難である場合，即ち，チーム医療において職種間で合意形成ができない場合（Problem A）および，意思決定の中心である患者が優柔不断で決断できない場合（Problem B），どうすればよいのであろうか．

　日本および諸外国の看護倫理教育における主流の意思決定モデルとして、フライとジョンストンの4ステップモデルとトンプソン夫妻の10ステップモデルがあるが，前者は看護師の意思決定の理論で，A，Bともに結論を出せない．後者はチーム医療を想定しているが，合意形成の方法論を欠いている．本論では，それら二つの欠点を克服するものとして，ムーアの紛争調停モデルを提案する．これは，当事者達の根本的なニーズ（interest）に焦点をあて，解決を図る "Interest-based Approach" を採用している．本論では上記A・Bの問題を克服できるかを基準に，このモデルの優位性を証明する．

【キーワード】看護倫理，意思決定，インフォームド・コンセント，コンセンサス・ビルディング，コンフリクト・レゾリューション

Introduction

"Informed consent" has been introduced to respect the autonomy and rights of patients. Patients have become the core members of the healthcare team who make decisions regarding their medical and health care treatments because they could be specialists in their own illness.

However, we currently wonder how faithfully the autonomy of patients can be respected since there are wide gaps between medical professionals and patients in their specialized knowledge. If some patients are indecisive, and cannot make any decisions, what should we do for the patients? Should medical professionals make decisions on their behalf? Are patients capable of only choosing from the options proposed and recommended by doctors? Is this not just returning to an old-fashioned paternalism? We are on the horns of a

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dilemma between respect for autonomy and paternalism. Moreover, there will be cases when the problems are too difficult for even medical professionals to make decisions. What should we do in such situations? As Yoshitake (2007, p. 81) states, "we need the method that leads to decision making even if the patient neither has any clear opinion about his/her own medical care, nor knows his/her own mind."

Moreover, health care professionals must work in collaboration on multidisciplinary care teams. Doctors, nurses, pharmacists, and other health care professionals must discuss information with one another and make decisions in cooperation.

In the past, doctors have often been assumed the most appropriate persons to make decisions. Doctors were once the only specialists in the medical field. This is not so widely accepted today because research in the fields of health and medical care is highly specialized and subdivided. Therefore, doctors are not always specialists in some fields of health care.

Sometimes, doctors must follow the advice of other health care professionals. A specialist is a specialist only in his or her field, and just a layperson outside his/her field. However, as the old proverb says, advice is seldom welcome, and an opinion may change if a person's standpoint changes. It is sometimes difficult to build a consensus among people with various standpoints (doctors, nurses, patients, etc.).

Aims and Method

The aims of this paper are to present a new decision making model for problems that are difficult to resolve and decide, to provide multidisciplinary care teams with a practical model for collaborative decision making, and lastly, to bridge gaps between different standpoints, especially between the judgments of specialists and patients (laypersons). To achieve these goals, we propose two problems (or subjects to be solved) as follows:

Problem A: What should we do if health care team members cannot reach an agreement?
Problem B: What should we do if some members (especially, patients) are so indecisive that they cannot reach any decision?

In this paper, I present two decision-making models that are standard and popular in the curriculum of nursing ethics education, not only in Japan but also worldwide. The first is four-step model of Fry and Johnstone (2008) that was originally introduced by the International Council of Nurses. The second is ten-step model of Thompson and Thompson (1992). These two models were introduced in Japan by the Japan Nursing Association for nursing ethics education. After examining these models through our two problems, we propose a third model: conflict resolution model (mediation) of Moore (2003).

Therefore, our research questions are formulated as follows:

Research Question 1: Can two traditional decision-making models satisfy our two problems?

Research Question 2: What kind of model can satisfy our two problems?

Four-Step Model of Fry and Johnstone

First, we would like to present the four-step model for decision making introduced by Sara T. Fry and Megan-Jane Johnstone (2008). The model is detailed in their textbook for nursing ethics education, Ethics in nursing practice a guide to ethical decision making, which is one of the most popular textbooks in Japan.

A value-centered approach.

According to Fry and Johnstone (2008, p. 65), the traditional model of decision making is "a principle-oriented approach to the resolution of value conflicts." This model considers whether an action would violate

any ethical principle (i.e., "respect for autonomy," "nonmaleficence," "beneficence," "justice," etc.; Beauchamp, 2009). In contrast, their model is "a value-centered approach to the resolution of ethical conflicts" (Fry and Johnstone, 2008, p. 65). This model concerns conflicts of values of the people involved. The aim of this model is to examine four aspects: (1) "the values involved and the interests at stake," because this model focuses on conflicts of values and attempts to resolve them; (2) "the context within which the decision will be made," since problems themselves change depending on the context (or the interpretations of the context by different people); (3) "the kinds of strategies that will need to be employed to achieve a resolution to the problems identified;" and (4) "the nature of the nurse's responsibilities in the situation" (Fry and Johnstone, 2008, p. 60).

The four questions within this model.

We can reach a decision by answering these four questions: (1) what is the story behind the value conflicts? (2) What is the significance of the values involved? (3) What is the significance of this conflict to the parties involved? and (4) What should be done?

Step 1: What is the story behind the value conflicts?

According to Fry and Johnstone (2008, p. 62), by asking this question, "the nurse begins to discover how the problem is defined by the parties experiencing the problem." The involved parties include patients, their families, doctors, nurses, other medical professionals, etc. By answering this question, the contexts of the problems will be made explicit, and the conflicts of values will be clarified.

Step 2: What is the significance of the values involved?

At this step, the nurse must analyze the values of all the parties involved, and gains "insight into the moral and nonmoral nature of the values and their potential cultural, religious, personal, professional, and even political

origins" (Fry and Johnstone, 2008, p. 63). However, Fry and Johnstone (2008, p. 63) insist that "this does not mean that all the values will always be protected," because there is an order of priority of values. Some values would be prioritized and others not. Therefore, the goal of nurses at this stage is to "help individuals prioritize their values" (Fry and Johnstone, 2008, p. 63). However, this would be a very difficult task, and the question remains: how and who shall prioritize?

Step 3: What is the significance of this conflict to the parties involved?

At the third step, the nurse must learn "how the parties involved relate their values to the present situation" (Fry and Johnstone, 2008, p. 63). Values are never static. They vary from person to person and change over time and in relation to human events and relationships. Therefore, if we can clarify the values of every person involved, it would help to resolve value conflicts for everyone.

Step 4: What should be done?

In the last step, "the nurse explores all of the ways in which the value conflicts might be resolved" (Fry and Johnstone, 2008, p. 64). According to Fry and Johnstone (2008, p. 64), "in most cases, ethical decisions are made based on the amount of relevant information available at that time, the significance (moral weight) of the value dimensions, and the 'best' judgment of the decision maker(s) or the collective ethical stance of the group." In such cases, we should take notice of the three following points: "the values held by the various parties," since values vary from person to person; "outcomes that may occur," because some actions may have both intended positive consequences as well undesired side effects, and the evaluation about them may differ from person to person; and lastly, "the moral rightness or wrongness of the various options according to agreed moral standards" (Fry and Johnstone, 2008, p. 64).

However, how can we get agreement on the moral

standards? They may differ from person to person, so how can we decide? Regardless, we must determine "what should be done," but the question of 'how' remains.

Examination of the two problems.

The aim of Fry and Johnstone's model is to educate nurses and enhance their capacity for moral judgment and decision making. As they say, "One goal of ethics teaching is to produce a morally informed, knowledgeable, sensitive, and accountable nurse who has the ability to make ethical decisions in practice" (Fry and Johnstone, 2008, p. 59). Although we appreciate the significance of this aim, we believe that it is not sufficient for a medical decision-making model since it fails to satisfy our two problems.

Problem A: What if members cannot reach an agreement?

Suppose that all the members have different opinions and cannot reach an agreement, what should you do?

At the second and fourth steps of Fry and Johnstone's model, they are approaching this problem. However, they did not present any concrete methodology to resolve it. Perhaps they must restart the discussion, but how can a consensus be reached? In the worst-case scenario, the argument would continue endlessly without resolution.

Problem B: What if some members (especially the patient him/herself) are at a loss and cannot reach any decision?

Suppose the people involved, especially the patients, were irresolute and could not find their way, and only you, as the nurse assigned to the case, could discover the most appropriate and effective way, what should you do? For instance, you might offer your opinion to adopt. Unfortunately, the others were not satisfied with your proposal. They would say to you, "indeed, we cannot find the best solution with which we can all be satisfied, and we are at a loss just now; however, we are trying to find the best solution with which we can be satisfied."

Then, what should you do? You would try to persuade them. However, if you are not successful, would you dare to force them or compromise with them? Alternatively, would you give up your proposal and remain silent?

Thompson and Thompson's Ten-Step Model

Next, we would like to examine the ten-step model of Thompson and Thompson (1992) for bioethical decision making, that is introduced in one of the most popular textbooks in Japan and worldwide, *Bioethical decision making for nurses*. We must verify whether we can reach a consensus on conflicts of values by following the ten steps of this model.

Overview of the ten-step model.

The following outlines the steps within the model.
Step 1: Review the situation, and Step 2: Gather additional information to clarify the situation.

In the first step, we must review the situation to answer the following questions: What are the health problems? Which problems are ethical and which are scientific? What decisions need to be made? What individuals are involved or affected by the decisions? Through answering these questions, we can clarify the situation (Thompson & Thompson, 1992, pp. 103–120).

It is well known that previously homosexuality was regarded as a theological or moral problem and then as a health problem. Today, it has become a problem of personal identity. As this example demonstrates, it is sometimes difficult to identify the problem. We examine this issue more closely in the next step.

After we identify the information that is lacking and the information that is needed in the first step, we gather additional information to clarify the situation in the second step.

Step 3: Identify the ethical issues in the situation, and Step 4: Define the personal and professional moral

positions.

In the third step, we must identify our ethical issues by consulting ethical principles, codes of bioethics, or other ethical or moral codes. Next, we investigate the historical, conventional, philosophical, and theological or religious bases for the issues.

In the fourth step, you must clarify your personal moral position and that of the health professionals and distinguish them from each other. Occasionally, they may differ. When the former interferes with the latter, in the worst case, the interference falls into an infringement on the values of others.

According to Thompson and Thompson (1985, p. 133), the deeper personal examination at this step moves you "toward greater understanding of yourself" and prepares you to examine the values of others. If we examine and understand ourselves more deeply, we can better understand the values and beliefs of other people, and perform our professional duties more effectively. Therefore, deeper self-examination is indispensable.

Step 5: Identify the moral positions of key individuals involved, and Step 6: Identify value conflicts, if any.

In the fifth step, you must gather the key people to discuss and identify their moral positions. Moreover, the person who is the most aware of the ethical issues and respectful of the values of other people is identified. This step enables us to predict who would be appropriate to be the final decision maker (who is determined in the seventh step).

If there are any value conflicts, you must identify how they conflict. Thompson and Thompson (1985, p. 143) state, "the resolution of value conflicts is predicted on clear identification of conflict." The criteria to identify value conflicts are as follows: (1) an awareness of different opinions, (2) understanding the ethical or moral nature of the issue, and (3) the existence of two or more possible actions with the freedom to decide between or among them.

It is definitely important to identify and understand

other people's values and the root causes of the conflicts. It is, however, difficult to move from understanding to the resolution of the conflicts. We will examine this issue later.

Step 7: Determine who should make the decision.

To determine the final decision maker, some questions should be asked: (1) Are people involved in and significantly aware of the critical elements of the situation? (2) Are they willing to use moral reasoning to reach a final decision? (3) Do they know themselves well enough to identify personal values and potential biases? (4) Are they willing to make a final choice from a list of alternatives with moral justification? (Thompson & Thompson, 1985, p. 161).

It is important to decide who would ultimately be responsible for decision making. However, the process of decision-making is more important.

Step 8: Identify the range of actions with anticipated outcomes, Step 9: Decide on a course of action and implement it, and Step 10: Evaluate/review the results of the decision/action.

In the eighth step, we should list as many possible actions or decisions as we can, and then identify the range of the resulting actions. Next, we should anticipate the outcomes of each alternative. Then, we should apply a reality test and eliminate alternatives that are unethical or unrealistic. In the ninth step, we decide on one course of action and carry it out. Lastly, we evaluate the results. We must ask ourselves whether the decision produced the intended results, whether additional action is needed, etc.

We think that the eighth and ninth steps would be the most difficult to accomplish because it would not be easy task to identify all possible solutions to resolve deeply complicated conflicts between the people involved. A specific methodology is needed to identify solutions. Although there are some methods to address this, they seem insufficient for our purpose. We will examine this

further in the next section.

Examination of the two problems.

Thompson and Thompson's model explains the moral decision-making process more systematically, precisely, and elaborately than Fry and Johnstone's model, but is slightly too complicated to use easily. Moreover, the merit of this model is that it considers decision making in cooperation with other medical personnel and patients. However, if an agreement cannot be reached, how should the conflict be resolved? This model also lacks a concrete methodology for consensus building. We will see how well it meets our two problems below.

Problem A: What if members cannot reach an agreement?

Steps 5 and 6 need to be followed if we cannot reach any agreement. In these steps, we examine the values of all the parties and if there are conflicts, we discuss and seek to resolve the problems. Next, at Step 7, we choose the most appropriate final decision maker to determine the most preferable action. However, what if there is no way to resolve the problems? Moreover, what if even the final decision maker could not decide on the most preferable action?

Problem B: What if some members (especially the patient him/herself) are at a loss and cannot reach any decision?

See Step 7 again. We choose the final decision maker. He or she could decide objectively on the most preferable action. However, is the decision most preferable for the patient? How can it be proven? Is this not returning to paternalism?

When we experience such aporias, Thompson and Thompson suggest the use of three main questions: (1) What are the characteristics of the ideal patient? (2) What are the characteristics of the ideal nurse? After we create lists of these answers, we should ask the third question, (3) what characteristics do you have listed for the ideal nurse that would describe yourself? (1985, p. 144).

However, such types of idealistic methods of settlement would be neither persuasive nor effective since an ideal solution would be difficult to reach in a society with a pluralistic sense of values such as ours. Thus, can a consensus be reached to resolve value conflicts?

The Third Model for Conflict Resolution

In recent times, new approaches to conflict resolution have been developed to disentangle complicated and interwoven conflicts, and to find settlement options that satisfy all those involved. This leads us to a "conflict resolution approach" or "interest-based approach." This approach was first introduced at Harvard University by Fisher and Ury, and his colleagues as the methodology and science of "negotiation" (Fisher & Ury, 1981). This approach was further developed by Moore as an alternative dispute resolution or "mediation" (Moore, 2003). Another successor of Fisher and Ury is "consensus building," developed by Susskind, focusing on collective or democratic decision making, such as for public policy formulation (Susskind, 1999).

These approaches are also gradually being introduced into the medical ethics education program in Japan. For example, Wada's approach is based partially upon Moore's, but was improved and optimized for medical dispute resolution (such as the resolution of medical accidents; Wada, 2011). Yoshitake's approach is based upon Susskind's approach from the perspective of medical and nursing ethics (Yoshitake, 2007).

The approaches of Moore and Wada are "retrospective" and focus upon the resolution of past conflicts. Yoshitake's approach is "prospective" and appropriate for decision making for future problems. However, this approach depends on Susskind's consensus building, which is optimized for public policy, but not for medical decision making. In public policy making, open and public discussion is essential, whereas in medical settings, closed and private discussion is essential.

In contrast, my approach, although based upon Moore's

mediation model, is "prospective" and suitable for future decision making (Yara, 2011). Rather than present my entire model, I would like to present "the interest-based approach" (one of the core theories of conflict resolution) in this paper.

I would like to explain what "mediation" is by contrasting it with "negotiation." Negotiation is a bargaining relationship between parties who have a perceived or actual conflict of interests. If it is difficult to reach an agreement, the parties may need assistance from someone who is independent, neutral, and outside of the dispute. Mediation is an extension or elaboration of the negotiation process that involves the intervention of an acceptable third party, who is called the "mediator" (Moore, 2003, p. 8).

Then, what is the role of the mediator? The mediator should not have decision-making power; s/he does not give any advice for settlement and only asks questions that promote discussion. The tasks of the mediator are as follows: (a) to assist the parties in examining their interests and needs, (b) to help them negotiate an exchange of guarantees by themselves, and (c) to redefine their relationships in a way that will be mutually satisfactory and meet their standards of fairness.

The procedures of mediation.

This is essential to the resolution of our problems (i.e., to the attainment of a settlement consensus). The central methodology of mediation (i.e., "the interest-based approach") consists of three steps: (a) the analysis of positions, issues, and hidden interests; (b) the discovery or excavation of hidden and underlying interests; and (c) the generation of options for settlement.

Analysis of positions, issues, and hidden interests.

First, we analyze the conflicts of all the people involved in a three-stratum (a position-issue-interest) structure as a basis of conflict resolution. The original idea of the three-stratum structure was conceived by Fisher and Ury (1981).

"Positions" are the concrete claims or statements of those involved. "Issues" are the formalization of positions and refer to the contents of the problem to be discussed. Issues are usually expressed in the form of a dichotomy (whether it is A; whether we should do something).

When people are in a dispute bargain over issues, they tend to lock themselves into their own positions and prevent themselves from viewing the issues from another perspective. If the people involved continue to stick to their own positions, the quality of the discourse degrades because people in a dispute overlook their own positions that reflect their genuine needs, concerns, and desires, and, eventually, forget the existence of their genuine needs. We call these genuine needs "interests." According to Fisher and Ury, the basic problem lies "not in conflicting positions, but in the conflict between each side's needs, desires, concerns, and fears" (Fisher & Ury, 1981, p. 40; Yara, 2011, p. 160). In short, the distinction between interests and positions is essential, and the models of Fry and Johnstone, and Thompson and Thompson miss this distinction.

People in a disagreement "rarely identify their interests in a clear or direct fashion" (Moore, 2003, p. 252). Furthermore, they have adhered so strongly to a particular position that the interest itself becomes obscured, altered, and finally equated with the interests, their true needs, and can no longer be seen as a separate and original entity. Therefore, we must attempt to discover the hidden and original interests that underlie opposing positions.

Discovery hidden and underlying interests.

Looking at interests instead of positions advances the resolution process because even if the positions and issues are not easily shared and compatible, at least the interests can be.

In order to uncover hidden interests and advance the resolution process, I would like to present two approaches. The first is "the interest-oriented discussion"

(Moore, 2003, p.258). In this approach, the mediator requires disputants to refrain from discussing specific issues or positions, and focuses instead on articulating their original interests or needs, the fulfillment of which would make a settlement more satisfactory for each of them.

A second approach is "the building-block approach," which requires disputants to divide an issue into sub-issues or component parts (Moore, 2003). Usually, working with these smaller elements makes problem solving more manageable, thus, making it easier to discover the settlement options. Therefore, an overall solution emerges from the resolution of all sub-issues.

Generation of options for reaching a settlement.

Next, we need to attempt to generate concrete options. To this end, "brainstorming" may be employed. It is a procedure that helps people to be more creative and productive to produce a variety of possible ideas or options.

The mediator instructs the disputants to suggest solutions rapidly that might meet the needs of all parties. The mediator should caution them against making any judgments of practicality or acceptability. The mediator should also encourage them to build upon and modify each other's ideas as long as the results propel them toward a choice that could meet the overall interests. After brainstorming, we must examine the lists of ideas and combine some together in order to produce the settlement options that can satisfy some of the interests or subdivided interests.

Examination of the two problems.

Is it possible for the "interest-based approach" of "mediation" to satisfy our problems? We would like to verify this now.

Problem 1: What if members cannot reach an agreement?

If we cannot reach an agreement on positions or issues, we can seek the underlying interests that are compatible

with each other, even if they are not common. If it is difficult to discover compatible interests, we should divide issues into sub-issues or smaller parts, and then it would be easier to discover interests. Then we will seek the settlement options that can meet and satisfy the interests of all parties.

Problem 2: What if some members (especially the patient him/herself) are at a loss and cannot reach any decision?

The patients' desires and preferences should not be disregarded based on the bioethical principle of respect for autonomy (Beauchamp, 2009). However, what if a patient is indecisive? Even if someone is at a loss and cannot reach any decision, he/she would have some desires or interests. Therefore, we should focus on, and discover the underlying interests, and then the settlement options will be found.

Discussion

Now, we can answer our two problems and we will also find the most effective method for resolving highly complicated value conflicts. The essential point of conflict resolution methodology is to distinguish interests from positions, although the models of Fry and Johnstone, and Thompson and Thompson overlook this distinction.

The conflict resolution technique of "mediation" was introduced and originally developed to resolve severe disputes as an alternative to lawsuits in the judicial field. It is an integrated composition of every possible method and theory that is effective for resolving disputes, of which we can only present the core theory in this paper.

However, this does not mean that any of the other models are useless and should be rejected. Rather, they are mutually complementary. An integrated composition of all methods and theories facilitates effective decision making in the medical health care field. Each model has its own advantages and disadvantages, therefore, we can use each model properly according to the situation and,

if necessary, a better combination of them could produce more productive outcomes.

There remains, however, one question that was mentioned and raised in the introduction: "How can we bridge the gaps between professionals and patients?" In our method, even if a person is at a loss and cannot reach any decision, if s/he has some desire or interest, she can still participate in decision making since special knowledge is not always necessary.

Moreover, we raise another question: "Can moral dilemmas or conflicts of ethical principles be resolved with our method?" Indeed, we may not always resolve conflicts with our method because some issues or interests may conflict with or violate some ethical principles. However, we can find concrete options that avoid violating principles since the aim of conflict resolution is not to resolve ethical conflicts or moral dilemmas, but to discover concrete measures that allow people to escapte and avoid violating ethical principles.

Conclusion

After considering all of these methods for conflict resolution, we can finally answer our two research questions.

Research Question 1: Can two traditional decision-making models satisfy our two problems? Our answer is negative.

Research Question 2: What kind of model can satisfy our two problems? Our answer is that "the interest-centered approach" of conflict resolution can satisfy them.

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【Original Article】

Decision-making models for multidisciplinary health care teams: from informed consent to conflict resolution

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【Abstract】 "Informed consent" has been introduced to respect the autonomy and rights of patients in order to overcome paternalism. However, when some patients are indecisive and cannot make any decisions, we cannot help returning to, and depending upon, paternalism. On the other hand, a health care professional must work in collaboration with others in the multidisciplinary care team. However, it is sometimes difficult to build consensus among different professionals.

The aim of this paper is to present a decision-making model that is able to resolve our two problems raised above by examining the two main decision-making models in the curriculum of nursing ethics education not only in Japan, but also worldwide (i.e., Fry and Johnstone's four-step model, and Thompson and Thompson's ten-step model), and to provide a new model, Moore's conflict resolution model.

In order to compare and examine the three models, we formulate our problems as follows:

Problem A: What if health care team members cannot reach an agreement?

Problem B: What if some members (especially patients) are so indecisive that they cannot reach any decision?

The third model focuses on the original needs or "interests" of the people involved, and resolves the two problems above (Interest-based approach). Therefore, we can prove the superiority of the third model by answering the two problems.

【Keywords】 nursing ethics, decision-making, informed consent, consensus building, conflict resolution

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