Virtual Mentor

Ethics Journal of the American Medical Association
May 2006, Volume 8, Number 5: 341-344.

Op-Ed

The Myth of Value Neutrality

by Paul J. Hoehner, MD, MA

The patient-physician encounter is, by its nature, a value-laden encounter, a fact that provokes a number of ethical questions, especially when differing values conflict within the clinical setting. Can the moral values that lead many students into the field of medicine be set aside when they conflict with those of patients? Are a physician's values always secondary to those of the patient? Whose values should guide clinical decisions? These are complicated questions. The loss of a moral consensus in the medical profession (and society as a whole) and the embrace of philosophical pluralism are evident in the medical profession's acceptance of the seductive but ill-defined concept of "physician value neutrality" [1].

The image of the physician as "natural scientist" has had a significant role in fostering this concept. Rosenberg and Towers write that, "The natural scientist has traditionally sought to suspend all feelings, attitudes, and other presumed sources of potential bias in the observations of external phenomena" [2]. Accepting the natural science approach to medicine presupposes that physicians should be value neutral, ie, completely objective, in order to prevent their therapeutic plans, diagnoses, and relationships with patients from being influenced by values, beliefs, feelings, and other "unscientific" biases. The value-neutral concept shows up early in medical school, where, sociologist Theodore Dorpat writes, there is a "misapplication of a natural science model of neutrality to the student's patient-physician relationships" [3]. But John Peppin notes in an essay entitled "Physician Values and Value Neutrality" that there is more than a misapplication of the natural science model going on here. The criticism of certain disciplines for their nonscientific bases, Peppin says, "ignores the reality that the foundations of science, those basic presuppositions that must be assumed to do science, are also without 'scientific' basis" [4]. Why then, should this critique apply to the art of medicine when our subjects are real people, with emotional, psychological, and spiritual natures?

Expectations that physicians will act objectively are well grounded. Beauchamp and Childress, in their seminal work Principles of Biomedical Ethics, believe that information provided to patients must be free from the "entrenched values and goals of medical professionals" [5]. Physician and health law scholar, David Orentlicher, states that physicians should "examine their practices in order to ensure that they are not imposing their values, wittingly or unwittingly, on patients' end of life decisions" [6]. And Bruce Miller concurs: "Physicians and other health professionals are to respect the values of patients and not to let their own values influence decisions about treatment"

[7]. Even television doctor Dean Edell suggests that physicians, "particularly when suggesting life-style changes…must act non-judgmentally—often despite their own feelings of anger or indignation" [8].

I believe that these expressions, said to be essential, even axiomatic, to the patient-physician relationship, have undermined our profession to a staggering degree. Any relationship between 2 people involves values, and these are especially significant in the advice and treatment physicians offer their patients. There have been scores of articles decrying the loss of empathy, sympathy, and compassion in the modern health care system—emotions that are at the core of what is envisioned as good health "care." But one wonders how these sentiments could ever be expressed in a value-neutral system.

Furthermore, physicians are consistently called upon to exhibit a whole range of ethical traits all of which are expressions of their underlying beliefs and are defined in value-laden language. As Peppin emphasizes,

The worth of persons, the importance of helping those in need, caring for the sick, and role of the physicians are all important aspects of the ability to express these traits in action. Religious beliefs, world views, and political beliefs all form the foundations upon which our values stand. We cannot separate our actions from these foundations without having actions which lack substance [9].

Moreover, to suggest that physicians should act "non-judgmentally" is to misunderstand how medicine works. Physicians constantly judge behavior, whether it is smoking, sedentary lifestyles, stress management, or interpersonal relations. Eric Cassell states that, "[o]nly the physician as a person can empathically experience the experience of a sick person," and

> the information on which the process of recreating the past is based is value laden and cannot be separated from the aesthetics of parts of wholes—the whole patient, the whole of patient and doctor, and the whole of patient, doctor and setting [10].

In other words, physicians' values affect how they interpret their patients' histories, their relationships with patients, and their therapies.

Proponents of neutrality claim there is a "2-tiered" system of values—with a distinction made between the "personal" and "professional." Professional values are those agreed upon by the majority of the profession that inform the set of "appropriate" principles for a physician to act upon within the context of the patient-physician relationship. Personal values, such as those derived from religious belief, neutrality proponents argue, should not enter into interactions with patients. But, as John Peppin observes, a profession has no values apart from those professed and exhibited by individuals within that profession [11]. What is the basis for deciding which of these are "professional" and which are "personal"? Physicians must engage all the values they hold when developing their relationships with patients. A truly value-neutral doctor would have no patient-physician relationship of significance. Even with respect to religious values,

Denise McKee notes that a "physician cannot choose whether to acknowledge religious variables in practice; they exist, whether recognized or not" [12]. And Roy Couser states in The Myth of Religious Neutrality that "religious belief is the most influential of all beliefs, and most powerful force in the world…the most decisive influence on everyone's understanding of the major issues of life" [13]. Clearly, physicians have the same "religious variables" (recognized or not) as non physicians, which have a profound effect on how they see and interpret the world. These beliefs help define who physicians are and, most importantly, form the foundations upon which all values rest. They also have a tremendous impact on how physicians practice medicine.

To expose the myth of value neutrality is certainly not to undermine the importance of patient values or the very real vulnerability of our patients in any clinical encounter. The power differential between physician and patient can easily be exploited, and we must be reminded of that possibility continually. There is a fine distinction between the values that guide our practices and patient interactions and how we engage our patients around those values. Not every meeting with a patient is an "evangelistic encounter," nor should it be. And certainly there are times when we must advocate for our patient's values, not ours, as they apply to important treatment decisions. To make these fine-line distinctions in our patient encounters takes wisdom, discernment, and judgment. But this is a far cry from being "value neutral," since wisdom, discernment, and judgment are also value-dependent concepts.

In this era of respect for diversity, we need more than ever to bury the myth of value neutrality. Not only is value neutrality impossible, but the pretense of practicing medicine under its umbrella only undermines a competent, caring, and honest patient-physician relationship. The myth is built upon a poor foundation and is ultimately a nonsensical intellectual surrender to philosophical pluralism. Dorpat suggests that members of his profession have a choice "between an open and honest expression of their values and pursuing a 'vain ritual' of moral neutrality that, because it invites men to ignore the vulnerability of reason to bias, leaves it at the mercy of irrationality" [14]. Physicians have the same choice. And patients also have a choice. As Peppin acknowledges,

> If patients could select physicians who shared similar values this would seem at least more honest and more in keeping with a number of current medical ethics paradigms including the principles approach of Beauchamp and Childress, the virtue approach of Pellegrino and Thomasma, and Siegler's 'Doctor-Patient' encounter [15].

It seems both timely and honest, given our pluralistic society, for physicians, as a first step in appreciating medical ethics and regaining the trust and confidence of their patients, to make every possible effort to understand more clearly and evaluate more critically their own worldview, values, and faith. They may then provide some type of honest statement that would give patients an idea of where they stand on important moral issues. In such a context, sharing—not imposing—one's faith and values is both truthful and commendable.

Notes and References

1. There is a confusion between "empirical plurality" and "philosophical pluralism" in American society today. Plural-*ity* sums up the growing diversity in our culture. It refers to the sheer diversity of race, value systems, heritage, language, culture, and religion in many Western and some other nations. Plural-*ism* is a philosophical or ideological statement which maintains that any notion that a particular ideological or religious claim is intrinsically superior to another is necessarily wrong. The practical result of philosophical pluralism is to deny any objective truth claim or deny that any objective truth can ever be obtained. It was natural for this type of thinking to spill over to the medical profession with the nebulous concept of "physician value neutrality."
2. Rosenberg JE, Towers B. The practice of empathy as a prerequisite for informed consent. *Theor Med.* 1986;7:182.
3. Dorpat TL. On neutrality. *Int J Psychoanal Psychother.* 1977;6:58.
4. Peppin JF. Physician values and value neutrality. In: Kilner JF, des Cameron NM, Schiedermayer DL, eds. *Bioethics and the Future of Medicine: A Christian Appraisal.* Grand Rapids, Mich: Eerdmans Publishing Company; 1995:41.
5. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 3rd ed. New York, NY: Oxford University Press; 1989:88.
6. Orentlicher D. The illusion of patient choice in end-of-life decisions. *JAMA.* 1992;267:2101-2104.
7. Miller BL. Autonomy and the refusal of life-saving treatment. In: Gorovitz S, Macklin R, senior eds. *Moral Problems in Medicine.* 2nd ed. Englewood Cliffs, NJ: Prentice-Hall; 1983:72.
8. Edell DS. Acting for patients. *JAMA.* 1993;269:1182, 1187.
9. Peppin JF, 39.
10. Cassell EJ. *The Nature of Suffering and the Goals of Medicine.* 1st ed. New York, NY: Oxford University Press; 1991:226-227.
11. Peppin JF. Physician's values and physician value neutrality: a Christian perspective. *Philosophia Christi.* 1995;18:61-68.
12. McKee DD, Chappel JH. Spirituality and medical practice. *J Fam Pract.* 1992;35:205-208.
13. Couser RA. *The Myth of Religious Neutrality: An Essay on the Hidden Role of Religious Belief in Theories.* South Bend, Ind: Notre Dame Press; 1991:1.
14. See Dorpat TL. On Neutrality. See also Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.*
15. Peppin JF. In: *Bioethics and the future of Medicine: A Christian Appraisal*, 46.

Paul J. Hoehner, MD, MA, is a cardiovascular and thoracic anesthesiologist in private practice in Charlottesville, Virginia. He is a Harvey Doctoral Dissertation Fellow in Theology, Ethics, and Culture in the Department of Religious Studies at the University of Virginia where he is completing his PhD in theological ethics.