

A Neo-Socratic Dialogue for Developing a Mutual Understanding of Rights and Responsibilities in the Healthcare System *

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Abstract

With people's value systems changing and becoming diverse, it is likely that there is a range in people's attitudes regarding the basic aims, values and principles of healthcare. Yet, there are few opportunities for sharing thoughts. We used a method called the Neo-Socratic Dialogue (NSD) and had two dialogues in which various categories of participants together discuss the rights and responsibilities involved in healthcare. The case-study based discussions generated generalized outlooks regarding the question. The NSD will be useful in mutually understanding problems and forming a consensus.

Keywords: The Neo-Socratic Dialogue; healthcare; right; responsibility; philosophical discussion.

1 Introduction

Ever since the Komatsu monograph, titled *The Collapse of Healthcare*, was published in 2006, the words in his title have been bandied about in the Japanese media ⁽¹⁾. Komatsu pointed out that an enormous gap has emerged in the differing conceptions held by physicians and patients, the mass media, the police, and the justice system regarding the uncertainty of healthcare. As a consequence, he asserted, doctors have lost their incentive to work and are leaving hospitals in order to open their own clinics. As a result, there are not enough providers of pediatric emergency care and obstetric services, leading to the collapse of those arenas ⁽²⁾. Additionally, Tsujimoto has noted that, approximately since the year 2000, the Japanese public's "mistrust of healthcare" has increased due to the extensive media coverage of several medical accidents ⁽³⁾. At the same time, abusive language and violence by patients has become a problem, with patients who act out being labeled "monster patients" ⁽⁴⁾. There is also the issue of "convenience-store consultations," the term for patients dropping in for emergency outpatient services even when their symptoms

* CAP Vol. 2 (2010-11) pp. 10001 - 10016. submitted: 2009.11.27 accepted: 2010.3.24 category: original paper published: 2010.6.13

are mild ⁽⁵⁾. Since the 1980s, the government has been limiting the number of physicians; in 2006 there were 2.1 doctors per 1000 people in Japan, just two-thirds of the average ratio of 3.1 doctors per 1000 people for the 30 nations belonging to the OECD ⁽⁶⁾. The introduction, in 2004, of a new clinical training system made obvious the shortage of doctors. This is because more interns were choosing to train at general hospitals rather than university hospitals, with the result that understaffed university hospitals had to recall the physicians they had sent out to regional hospitals ⁽⁷⁾. In the embattled arena of emergency medical services, hospitals were unable to accept patients and “shunted them around” from one facility to another; there was also an increase in defensive medical treatment or refusal to provide treatment, resulting from the fear of potential disputes and lawsuits.

Komatsu proposes that, “We need to assemble a national council invested with great authority, and have that council attempt to formulate a consensus among people regarding their awareness of what constitutes healthcare, the problems confronting the system, and the principles that will underlie the countermeasures necessary to address those problems.” He also cautions that, “If we do not make efforts, at the national level, to eliminate the mutual distrust between patients and healthcare professionals, the problems will become insurmountable. The situation calls for immediate action.” ⁽²⁾

Tsujimoto declares that patients themselves, as subjects with rights and responsibilities, need to change their habits with respect to receiving healthcare. In other words, they need to accept the current state of the healthcare system, and instead of merely asserting their rights, must accept responsibility as half of the healthcare equation. They should participate in their healthcare with an attitude based on an acceptance of the limits and uncertainty of medicine, acquiring a capacity for mature judgment regarding their care. Tsujimoto goes on to say that it is necessary for patients and healthcare professionals to improve their mutual communication abilities, to acknowledge each other’s positions, and to rebuild “safety, ease of mind, and satisfaction” into a more collaborative healthcare relationship ⁽³⁾.

With people’s value systems changing and becoming more diverse, it is likely that there is a range in people’s attitudes regarding even the basic aims of healthcare, not to mention the values and principles that should be emphasized. Yet, there are few opportunities for on-the-job discussions of these developments among busy healthcare professionals, and so the sharing of thoughts has been difficult. Nevertheless, there are many issues that need to be addressed with respect to what healthcare should be like in the future. It is vital for us to explore the many concerns associated with healthcare together, and to create and test a communication model for attempting to generate mutual understanding and form a consensus.

In light of the above circumstances, we used a method called the Neo-Socratic Dialogue (NSD) and established a setting in which various categories of participants could together discuss the “rights and responsibilities” involved in healthcare. Our objective was for participants to respond to the issues at hand by putting forth concrete examples, and through discussion, to clarify the ethical principles and values associated with the rights and responsibilities that form the basis of their judgment regarding those experiences. Another objective was for participants, in the process of discussion, to form a shared value system as they identified differences and commonalities in their opinions. We also asked them to assess their experience and tried to evaluate the validity of the method itself besides the content of the discussion.

2 Methods

The NSD is a method for conducting philosophical dialogue among small groups of approximately seven people. It was formulated by Leonard Nelson (1882-1927), and is used in Germany, England, and Holland for philosophical training, dialogue-based education, discovering problems,

and forming a consensus^(8–10). It was introduced in Japan in 1999 and has been in use ever since^(11–22).

The NSD starts with the specification of a general question. Case studies relating to the question are then gathered from participants, and one case study is chosen for detailed investigation. The participants confirm the judgments and actions involved in the case study, abstract the principles and values underlying them, and gradually formulate a consensus regarding the question. For the dialogue to succeed, participants are asked to submit to certain rules, such as speaking clearly, listening carefully to other participants' statements, and always asking if something is unclear; they are also provided with standards for selecting a case study suitable for the dialogue. This series of dialogues was divided into six sessions of 90 minutes each, conducted over a total of a day-and-a-half. They took place in 2009 with one group each in Kumamoto and Osaka, or a total of two groups. The question asked of them was, "In the context of the patient-healthcare professional relationship, what rights and responsibilities does each party have?" We planned on having seven participants per group, and we recruited them from among acquaintances of the researchers contributing to this study and from additional people introduced by the researchers' acquaintances. Our aim was to include the following categories of participants: someone who could represent the perspective of general citizens (2 persons); an ethicist, bioethicist, or someone with a legal background (1 person); someone involved in the mass media or a sociologist (1 person); a physician (1 person); a nurse (1 person); and some other kind of healthcare professional (1 person). We also attempted to recruit in such a way that we had at least three men and three women. During the discussions, a facilitator wrote up the main points on a flip chart, and at the same time a scribe typed up the content of participants' statements on a computer. This study was authorized at a General Research Ethics Review under the auspices of the Faculty of Medical and Pharmaceutical Sciences at Kumamoto University (Ethics No. 282, issued September 20, 2008).

3 Results

3.1 The First NSD

Participants in the first group were as follows: a bioethicist, journalist, doctor, and nurse, all four of whom participated for the entire day-and-a-half, and a nursing care consultant who participated for one day. In addition, an ethicist familiar with the NSD method observed the events of the first day. The investigators of this study took on the roles of facilitator (A.K.) and scribe (A.A.). On the second day, a Citizen NPO Representative (H.K.) sat in to observe. In response to the question, "In the context of the patient-healthcare professional relationship, what are the rights and responsibilities of each party?" the participants came up with seven case studies, then chose the following study as the most conducive to dialogue:

Case Study 1: A patient angered that his intravenous drip (I.V.) was not exactly on time
Contributor of Case Study: A nurse

Summary: Middle-aged male patient hospitalized with thoracic empyema. He was treated with an I.V. and underwent drainage of the pleural cavity; he experienced fever as well as the pain and constraint of the insertion point of the drainage tube. Due to anxiety and irritation resulting from prolonged hospitalization, he showered verbal abuse on a young nurse, telling her, "My I.V. is not ending punctually," "You're impolite and have a bad attitude," "You should resign," and so forth. The nurse explained that it was difficult for the duration of the I.V. to be exact, and made various efforts to please him, but felt that

his complaints were inappropriate. A Nurse Conference was held, and a veteran nurse took over the patient's care. Taking into consideration both the convenience of the patient's family during visiting hours and the effect of that patient's behavior on other patients, the patient was encouraged to transfer to another hospital; however, he did not request that option. The patient behaved appropriately in front of the attending physician. His wife had to work, and she did not visit often. As his discharge date approached, the patient calmed down; at the time of his release he smiled and apologized for his childish behavior. However, the experience left a bad aftertaste for the nurse.

With respect to this case study, the participants identified the following points as judgments and actions relating to rights and responsibilities:

- Were the patient's words and actions a result of his illness? Or were they inappropriate?
- The patient's abusive statements to the nurse, including "You should resign," felt to her like a denial of her personhood.
- Patients tend to lash out more often at nurses than at doctors.
- Nurses have a responsibility to accept a patient's feelings and to advocate for the patient. This is not the same as accommodating every whim of the patient.
- The healthcare team did everything possible to handle the situation.
- Did advocacy for the patient occur? What does it mean to advocate for a patient?
- The nurse was provided with mental care.
- When a patient is physically or psychologically abusive, or is unmanageable, it may be necessary not only for the medical team, but for managers or the organization itself to get involved.

With regard to the respective rights and responsibilities of patients and healthcare professionals, the participants summarized their abstractions as follows, based on the judgments and actions involved in the case study. Furthermore, the opinion was expressed, in the course of discussion, that because "patients" are not just the individual patients but include their families and other patients, they ought to be referred to as the "patient side," while "healthcare professionals" are not just individual healthcare professionals but include their teams and facility managers, and therefore ought to be referred to as "the healthcare professional side."

Rights of those on the patient side

First of all, patients have the right to receive sufficient explanations regarding their treatment options, as well as the right to choose, agree to, or reject courses of treatment. Additionally, patients have the right to express their emotions. They also have the right not to be exposed to harm or to be disadvantaged, and they have a right to receive fair medical care. In sum, patients have a right to receive a fair share of the most suitable healthcare.

Responsibilities of those on the healthcare professional side

In responding to the rights of patients, healthcare professionals have a responsibility to provide sufficient explanations to patients, including their families, and to accept their emotions. Sometimes, appropriate acceptance of a patient's emotions may mean shrugging them off. Also, whether a healthcare professional is trusted is up to the patient, but the professional ought to make efforts to act in a way that leads to gaining the patient's trust. Moreover, whether in dealing with a patient's problematic behavior or in providing fair and equal medical care, it is necessary to have and communicate the consensus of the healthcare team and the structural maintenance team of the healthcare facility. In sum, healthcare professionals have a responsi-

bility to provide fair and equal access to the most suitable medical care.

Responsibilities of those on the patient side

First of all, patients have a responsibility to cooperate with the treatment options that they have understood and agreed to after the sufficient explanations they received. However, some patients are unable to fulfill their responsibilities. They are also responsible for obeying the rules of their healthcare facility. For example, the prioritization of emergency or critical patients is a rule that benefits patients generally, and patients ought to understand and accept it as such. Another responsibility might be for the patient's family to cooperate as much as possible when it comes to consenting to and paying for treatment, as well as visiting the patient. Patients are responsible for not harming or disadvantaging other patients. There is also an expectation that patients display responsibility, manners and commonsense "as human beings," for example, by respecting healthcare practitioners as fellow humans or being moderate in their demands. Additionally, participants debated whether patients were responsible for developing a trusting relationship with healthcare professionals. The opinion was expressed that healthcare professionals do not expect that of patients and another that likewise, patients do not explicitly have such an attitude. Nevertheless, the group concluded that patients had a responsibility at least to try to develop a trusting relationship with healthcare providers. It was also confirmed that certain responsibilities fall less into the category of firm legal responsibilities like contracts, and are more gentle moral responsibilities, such as manners that avoid inconveniencing others.

Rights of those on the healthcare professional side

One participant expressed the opinion that when those on the patient side are clearly violating their responsibilities, it is acceptable for those on the healthcare professional side to reproach them. However, another participant countered that healthcare professionals hesitate to reproach patients, and that even if they were to reproach one, it was still their responsibility to deal with them as generously as possible. It was agreed that healthcare professionals have a right to be respected as human beings. One person expressed the opinion that healthcare professionals, as workers, have a right to work under suitable working conditions.

3.2 The Second NSD

There were seven participants in the second group, including a social activist, an ethicist, two individuals from the mass media, a physician, a nurse, and a healthcare manager. The researchers involved were one facilitator (A.K.) and one scribe (A.A.). In response to the same question asked of the first group, nine case studies were presented by the participants, who chose the following case study from the perspective of exploring how patient rights are secured.

Case Study 2: A patient who had difficulty switching attending physicians

Contributor of Case Study: A healthcare manager

Summary: The patient was an elderly male who lived with his older sister. He was receiving regular outpatient treatment to control symptoms of terminal hepatic cancer. The patient was hard of hearing, and depended on his older sister to speak for him. While discussing the patient's condition, Dr. A, his attending physician, had frightened the sister by telling her, "It's useless to explain any more. It's only a matter of time before his liver ruptures and kills him." One day, during an emergency trip to the same hospital, the patient was seen by Dr. B. The latter's attitude during the examination was polite, his explanations were easy to understand, and he also suggested a nursing care consultation. The sister met

with the contributor of this case study as a result of Dr. B's suggestion, and was able to undertake a number of treatment options through the patient's nursing care insurance. The sister preferred Dr. B over Dr. A, but Dr. B was not only enormously popular but also overworked. The sister, deferring to Dr. A, was unable to express her desire to switch to Dr. B, and continued to visit Dr. A while sometimes seeing Dr. B when he was on emergency duty. Dr. B was distressed by this, and Dr. A also stopped the sister from seeing Dr. B, telling her, "I'm going to oversee the patient's care until the end." Desiring to switch to Dr. B, the sister consulted with the healthcare manager. The head outpatient nurse also sided with the sister. The patient, his sister, and the healthcare manager discussed the matter with Dr. B, and Dr. B informed Dr. A that he too would treat the patient. (Dr. B was Dr. A's senior.) The relationship between the sister and Dr. A worsened, but eventually Dr. A retired and the patient died with Dr. B at his bedside. It was an end the sister could accept.

In relation to the patient's right to switch doctors in the context of this case study, the following points were raised regarding the judgments and actions relating to the patient's and healthcare professionals' rights and responsibilities, and the reasons underlying those judgments and actions.

1. The patient (family) wanted to switch doctors.
 - The reason was dissatisfaction with Dr. A.
 - The conditions by which a patient judges a doctor or hospital to be satisfactory include the examination and facility, the diagnosis, supportive explanations, manner of interaction, and support of families and daily lives. These are what reassure a patient, and cause them to trust and feel satisfied with the doctor or hospital.
2. The patient (family) felt that it would be difficult to switch doctors.
 - The reason was an inadequate system and consideration for human relations.
 - The factors for those on the patient side included a sense of responsibility and morality regarding the belief that they should trust the doctor as a professional, and to submit to his treatment; deferring to the doctor; inadequate recognition of rights; and their inability to express comfortably their desire to switch attending physicians.
 - The factors for those on the healthcare professional side included having a sense of one's discretionary powers and responsibilities as a professional, but failing to develop avenues for either coordination or criticism among doctors; and often not giving consideration to support of patients' daily lives. Doctors should delegate responsibilities for support of daily life to other types of staff.
 - Systemic factors included a lack of clear rules about a patient's right to choose, e.g., as part of a medical services contract in the context of a long-term attending-doctor-care system; lack of systems for securing the patient's right to switch attending doctors within the hospital, or improving and standardizing the quality of doctors, lack of measures by which doctors are screened, and the lack of a healthcare remuneration system that coordinates healthcare and support of patients' daily lives.
3. The healthcare manager and other staff members helped the patient switch doctors within the constraints placed on the healthcare environment.
 - The factors included their judgment that there was no means to correct the difference in doctor quality; that the fact that the patient's condition was terminal was creating additional stress; and that because the family was dedicated, they should respond to

the reasonable requests of those on the patient side. (What constitutes an appropriate request, and how should one respond to such?)

4. The patient was able to switch doctors.

- The factors included the fact that there were staff members who could be consulted; and that because those on the patient side were dedicated, the staff responded in kind by taking action.

Based on the judgments, actions, and reasons involved in this case study, the participants examined what can be viewed as appropriate rights and responsibilities for patients and healthcare professions when it comes to doctor-switching rights of those on the patient side. The answer of the participants was as follows. In this discussion as well, the terms “those on the patient side” and “those on the healthcare professional side” are used.

Rights of those on the patient side

Selecting a doctor is a right, since it fulfills healthcare needs and preserves welfare as well as representing the pursuit of healthcare that is reassuring, trustworthy, and provides satisfaction. However, there is a risk of doctor shopping and other unproductive selections of doctors.

Responsibilities of those on the healthcare professional side

Healthcare professionals are responsible for making efforts worthy of gaining the trust of those on the patient side. However, they are not responsible for responding to the wishes of those on the patient side to such an extent that individual doctors exceed their primary care abilities or work hours. Rather than depend on the devotion of individual healthcare professionals, there should be systemic maintenance that allows responsiveness to appropriate patient requests. When the hospital assigns patients to doctors, it should balance its responsibilities both towards individual patients and to its healthcare system overall.

Responsibilities and morals of those on the patient side

First, it is necessary for patients to communicate with the healthcare professional side. They should politely convey their wishes, seek out explanations, and express appreciation. There might be a need for patients to attempt to become “likable” patients, and not simply to seek out trustworthy healthcare professionals or choose them in a one-sided manner. Additionally, as members of society, it is necessary for patients to give general consideration to healthcare overall. In view of the overall healthcare system, there are limits to the doctor-selection rights of individual patients. Patients are therefore expected to make efforts to possess knowledge about the healthcare system, think about the social effect of their actions, and use limited healthcare resources appropriately.

The system

Even when a request seems legitimate to the patient, environmental conditions could be such that it may not be possible to act on the request. Therefore, it is necessary to devise a system for actualizing legitimate requests, taking into consideration the limited nature of healthcare resources.

Rights of those on the healthcare professional side

Although there was no explicit discussion of the rights of those on the healthcare professional side, they might have the right to discretionary powers and respect in their capacity as professionals, and the right to decline impossible requests from those on the patient side. Also, as in Case Study 1, they might have the right, as workers, to work appropriate work hours and be assigned

appropriate workloads, and their managers probably have the responsibility to maintain such work environments.

Other

The participants were unable to discuss sufficiently, either the excessive requests and moral hazards of those on the patient side, or approaches to handling them. However, the opinion was expressed that although at times individual patients undeniably make inappropriate requests, those on the healthcare professional side are expected to respond first from the perspective that there might be a legitimate reason for the request. It was also pointed out that while those on the patient side lack an understanding of the healthcare insurance system, it is a challenge to understand the system in the context of a market society. The opinion was expressed that although the current healthcare system is not responding to the phenomenon of night-time emergency “convenience-store consultations,” there may well be a demand for healthcare to respond to the 24-hour-a-day social structure. Just as patients have become aware of their rights, the public’s thoughts are changing with regard to what the healthcare system ought to be like, and questions are arising as to the kind of system needed to respond to these new ideas.

3.3 The Evaluation of the NSDs

At the end of the meetings, the participants were asked to fulfill an evaluation sheet on their experience of the NSDs. (N=11. 4 in the first NSD and 7 in the second NSD.) Evaluation in the two NSDs showed a similar tendency. (See <Figure>.) The average of overall evaluation was “good.” The respondents strongly agreed with “the participants listened to my opinion and made efforts to understand it” and “the NSD was helpful to see the viewpoints of the participants.” On the other hand, they were uncertain whether “all participants had a discussion on an equal footing” and “the NSD helped develop my communication skill.”

They pointed out the advantages and aspects that the NSD should hold: participants with different background could understand the circumstances of an issue on a case study, clarify different opinions and the main points of the issue, gradually share basic concepts, and find a consensus; the NSD is a valuable method.

At the same time, a response was made that “although the aim of the project is significant, big hurdles seem to exist to realize it.” Following points were indicated as the weaknesses and aspects to be improved.

Question

“Principles” and “values” would not be easy to approach for ordinary people. A view was expressed that the question on rights and responsibilities of patients and medical professionals was inappropriate because it would be just enough that patients expressed their gratitude as persons and medical professionals parried patients’ impossible demands. An objection to it was also raised because some patients made too much demands but neglected their responsibilities these days.

Case studies

To select a case study that conformed to reality would be important. Still full elements in a case study would not always be drawn out. A case study might not provide wide and comprehensive coverage of an issue.

Participants

Despite the limited number of participants, people with more diverse backgrounds and of different ages should have been recruited to enrich background experience and knowledge in a

dialogue. A discussion depended on the communication skills of participants. Some participants tended to speak up more than the others.

Finding an answer and a consensus

To find principles on a case study was difficult. The order of priority of principles was not clarified. It would be better to make clear which is more important an arrival at a conclusion or the process of reaching it.

Time

One responded that the time was a bit too long, and others responded that it was a bit too short.

Facilitation

The facilitator should have intervened more to get the point and to specify objectives. Researchers would be better working out a joint facilitation.

Problem solving

Skill to find a consensus for a goal was required in various occasions. The result of the NSD was not necessarily applicable for solving social issues. More or another discussion would be necessary for improving the point at issue.

4 Discussion

The rights and responsibilities of those on the patient side and those on the healthcare professional side, as extrapolated by the two NSDs, are gathered in <Table>. The table demonstrates that patients seek the most suitable healthcare that they can accept and find satisfaction in. "Trust" appears to be a keyword in that context. In healthcare, patients are usually the weaker party and have no choice but to trust healthcare professionals without equal reciprocation, and therefore a responsibility probably emerges for those on the healthcare professional side to respond to that trust. It is impossible for the opposite to occur. However, whether or not they trust their healthcare professional is up to those on the patient side, and as consumers, the patient side is invested with the power to choose its healthcare professionals. It is the responsibility of the healthcare professional side to make efforts to act so as to gain trust. At the same time, those on the patient side also have a responsibility to make efforts to build a trusting relationship. This is not only a human-relations responsibility that precedes the healthcare relationship, but a responsibility for the patient herself or himself to make efforts to build partnership while respecting the healthcare profession.

The patient's capacity to carry out responsibilities was not sufficiently articulated at the first NSD. In many cases, patients are unable to cooperate with their treatment because they either are incompetent or psychologically vulnerable. In such cases, they are not violating their responsibilities, but rather should be excused from them. Instead of reproaching such patients, healthcare professionals should protect and support them. Although the extent to which patients shoulder their responsibilities may depend on the extent of their ability to do so, it is difficult to discern that extent. For that reason, healthcare professionals are generally unlikely to reproach patients. However, in some cases, they release uncooperative patients from the hospital. There was insufficient discussion regarding the responsibility of those on the healthcare professional side in the event of patients violating responsibilities, or possibly abandoning their right to receive healthcare. In such cases it may be that those on the healthcare side are released from their responsibility to provide treatment. This point requires further investigation.

When it came to the responsibilities and violations thereof on the patient side, a difference in outlook was revealed in the first group between the participants on the patient side (the bioethicist and those involved in the mass media) and those on the healthcare professional side (the doctor and the nurse). Those on the healthcare side took patient responsibilities for granted, but felt that they could not reproach patients. Those on the patient side, even if they were fulfilling their responsibilities, had only a vague sense that those were indeed “responsibilities.” Yet, when it came to patient violations of responsibilities, they took it for granted that they ought to be admonished. The attitude of those on the healthcare professional side, who interact daily with patients, is likely a realistic one. However, it would appear that, by recognizing the difference in outlook between their two sides, they had each deepened their understanding of the responsibilities of those on the patient side and the authority of those on the healthcare professional side.

With respect to the responsibilities of those on the patient side, they can be conceived as those that secure the rights of those on the patient side, including the patient and others, and those that maintain the authority of the healthcare profession. At the same time, the responsibilities of those on the healthcare professional side can also be conceived as those that secure the rights of those on the patient side, and those that suitably wield the authority of those on the healthcare side. That is, the rights of the patient side and the authority of the healthcare professional side respectively are likely to be the basis of the responsibilities of the both sides. If that is indeed so, then the rights of those on the patient side and the authority of those on the healthcare side are concurrent, and thus it is no surprise that the relationship between them has been problematic. What is the basis of the authority of the healthcare side? Who or what gives it to them? The rights of the patient side have been discussed, as well as the responsibilities of both the healthcare and patient sides that respond to those patient rights. In contrast, the rights and authority of healthcare professionals were not discussed very much. Now that the rights of those on the patient side are being emphasized, perhaps it has become difficult either to mention the rights and authority of those on the healthcare side, or to be aware of them. It would seem that a balanced awareness of each side’s rights and responsibilities is needed.

The rights of those on the patient side are constrained by the limited nature of healthcare resources. But it would seem to be the mutual responsibility of both sides to take the limited resources into consideration, and within those limits, to devise a system that can actualize patient rights and improved healthcare. Several concrete systems were proposed during the NSD sessions that would implement the rights of patients. However, the case studies this time did not allow for discussion of the macro-distribution of resources.

Moreover, the basis of the rights of those on the patient side may be their rights as human beings, which means they also have responsibilities. Although there is a philosophical significance to investigating further the nature and basis of human rights and responsibilities, regrettably it was not possible to take up such issues in this dialogue, which examined healthcare rights and responsibilities.

The method of the NSD cannot be fully evaluated, because of the small number of the meetings and the participants. The evaluation would also differ within some range by different facilitators and variations in facilitation. Nevertheless, the advantages of the NSD are indicated by the participants. In the NSD, all participants can take part in deliberation. In particular, a case study that is contributed and chosen by participants seems to make possible for participants with different backgrounds to discuss concretely a problematic situation and to understand it well. It promotes more active participation and interaction than a general topic. At the same time, to try to answer a general question would encourage participants to clarify major issues and different opinions, to find basic concepts, and to reach a consensus. It is a distinct feature of the NSD while in a clinical ethics conference a specific decision making or a solution is often required among the people concerned in a relatively short time.

Steinkamp and Gordijn analyze and compare four methods of ethical case deliberation: Clinical Pragmatism, the Nijmegen Method, the Hermeneutic method, and Socratic Dialogue ⁽²³⁾. They conclude that a method should be chosen depending on a type of moral problems. They include such aspects as occasions (i.e., moral conflicts, decision making, moral uneasiness, or conceptual uncertainty), perspectives (i.e., prospective and retrospective), and aims (i.e., consensus, justified decision, comprehension, or clarification of basic concepts and principles.) In their assessment, “a strong point of NSD is its being philosophically reflective beyond mere problem solving, allowing to produce insight into conceptual questions more than the other methods,” while the insight stays into contact with reality. As the method requires much time and abstraction, however, it is apt “for conceptual deliberation inside an ethics committee or philosophical dialogue in educational endeavours.” “[I]ssues of organizational philosophy can be deliberated upon as well with this method, e.g., by the board of directors or other sectors of the management.” Based on this assessment, NSD is also suitable for our project that intends people representing various backgrounds to clarify together principles, values and philosophy in today’s medicine.

Birnbacher suggests that NSD “is highly successful in both cognitive and non-cognitive respects,” because participation in a NSD “is a particularly satisfactory experience of an equilibrium of rationality and matter-of-factness on the one hand and of warmth, acceptance and openness on the other hand” ⁽²⁴⁾. Moreover, NSD is “democratic deliberation,” having an original idea that truth is reserved to everyone ⁽²³⁾. As a model of an “egalitarian and rational exchange of arguments,” it can offer an antidote to hierarchical structures of domination in interaction and communication in the medical sphere ⁽²⁴⁾. The positive feedback by the participants in our NSDs in general illustrates these features.

The method imposed certain limitations. First, the question, “healthcare rights and responsibilities,” might have resulted in forced conversation about matters that are not easily framed in terms of those words, or in overlooking other issues. Also, there was bias among the few case studies discussed, and that might have resulted in insufficient exploration of answers to the question. Moreover, the discussion might have been biased and insufficient due to limitations in the number of participants and the diversity of their positions, their ability, the time allotted, or the technical skills of the facilitator. Additionally, we ought to think in the future about measures for putting this study to use for problem solving at healthcare sites.

If the question were reworded in terms of the “trust” and “fairness” also discussed in these sessions, new viewpoints might emerge. The case studies should be selected based on their reflection of the question and of reality, and moreover, they should easily generate dialogue. The bias of case studies can be overcome to some extent by confirming matters that could not be sufficiently clarified during discussion, or by discussing the same question using multiple case studies, as we have done. The limitations of the participants can be addressed by maintaining their diversity over the course of multiple dialogues. Also, goals need to be established for the participants’ dual tasks to uncover answers and deepen their mutual understanding, and there needs to be a balance between those tasks and the screening of participants. The NSD is a method for participants to arrive at a consensus formed through long equal discussion; however, this method cannot be completely actualized in a limited timeframe. The facilitation needs to take all of these constraints into consideration.

5 Conclusion

The objective of this study was for diverse participants to seek out answers and come to a consensus about healthcare rights and responsibilities and associated principles and values. The discussion sessions responded to current healthcare issues, such as mistrust of healthcare, the

collapse of healthcare, convenience-store consultations, and monster patients, by exploring them from the perspective of patient responsibilities and a system that secures patient rights. “To receive and provide fair shares of the most suitable healthcare” would be the rights and authority of those of the patient side and those of the healthcare professional side. The both sides would be responsible for it.

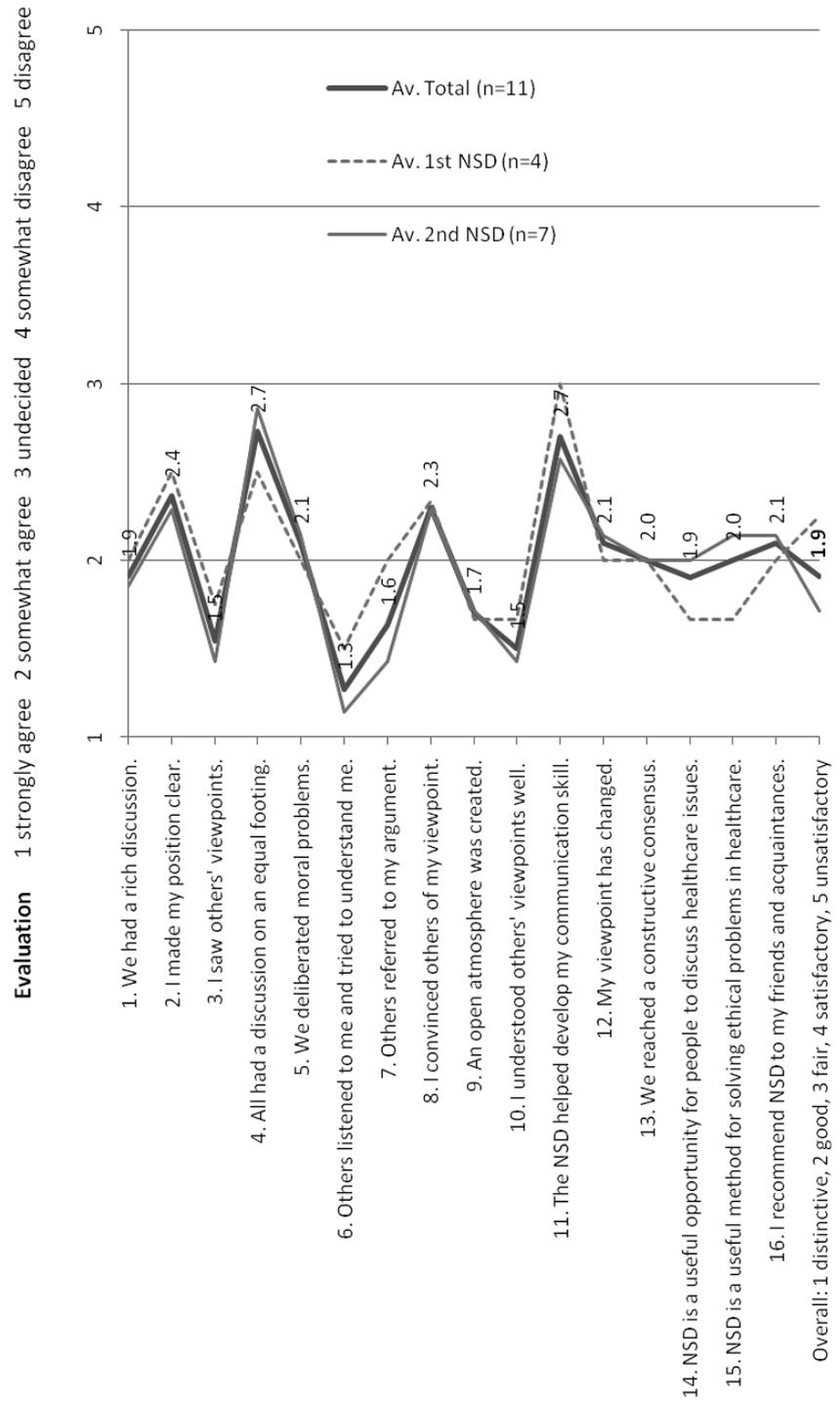
The case-study based discussions, while insufficient, generated somewhat generalized outlooks regarding the various issues. The use of a philosophical method of dialogue, called the NSD, based on an examination of case studies, made possible the resulting mutual understanding and consensus formation. Although the NSD has various limitations, repeating such dialogues should enable us to clarify the issues, facilitate mutual understanding and consensus formation, and uncover issues that require resolution.

Acknowledgment

This research is supported by “A Research Project to Develop Patient-Healthcare Professionals Relationship for ‘Health Care Thinking Together’,” Head Investigator: BITO Seiji, Basic Research (A) #20249035, Grant-in-Aid for Scientific Research, 2008-2012, MEXT, Japan.

We are deeply grateful for the research participants and their recruiters.

<Figure> The evaluation of the NSDs



<Table> The rights and responsibilities of the patient side and the healthcare professional side

Rights of those on the patient side	Responsibilities of those on the healthcare professional side
<p>(The basis of the responsibilities of the both sides.) To receive fair shares of the most suitable healthcare. • To receive sufficient explanations and understand them according to one's ability. • To choose, agree to, or reject treatment options. • To express emotions. • To receive support of families. • To receive support of daily lives. • To pursue trustworthy healthcare. • Not to be exposed to harm or to be disadvantaged. • To receive fair medical care. • To reproach the both sides with their violation of responsibilities.</p>	<p>(For the rights of the both sides.) • To provide sufficient and understandable explanations. • To get an agreement. • To accept their emotions. • To provide support of families. • To provide support of daily lives. • To protect and support vulnerable patients. • To make efforts to act worthy of gaining trust. • To share responsibilities with other types of staff. • To have the consensus of the healthcare team. • To have the structural maintenance team of the facility. • To devise and maintain a system taking limited resources into consideration. • Is the professional side released from their responsibility when patients violate their responsibilities?</p>
<p>Rights as human beings (The basis of human responsibilities.) (The basis of the rights of the patient side.) • To be respected as fellow humans. (What is the basis of rights as human beings?)</p>	<p>Responsibilities as fellow humans (For rights as human beings.) • To respect fellow humans.</p>
Responsibilities and morals of those on the patient side	Rights and authority of those on the healthcare professional side
<p>(For the rights of the both sides.) • To cooperate with the treatment options that they have understood, accepted and agreed to after sufficient explanations. • To obey the understandable rules of the facility. • The patient's family to cooperate. • Not to harm or disadvantage other patients. • To respect healthcare professionals. • To make efforts to communicate and build partnership with the healthcare professional side. • To give general consideration to healthcare overall. • To devise a system taking limited resources into consideration. * The extent to which patients shoulder their responsibilities depends on the extent of their ability. When they are incompetent, they are excused from their responsibilities.</p>	<p>(The basis of the responsibilities of the both sides.) To provide fair shares of the most suitable healthcare. • To be respected as professionals. • To reproach the both sides with their violation of responsibilities. * To discern patients' ability to shoulder their responsibilities is difficult. (What is the basis of the rights and authority of the healthcare professional side?) Workers' rights (and managers' responsibilities) • To work appropriate hours, workloads, and with a good mental condition.</p>
<p>Responsibilities and manners as fellow humans (For rights as human beings.) • To respect fellow humans.</p>	<p>Rights as human beings (The basis of human responsibilities.) • To be respected as fellow humans.</p>

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