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The Overlooked Dimension: Integrating Spirituality, Fate, and Free Will in Medical Decision-Making Models

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ABSTRACT

Medical decision-making frameworks have traditionally focused on rational, evidence-based approaches while neglecting the significant influence of spirituality, concepts of fate, and free will. This paper examines how spiritual beliefs and the notion of free will impact healthcare decisions and proposes an integrated model that acknowledges scientific, spiritual, and volitional dimensions.

This study employs a hermeneutic analysis of contemporary literature on medical decision-making, alongside evidence from studies on spirituality in healthcare and philosophical work on free will. Drawing on Masic's framework of medical decision-making, Zürcher et al.'s compatibilist approach to free will, and empirical studies of spirituality's impact on healthcare choices, the paper develops an expanded model that incorporates spiritual and volitional dimensions.

Evidence demonstrates that spirituality and the exercise of free will significantly influence medical decision-making across multiple contexts. Patients with greater spiritual well-being show less decisional conflict and uncertainty. Religious convictions directly affect treatment preferences, from life-sustaining interventions to end-of-life care. The concept of free will, understood in compatibilist terms following Frankfurt's hierarchical model, provides a theoretical framework for understanding how patients can make authentic decisions aligned with their deeper values even in constrained circumstances. Despite this evidence, mainstream medical decision-making models continue to exclude spiritual and volitional factors.

An integrated hermeneutic approach to medical decision-making one that acknowledges spiritual dimensions and the importance of free will alongside clinical evidence enhances patient care by addressing both physiological needs and deeper questions of meaning and authenticity. By recognizing spirituality and free will as central rather than peripheral factors, healthcare providers can create more holistic, patient-centered approaches that honor the full spectrum of human experience in medical contexts.

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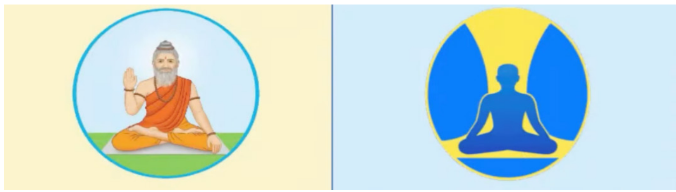


Introduction

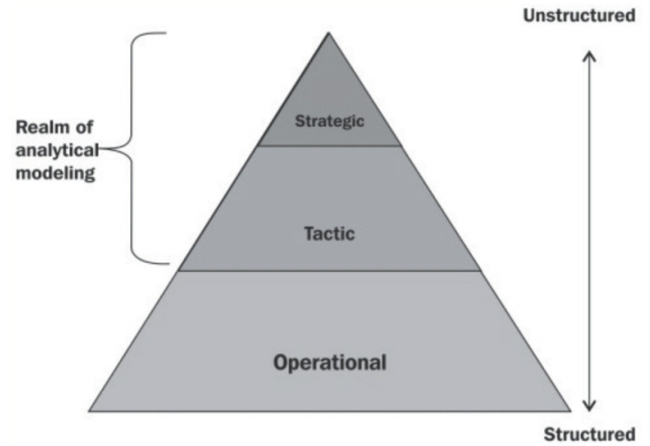
Medical decision-making represents one of the most consequential activities in healthcare, with implications that extend from individual patient outcomes to broader societal impacts. As Masic describes healthcare professionals "must make calculated decisions which have important consequences, impacting patients on the individual level, and communities and nations on a more global level" [1]. These decisions are made within complex constraints of limited information, resources, and knowledge, yet are expected to be highly accurate and effective.

Contemporary models of medical decision-making emphasize rational, evidence-based approaches, categorizing decisions as strategic, tactical, and operational/technical [1]. These models focus primarily on quantifiable factors: risk assessment, resource allocation, diagnostic accuracy, and expected outcomes. While valuable, such frameworks systematically overlook dimensions that profoundly influence how many patients and healthcare providers approach medical decisions: spirituality, concepts of fate, and the exercise of free will.

Informed consent, a cornerstone of ethical medical practice, presupposes decision-making capacity (DMC), which in turn raises fundamental questions about the nature of autonomy and free will. As Zürcher et al. note, "Informed consent is central to the legitimation of medical treatments" and "obtaining the patient's informed consent is not only a legal prerequisite... it is considered a moral duty because it reflects the healthcare professionals' respect for personal autonomy and the individual's right to self-determination" [2]. Yet the philosophical foundations of this autonomy particularly the concept of free will that underlies authentic decision-making remain underexplored in clinical contexts.

Recent research has increasingly recognized the importance of these previously neglected dimensions. A 2022 systematic analysis published in JAMA found that "for many patients, spirituality is important and influences key outcomes in illness, such as quality of life and medical care decisions" [3]. Similarly, a 2024 article in Health Affairs identifies spirituality as "a social determinant of health that is linked to human goods and is deeply valued by people and their communities" [4]. Despite this growing evidence, mainstream decision-making frameworks continue to marginalize these factors.

This paper argues that spirituality and free will are not merely peripheral considerations but fundamental dimensions of medical decision-making that deserve formal recognition within decision-making frameworks. Drawing on evidence from multiple studies and philosophical analyses, we demonstrate how spiritual beliefs and the exercise of free will shape healthcare decisions across contexts from routine care to end-of-life choices. We then propose an expanded model of medical decision-making that integrates spiritual and volitional dimensions with traditional evidence-based approaches, creating a more comprehensive framework that better reflects the lived reality of healthcare decision-making.



Three levels of decision making: strategic, tactic and operational (technical) from Masic (1)

Traditional Frameworks

Masic defines decision-making as "a choice between two or more options" made by a "decision maker" who selects "some specific action which is selected from several variables, or which satisfies the expectation that is previously set" [1]. This definition emphasizes the rational selection process weighing options, calculating risks, and choosing the optimal course of action based on expected outcomes.

Medical decisions operate across three levels according to Masic: strategic (broad policy decisions), tactical (implementation decisions), and operational/technical (specific clinical decisions) [1]. Each level involves different scopes, timeframes, and impacts, but all follow similar rational processes of gathering information, identifying options, assessing risks and benefits, and selecting the optimal course of action.

According to the scope of the theme	According to the kind of treatment	According to the times of events	According to the kind of the medical problem	Individual decision making
Disciplinary	Diagnostic decisions making	Decision making backward	Routine structured decision making	Individual decision making
Interdisciplinary	Prognostic decision making	Diagnostic decision making	Routine unstructured decision making	Double decision making
Inter scientific decision making problem	Therapeutic decision making	Decision making forward	Complex or weak structured decision making	Group decision making
		Prognostic decision making	Complex and structured decision making	

Type of medical decision making from Masic [1]

Masic identifies several types of medical decision-makers, including:

- Risk-takers ("gamblers"): Physicians willing to pursue higher-risk options when potential benefits are significant
- Detectives: Physicians who systematically analyze available evidence to reach diagnostic conclusions
- Artists: Clinicians who rely heavily on intuition and imagination in decision-making [1]

This taxonomy provides valuable insight into decision-making styles but does not account for how spiritual beliefs might influence these approaches.

Analysis	Monitoring
Argumentation	Suggesting
Diagnostic	Suggestion
Education	Representation
Identification	Prognosis
Interpretation	Projecting
Researching	Finding out
Categorization	Lighting
Communication	Self education
Conceptualizing	Advancing
Construction	Testing
Consultation	Management

The expert systems imitate a man in a field of knowledge and are capable for the various activities which belong to the consultative -advising activity from Masic [1]

Masic categorizes physicians based on their relationship to knowledge:
Those who know that they know
Those who know that they don't know
Those who don't know that they know
Those who don't know that they don't know

This framework acknowledges the critical role of metacognition in decision-making but does not explore how spirituality might influence a physician's understanding of knowledge limits or how patients' spiritual beliefs might affect their trust in medical knowledge.

The Missing Dimension

Traditional frameworks of medical decision-making, while sophisticated in their approach to rationality, evidence, and risk assessment, consistently overlook the roles of spirituality and free will. This omission creates significant gaps in understanding how decisions are actually made in clinical contexts where patients, families, and healthcare providers may all incorporate spiritual beliefs and existential concerns into their decision processes.

The concept of free will is intimately connected with DMC and informed consent. As Zürcher et al. argue, "free will is largely considered as a necessary condition for moral responsibility" [2]. Their analysis identifies a critical gap in the traditional understanding of DMC: while standard criteria include understanding, appreciation, reasoning, and communication, they fail to explicitly account for the exercise of free will that makes a decision authentically one's own.

The philosophical debate around free will has traditionally been polarized between compatibilism (the view that free will can exist even if determinism is true) and incompatibilism (the view that determinism precludes free will). For clinical applications, Zürcher et al. make a compelling case for adopting a compatibilist framework based on Frankfurt's hierarchical model of the will [2]. This approach understands free will as a harmony between first-order desires (what one wants to do) and second-order desires (what one wants to want), regardless of the causal history of those desires.

This compatibilist framework is particularly valuable for clinical contexts because it "does not make any metaphysical assumptions, i.e., it is irrelevant as to whether determinism is true or false" [2]. This practical neutrality allows clinicians to focus on what matters most: whether patients can identify with their desires and whether their decisions reflect their deeper values and life goals.

A 2024 study published in Frontiers in Psychology notes that compatibilism is increasingly supported by empirical evidence. Inarimori et al. found that "participants who correctly understood determinism had compatibilist intuitions," suggesting that incompatibilist views often stem from misunderstandings about the nature of determinism rather than genuine philosophical commitments [5]. This finding has important implications for how clinicians might approach discussions of autonomy and decision-making with patients.

Similarly, spirituality has been recognized as a crucial factor in healthcare decision-making that traditional frameworks fail to adequately address. A 2024 article in the Harvard Primary Care journal notes that "introducing spirituality in healthcare is a way to humanize an otherwise sterile and foreign experience within the context of a person's values and beliefs" [6]. This humanization is essential for meaningful patient participation in decision-making processes.

Recent research published by Harvard T.H. Chan School of Public Health has found that "spirituality should be incorporated into care for both serious illness and overall

health" [3]. Their systematic analysis revealed that spiritual community participation is associated with healthier lives, including greater longevity and less depression, while also significantly influencing medical care decisions. Despite this evidence, formal attention to spirituality remains peripheral in most healthcare settings and absent from dominant models of medical decision-making.

Spirituality and Treatment Preferences

Substantial evidence demonstrates that spiritual and religious beliefs directly influence treatment preferences across a range of contexts. Puchalski notes that "religious convictions may affect health care decision making. Jehovah's Witness patients rejecting blood transfusions is a classic example, but there are also beliefs around use of ventilators and feeding tubes" [7]. These are not isolated examples but represent systematic patterns of how spiritual beliefs shape medical choices.

Research has consistently shown that patients with stronger religious beliefs tend to favor more aggressive interventions at the end of life. As Torke et al. found, "several studies have found that patients who rate themselves higher on various dimensions of religious experience tend to favor more aggressive care at the end of life" [8]. This suggests that beliefs about divine intervention and the sanctity of life significantly influence how patients approach life-sustaining treatments.

My work on "Divine Presence in Healing" and "The Spiritual Space Between Nurse and Patient" explored how spiritual dimensions transforms the clinical encounter into a sacred space where healing can occur beyond the limitations of biomedical interventions [9,10]. The concept of the "therapeutic space" as a zone where spirituality and clinical care intersect provides a theoretical framework for understanding how patients incorporate spiritual beliefs into their medical decisions.

This perspective aligns with Vincensi's model of interconnectedness between spirituality, spiritual care, and patient-centered care, which identifies spirituality as an inner resource for health that "promotes hope, coping, and resilience during illness concerns; encouraging health promotion and maintenance; and improving patient outcomes" [11]. Vincensi emphasizes that individual spirituality develops through relationships with self, with the external environment and others, and with the Transcendent/God/Supreme Being all of which contribute to how patients make meaning of their illness experiences and treatment options.

Spirituality and Decision Quality

Beyond influencing specific treatment preferences, spirituality appears to affect the quality of the decision-making process itself. Research by Rego et al. demonstrates that "greater spiritual wellbeing was associated with less decisional conflict, decreased uncertainty, a feeling of being more informed and supported and greater satisfaction with one's decision" [12]. This indicates that spiritual well-being functions as a resource that helps patients navigate the complex and often emotionally challenging process of medical decision-making.

Evidence also suggests that incorporating spirituality into clinical practice leads to better treatment decisions. According to Kleinman's research, "a study on end-of-life outcomes showed that spiritual support from a patient's medical team resulted in greater hospice utilization, less aggressive interventions, and fewer ICU deaths" [6]. These findings indicate that spirituality not only influences patients' decisions but can lead to objectively different patterns of care when acknowledged by healthcare providers.

In my essay "The Crisis of Language in Therapeutic Spaces," I examined how conventional clinical discourse often failed to capture the spiritual dimensions of patients' experiences [14]. I argued that "patients experiencing profound spiritual crises, existential uncertainties, or trauma that defies articulation often struggle against the very linguistic frameworks intended to facilitate healing" [10]. This linguistic limitation can impede truly informed decision-making by restricting how patients conceptualize and communicate their experiences and preferences.

Vincensi further elaborates on this connection between spirituality and decision quality, noting that spiritual care occurs within interpersonal relationships when healthcare providers recognize and support patients' inner spiritual resources [11]. Her research identifies that "the ability to be more sensitive to others' spiritual care needs often increases when spiritual self-awareness develops within the advanced practice nurse and specialty nurse, promoting a holistic and mutual approach to patient care" [11]. This self-awareness enables healthcare providers to better facilitate decision-making processes that honor patients' spiritual dimensions.

Authentic Decision-Making

The exercise of free will in medical contexts is complicated by various constraints both external (institutional, social, financial) and internal (fear, pain, depression). Zürcher et al.

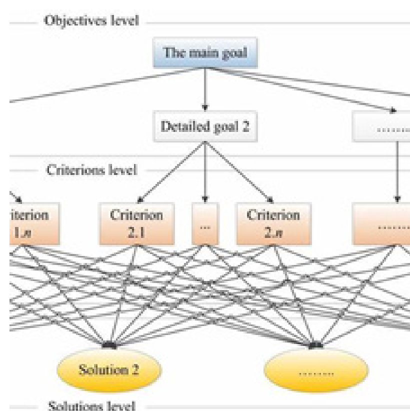
distinguish between these types of constraints, noting that while external constraints primarily affect freedom of action, internal constraints can directly impair freedom of will [2].

Their analysis introduces Frankfurt's hierarchical model of the will as a framework for understanding authentic decision-making. According to this model, a decision reflects free will when "what we want is what we want to want" [2] that is, when our immediate desires align with our higher-order values and self-conception. This model helps explain why patients with the same condition might make radically different but equally autonomous decisions based on their differing values and self-understanding.

Consider a patient with a phobia of general anesthesia who must undergo surgery. If the patient reflexively refuses surgery due to fear, despite wanting at a deeper level to overcome this fear and receive treatment, their decision lacks the harmony that characterizes free will in Frankfurt's model. As Zürcher et al. explain, "The only way to clarify whether the rejection of any surgical procedure is a direct consequence of the phobia is to consider the system of desires, especially on the second-order level" [2].

Recent neuroscientific research provides additional support for this framework. A 2023 study published in Scientific American found that meaningful choices are processed differently in the brain than arbitrary ones. As Buccella and Dominik report, "Meaningless choices were preceded by a readiness potential, just as in previous experiments. Meaningful choices were not, however" [14]. This suggests that when we care deeply about a decision and its outcome as most patients do about medical decisions our brain engages different mechanisms than when making insignificant choices, potentially involving more reflective, higher-order cognitive processes.

This analytical framework enriches our understanding of DMC by emphasizing that true appreciation involves not just understanding information but integrating it into one's self-conception and value system in a way that allows for authentic decision-making. A 2022 study published in Medicine, Health Care and Philosophy further supports this approach, arguing that "those aspects of oneself on which one draws to exercise one's autonomy are already operative in our everyday understanding" [15], highlighting the need to consider patients' pre-existing values and self-conceptions when assessing their decision-making capacity.



Hierarchical Models

Frankfurt's hierarchical model of the will provides a valuable framework for understanding how patients exercise free will in medical decisions. According to Zürcher et al., Frankfurt "proposed a theory that simply assumes us to be free when 'what we want is what we want to want'" [2]. This elegantly simple formulation captures the essence of autonomous decision-making: a harmony between immediate desires and deeper values.

In clinical contexts, this means that a patient has DMC not merely when they can understand and process information but when they can reflectively endorse their desires from a higher-order perspective. As Zürcher et al. explain, "Persons enjoy free will when they are able to evaluate their desires by withholding some of them and identifying one that seems the best choice 'overall'. Accordingly, with respect to DMC, these persons understand the relevant information and can appreciate what is at stake" [2].

This perspective enriches the traditional appreciation criterion of DMC, which requires patients to "apply the information abstractly to his or her own situation" [2]. True appreciation, in this expanded sense, involves not just recognizing factual implications but integrating them into one's self-conception and values system precisely what Frankfurt's model of reflective endorsement describes.

A hermeneutic approach to medical decision-making, as developed in the author's previous work, offers a framework for integrating spiritual and clinical dimensions [16]. This approach recognizes both medical evidence and patient encounters as texts requiring interpretation rather than merely facts to be calculated. By combining scientific rigor with interpretive wisdom, a hermeneutic approach creates space for spiritual dimensions without sacrificing clinical excellence.

This integration is particularly valuable when working with patients experiencing profound spiritual crises, existential uncertainties, or trauma that defies articulation through conventional clinical language [16]. In these contexts, purely rationalistic approaches to decision-making fail to capture the full complexity of the patient's experience and the factors influencing their medical choices.

Vincensi's research affirms the importance of this interpretive approach, noting that spiritual caregiving requires healthcare providers to develop spiritual self-awareness through "life experiences, education, and reflective practices which help to promote existential and spiritual well-being while elevating one's consciousness to a higher level" [11]. This elevation of consciousness enhances the provider's ability to recognize patients' spiritual needs and provide appropriate care. As Vincensi explains, "transcending to a higher level of consciousness occurs through self-connections and pattern recognition, allowing one to become more sensitive to others' spiritual care needs" [11].

Surrogate Decision-Making

When patients cannot make decisions themselves, spiritual factors become even more consequential for surrogate decision-makers. Maiko et al. note that "when faced with major life crises, many people use spirituality and religion (S/R) as coping strategies" and that these resources are "important coping strategies for surrogates of critically ill patients" [17]. Given that surrogate decision-makers are involved in 24-47% of medical decisions for hospitalized patients with life-threatening illnesses [17], the influence of spirituality on these decisions represents a significant factor in healthcare outcomes.

Family members making end-of-life decisions often frame these choices in explicitly spiritual terms. One study documented how a family initially refused to withdraw life support for an 88-year-old man dying of pancreatic cancer, stating that "their father was in God's hands and keeping him on support might make a miracle possible" [7]. After consultation with a chaplain, the family "saw that a peaceful death and their father's union with God could be the miracle" [7]. This example illustrates how spiritual frameworks fundamentally shape how families understand medical situations and the decisions before them.

Integrating Spiritual Care

Research consistently shows that patients want spiritual needs addressed in healthcare contexts. Balboni et al. found that "for many patients, spirituality is important and influences key outcomes in illness, such as quality of life and medical care decisions" [18]. Despite this evidence, formal attention to spirituality remains peripheral in most healthcare settings and absent from dominant models of medical decision-making.

Similarly, while free will is implicitly assumed in the concept of informed consent, explicit attention to volitional authenticity is rarely incorporated into clinical assessment or decision support. Zürcher et al. argue that "attention to free will, according to the compatibilist understanding defended in this paper, therefore helps to fill gaps that might arise in the application of the classical criteria for DMC, because the embedding of a wish into the higher-order desires...such as life plans or overall goals, are not sufficiently taken into account" [2].

The neglect of both spirituality and free will represents significant gaps between the lived reality of how medical decisions are made and the theoretical frameworks used to understand and guide these decisions. These gaps have real consequences for patient care, as they mean that healthcare providers may not adequately account for or address central factors in how patients approach medical choices.

Toward an Integrated Model

Masic describes decision-making as a "decision tree" with branches representing courses of action and leaves representing outcomes [1]. This metaphor can be expanded to include both spiritual considerations and the exercise of free will as integral factors in the branching structure. Rather than treating spirituality and volitional authenticity as external to the decision process, an integrated model would incorporate these factors at multiple points:

Assessment of the situation: Including spiritual and volitional dimensions alongside physiological and psychological ones

Identification of options: Considering spiritually acceptable choices and options that align with the patient's higher-order desires

Evaluation of outcomes: Assessing spiritual well-being and authentic satisfaction alongside physical outcomes

Implementation: Incorporating spiritual practices and supporting the patient's exercise of free will throughout treatment

This expanded decision tree acknowledges that spiritual considerations and the exercise of free will may influence every stage of the decision process, not merely serving as afterthoughts or personal preferences disconnected from the "real" medical decision.

Vincensi's model of interconnectedness between spirituality, spiritual care, and patient-centered care provides further support for this integrated approach [11]. Her research demonstrates that these three domains overlap significantly, particularly within interpersonal relationships and healthcare environments. As she notes, spirituality functions as "an inner resource for health, promoting hope, coping, and resilience during illness concerns; encouraging health promotion and maintenance; and improving patient outcomes" while spiritual care "supports this inner resource and is provided by others." Patient-centered care models, in turn, facilitate spiritual care "by supporting the inter-personal relationships as well as transdisciplinary collaborations" [11].

Sacred Spaces in Clinical Encounters

The concept of transforming clinical encounters into sacred spaces represents another dimension of an integrated approach to medical decision-making. As Rego et al. note, "spirituality is essential for coping with illness, yet determinants of the decision-making process are not completely understood" [12]. By conceptualizing clinical encounters as potentially sacred spaces, healthcare providers acknowledge that healing involves more than physiological interventions it requires recognition of the patient's whole being, including spiritual dimensions.

This approach aligns with research showing that "individualised; care that promotes engagement in decision-making and considers patients' spiritual needs is essential for promoting patient empowerment, autonomy and dignity" [12]. Rather than treating spirituality as separate from medical care, this integrated model sees spiritual well-being as intrinsically connected to overall health outcomes and the quality of medical decisions.

In my "A New Vision for the Physician-Patient Relationship" and "Sacred and Profane Space in the Therapeutic Encounter" [19,20] I proposed a model that "embodies and operationalizes an interdisciplinary approach to healing that transcends traditional biomedical paradigms" by creating therapeutic environments that honor the unity of mind, body, and spirit [10]. This conceptualization provides a practical framework for integrating spirituality into medical decision-making processes while maintaining clinical rigor.

Vincensi further develops this concept by identifying the interconnections between spiritual care and patient-centered care within healthcare systems [11]. Her research indicates that systems can either facilitate or hinder spiritual care by the degree to which they support "inter-personal relationships and transdisciplinary collaborations." As she notes, "a system in which care is provided is the environment in which spiritual care and patient-centered care transpire with transdisciplinary and collaborative relationships occurring" [11]. This insight highlights the importance of creating organizational environments that explicitly value and support spiritual dimensions of care.

Supporting Authentic Choice

Masic discusses collective responsibility the right of groups of doctors to work together for what's best for the patient [1]. An integrated model would expand this concept to include spiritual advisors and support for authentic decision-making as contributors to the decision-making process. Research indicates that spirituality and religion "promote healthy adaptation to significant life events" and serve as important coping strategies for patients and surrogate decision-makers alike [17].

By acknowledging the role of spiritual communities in supporting patients through medical decisions and by helping patients identify and express their authentic wishes, healthcare providers can leverage existing support systems rather than attempting to address all patient needs within the confines of clinical relationships. This expanded understanding of collective responsibility creates a more comprehensive support network for patients facing difficult medical choices.

Vincensi's research provides additional insights into how this collective responsibility might be structured. She notes that "patients often share spiritual concerns within this patient encounter because of this trusting relationship, providing an opportunity for advanced practice nurses and specialty nurses to contribute to patient-centered care through spiritual care within systems" [11]. This transdisciplinary approach acknowledges the need for multiple types of expertise when addressing patients' spiritual needs.

Vincensi further identifies specific spiritual care interventions that can support authentic decision-making, including "respecting patient individuality including values and beliefs; connecting and presence; finding meaning and purpose in life; appropriate touch; excellent communication skills; divine-related spiritual care (religion); reciprocal nurse-patient relationship; environmental support conducive to privacy and spiritual care; and referral" [11]. These interventions, when incorporated into patient-centered care models, can enhance patients' ability to make decisions that truly reflect their deeper values and identity.

Implications

An integrated approach to medical decision-making would expand assessment and evaluation processes to include spiritual dimensions and the exercise of free will. While Masic emphasizes the importance of evaluation in medical decision-making, his suggested evaluation questions focus primarily on systemic factors: population health status, economic resources, and healthcare model effectiveness [1].

Adding spirituality and free will as factors would expand this evaluation framework to include questions such as:
How do the patient's spiritual beliefs influence their perception of illness and healing?
What role does fate, or divine providence play in the patient's understanding of their condition?
How might spiritual resources support the patient's coping and recovery process?
Do the patient's expressed wishes align with their higher-order desires and fundamental values?
Are there "inner constraints" such as fear, pain, or depression that might be impeding the patient's ability to exercise free will?
Does the patient identify with their expressed wishes, or do they experience them as alien forces?
How do the healthcare provider's own spiritual beliefs and conception of free will influence their decision-making process?

These questions acknowledge spirituality and free will as central rather than peripheral factors in how patients understand and respond to medical situations. As Zürcher et al. note, "a will cannot be free when persons are compelled or manipulated in their wishes and opinions in a way that leads to a will that seems alien to her or him" [2]. Identifying such alienation is crucial for assessing authentic decision-making.

Recent research supports this integrated approach. A 2024 survey study published in BMC Palliative Care found that "religious affiliation correlates with daily decisions to various degrees" including medical decisions related to "diet," "alcohol consumption," "drug use," and "tobacco consumption" as well as "acceptance of medical recommendations" [21]. This confirms that spirituality and religious beliefs profoundly shape healthcare choices and should be systematically addressed in decision-making frameworks.

Similarly, a 2024 article in Frontiers in Medicine on physician autonomy in the face of AI support argues that "autonomy is purposeful" and must be understood in terms of its underlying values and goals [22]. This perspective resonates with Frankfurt's hierarchical model of the will, emphasizing that autonomy is meaningful not as an abstract notion of control but as an expression of one's deeper purposes and values. This insight applies equally to patient autonomy, suggesting that assessment of decision-making capacity should focus on alignment with patients' fundamental goals rather than merely on cognitive understanding or procedural reasoning.

Masic describes how when a "patient enters the system of healthcare protection, he makes with a doctor a special social agreement...according to which he leaves all of his/her own expectations regarding the healthcare and the diseases to the knowledge and the responsibility of a doctor" [1]. While this traditional model increasingly incorporates patient autonomy, it often still neglects spiritual dimensions and questions of volitional authenticity.

An integrated approach would reconceptualize the patient-physician relationship to include explicit attention to spiritual beliefs and resources, as well as support for authentic decision-making. This aligns with research showing that "introducing spirituality in healthcare is a way to humanize an otherwise sterile and foreign experience within the context of a person's values and beliefs" [6]. By acknowledging spiritual dimensions and supporting patients in identifying their authentic wishes, healthcare providers can create more genuine relationships with patients that honor the full spectrum of factors influencing medical decisions.

Recent bioethical research has increasingly recognized the complexity of patient autonomy in clinical contexts. A 2024 article in Voices in Bioethics notes that "medicine is intertwined with promotion of positive health while prioritizing a patient's diagnosis, prognosis, and treatment" and that "the practice of allowing patients to make their own medical decisions is called autonomy, and it is vital to biomedical ethics because it emphasizes the concerns of the patient" [23]. However, the article also acknowledges the limitations of informed consent, noting that patients may be "overly optimistic about the success of a treatment or procedure" or may "possess fear and anxiety, causing them to overestimate the effects of treatment" [23].

These insights resonate with Frankfurt's hierarchical model of the will, suggesting that true autonomy requires not just formal consent but alignment between immediate choices and deeper values. A 2024 article published by the University of Miami Institute for Bioethics further elaborates on this tension, noting that "one major dispute related to patient decision-making centers on the tension between autonomy and beneficence" [24]. This tension becomes particularly complex when spiritual values and beliefs are involved, as these may lead patients to make decisions that appear contrary to conventional medical judgment.

Addressing Uncertainty

Masic identifies uncertainty and ambiguity as the essential limitations of medical decision-making [1]. Both spirituality and a compatibilist understanding of free will offer unique approaches to navigating uncertainty that complement medical frameworks. By integrating spiritual wisdom and insights about volitional authenticity with modern science, healthcare providers can offer a more comprehensive approach to uncertainty that acknowledges both the scientific unknowns and the deeper questions of meaning and identity that arise in medical contexts.

Zürcher et al. highlight the importance of distinguishing between different types of constraints on decision-making. While external constraints affect freedom of action (what one can do), internal constraints can affect freedom of will (what one can authentically want). Their analysis of inner and outer constraints provides a valuable framework for understanding how patients might adapt their desires in response to illness without sacrificing authenticity: "Under normal circumstances, an outer constraint is an obstacle for freedom of action... However, the outer circumstances could very easily impact the will... This does not necessarily mean unfree will, but perhaps rather a reasonable adaption of the will to the present situation" [2].

This nuanced understanding helps clinicians distinguish between adaptive responses to illness (which may be authentic expressions of free will) and pathological responses that compromise autonomy. The integrated approach aligns with the Christian perspective that sets "boundaries for accepting choices/options when making decisions" with a particular focus on "lessening human suffering, augmenting wellbeing, and restoring life" [25]. By acknowledging how spiritual frameworks and reflective endorsement help patients make sense of uncertainty, healthcare providers can better support decision-making processes that align with patients' core values and beliefs.

Recent research provides additional insights into these dynamics. A 2024 article in UCSF Synapse entitled "The Ethics of Patient Autonomy: Where Do We Draw the Line?" argues that "patient autonomy is a fundamental principle in medical ethics, emphasizing the right of patients to make informed decisions about their own healthcare" but also notes that "the practical application of this principle often raises complex ethical questions" [26]. The article emphasizes that autonomy is not absolute but must be balanced with other ethical principles, particularly when patients may lack decision-making capacity due to internal constraints such as mental illness or overwhelming fear.

This balancing act becomes even more complex when spiritual and existential concerns are involved. A 2024 article in Medicine, Health Care and Philosophy examines how "phenomenology gives rise to certain ontological considerations that have far-reaching implications for standard conceptions of patient autonomy in medical ethics" [15]. The authors argue that a phenomenological approach reveals that "those aspects of oneself on which one draws to exercise one's autonomy are already operative in our everyday understanding" [15], suggesting that authentic decisions emerge from patients' pre-existing frameworks of meaning rather than from abstract rational deliberation.

Discussion

I attempt to claim in this paper that spirituality and free will are not merely peripheral considerations but central factors in how many patients, families, and healthcare providers approach medical decisions. Despite this evidence, dominant models of medical decision-making continue to exclude these dimensions, creating a significant gap between theory and practice.

This gap has real consequences for patient care. When healthcare providers fail to acknowledge or address spiritual factors and questions of volitional authenticity in decision-making, they may miss crucial information about what matters most to patients and families. This can lead to decisions that, while technically sound from a clinical perspective, fail to align with patients' deeper values and beliefs, potentially resulting in reduced satisfaction, increased conflict, and poorer outcomes.

The integrated model proposed in this paper offers a more comprehensive framework that acknowledges scientific, spiritual, and volitional dimensions of medical decision-making. By expanding traditional decision trees to include spiritual factors and considerations of free will, adopting a hermeneutic approach that honors both evidence and interpretation,

conceptualizing clinical encounters as potentially sacred spaces, and broadening collective responsibility to include spiritual communities, this model better reflects the complex reality of how medical decisions are actually made.

Frankfurt's hierarchical model of the will, as championed by Zürcher et al., offers a particularly valuable tool for understanding authentic decision-making. It allows clinicians to distinguish between cases where patients are truly exercising free will and cases where their decisions are compromised by inner constraints. As Zürcher et al. explain through the example of a patient with a phobia of general anesthesia: "The only way to clarify whether the rejection of any surgical procedure is a direct consequence of the phobia is to consider the system of desires, especially on the second-order level" [2]. By exploring patients' higher-order desires what they want to want clinicians can better support truly autonomous decision-making.

This integrated approach does not diminish the importance of clinical evidence or scientific rigor. Rather, it creates a more holistic framework that acknowledges all the factors physiological, psychological, social, spiritual, and volitional that influence medical decisions. By recognizing spirituality and free will as central rather than peripheral considerations, healthcare providers can make more informed decisions that better align with patients' values, priorities, and authentic selves.

Conclusion

Medical decision-making frameworks that exclude spiritual dimensions and considerations of free will fail to capture the full complexity of how patients, families, and healthcare providers approach healthcare choices. The evidence presented in this paper demonstrates that spirituality and authentic volition significantly influence medical decisions across contexts, from routine care to end-of-life choices, and for both patients and surrogate decision-makers.

An integrated hermeneutic approach to medical decision-making one that acknowledges spiritual dimensions and the importance of free will alongside clinical evidence enhances patient care by addressing both physiological needs and deeper questions of meaning and authenticity. By recognizing spirituality and free will as central rather than peripheral factors, healthcare providers can create more holistic, patient-centered approaches that honor the full spectrum of human experience in medical contexts.

Zürcher et al. conclude that "even though free will is not an additional criterion for DMC, the common understanding of the appreciation criterion shows gaps because certain types of lacking free decision-making that are the consequence of a non-harmonious will are not addressed clearly enough" [2]. Their analysis suggests that while the traditional criteria for DMC implicitly assume free will, making this assumption explicit and incorporating Frankfurt's hierarchical model would strengthen the assessment process and better ensure that patients' decisions authentically reflect their deeper values.

In my essays "Hermeneutic Approaches to Medicine" and "Evidence Distortion and Clinical Decision-Making" [16,27]. I proposed how integration of spirituality and scientific rigor challenges the "Cartesian dualism embedded in modern medicine" that can lead to "fragmentation in trauma care and misdiagnosis" [10]. By drawing on both kabbalistic concepts and contemporary neuroscience, I proposed a pathway to more authentic and effective in medical decision-making that honors both scientific evidence and spiritual dimensions.

Vincensi's research on the interconnections between spirituality, spiritual care, and patient-centered care further reinforces the need for an integrated approach [11]. Her model demonstrates how these three domains overlap and interact within interpersonal relationships and healthcare systems. As she notes, "organizational support is needed to develop environments which support the provision of spiritual care to patients as well as developing environments that sustain meaningful work for providers." This systemic approach acknowledges that effective integration requires not just individual practitioner skills but also organizational structures and cultures that value spiritual dimensions of care.

Future research should focus on developing and validating assessment tools that incorporate spiritual dimensions and considerations of free will in decision-making, exploring how these factors influence decision-making across different cultural contexts, and evaluating interventions designed to support integrated decision-making processes. By continuing to bridge the gap between scientific, spiritual, and philosophical approaches to healthcare, we can create more comprehensive models that better serve patients in their moments of greatest need.

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