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# Between Life Prolongation and Meaning Preservation: A Heideggerian–Gadamerian Perspective on Medical Futility

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## Abstract

In cases of medically futile care, clinical choices frequently turn into deeply complex ethical and existential dilemmas. Physicians and patients must navigate the difficult balance between extending life and maintaining its meaningful quality. Traditional shared decision-making (SDM) models primarily focus on evidence-based rationality but often fail to address the deeper ontological aspects of patients' lived realities. The present study employs interpretative phenomenological analysis (IPA) to explore the personal narratives and value systems of Ms. M and her three attending physicians. Guided by Heidegger's idea of being-in-the-world and Gadamer's concept of the fusion of horizons, we conducted an interpretative phenomenological analysis (IPA) based on extensive interviews with one terminal cervical cancer patient and her three treating physicians (experts in cardiology, cardiac surgery, and gynecologic oncology). These philosophical lenses informed both our analytical framework and the ethical evaluation of SDM practices when medical interventions offer no realistic benefit. The findings demonstrate that pursuing aggressive therapies despite clear medical futility cannot be dismissed as mere irrational behavior. Such decisions instead stem from fundamentally different value systems and understandings of time between patients and physicians. Even a clinically appropriate choice may fall short ethically if it disregards the patient's personal lived horizon. We introduce a hermeneutic approach to SDM that builds on the standard evidence-based model by incorporating three key elements: deep attunement to the patient's existential reality, genuine fusion of horizons between the patient and the physician, and acceptance of irreducible differences. This framework enables ethically robust decisions while respecting both clinical expertise and the patient's fundamental way of being-in-the-world.

**Keywords:** Medical futility, Shared decision-making, Hermeneutics, Interpretative phenomenological analysis, Fusion of horizons

## Introduction

When doctors determine that further curative efforts are medically futile, patients still cling to hopes for life-prolonging options. How should ethical clinical decisions weigh professional medical judgment against individual patient values? In early 2021, Ms. M, a woman in her late forties, was diagnosed with stage I cervical cancer at Hospital (A). Following three rounds of chemotherapy, her approximately eight-centimeter tumor showed no signs of shrinking. By October, the cancer had spread to her heart and left supraclavicular area. Hospital A judged additional aggressive treatment to be futile and suggested moving to palliative care. Unwilling to lose hope, Ms. M transferred her care to Hospital (B). In response to her strong desire to extend life, the medical team at Hospital B performed surgery to remove the tumor from her right ventricle and administered further chemotherapy (All personal and institutional identifiers have been removed). This situation reveals not only the practical difficulties in defining medical futility but also how deeply contrasting lifeworlds between physicians and patients hinder effective shared decision-making. Currently, there is no universal agreement on who holds ultimate responsibility for declaring medical futility. Certain scholars contend

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that these judgments should rest solely with physicians, relying on their professional knowledge and scientific evidence [1]. Yet this view may undermine the ethical obligation to honor patient autonomy. On the other hand, giving absolute priority to patients' values and wishes [2] might compromise the physician's duty to act beneficently as a moral professional [3]. Alternative viewpoints emphasize collaborative dialogue between physician and patient [4] or the establishment of clear, predefined treatment goals [5]. These differing positions highlight that medical futility decisions are rarely simple or one-sided but instead highly intricate [6, 7]. Although much existing research has emphasized normative models, there is still a significant gap in interpretive studies examining how such value conflicts actually play out in real-world clinical encounters. This paper applies interpretive phenomenology to examine the ethical foundations that enable shared decision-making to become a truly relational and interpretive process [8-10].

In clinical situations involving medical futility, the conflict between physician and patient frequently goes beyond simple differences in information. It arises instead from fundamentally divergent existential frameworks. Heidegger's [10] concept of being-in-the-world posits that human existence is always situated within specific, historically shaped contexts. Every individual lives in a unique lifeworld defined by temporality and thrownness. His account of temporality shows that patients' immediate decisions cannot be separated from their lived past and projected future. In this view, illness represents more than a biomedical event; it constitutes a profound existential disruption that alters the patient's entire way of being. Patients, therefore, should never be reduced to mere diagnostic labels or statistical prognoses.

The disagreement regarding whether Ms. M had reached a state of medical futility did not stem from conflicting clinical facts but from the markedly different existential horizons through which physicians and the patient understood her condition. This indicates that the ethical difficulty in determining futility is essentially ontological: physicians and patients do not automatically inhabit the same interpretive world; they operate within distinct horizons of meaning and concern.

In this setting, Gadamer's [8] idea of the fusion of horizons (Horizontverschmelzung) provides a valuable philosophical foundation for ethical engagement. According to Gadamer, true understanding does not result from simply exchanging information but emerges through genuine dialogue between differing viewpoints. Although complete convergence of values may be unattainable, meaningful mutual understanding can develop when both parties make a sincere effort to enter the other's lifeworld. This interpretive fusion transforms shared decision-making (SDM) from a mere procedural tool into a deeper ethical practice.

From this hermeneutic standpoint, assessments of medical futility should not rely exclusively on standardized clinical benchmarks. Instead, they should be viewed as continuous interpretive negotiations. To investigate this idea, the present study employs interpretative phenomenological analysis (IPA) to explore the personal narratives and value systems of Ms. M and her three attending physicians. Through in-depth interviews and careful textual examination, the study uncovered three central themes:

(1) Entering the horizon—the patient as a whole person being seen;

(2) Fusion of horizons—from the right decision to the good decision;

(3) Practicing shared decision-making—a hermeneutic framework.

These results shed light on the ethical challenges present in clinical communication and present a humanistically oriented framework for decision-making in modern medicine.

## Materials and Methods

To examine the ethical tensions created by clinical judgments in medically futile situations, we chose an interpretive methodology centered on lived experience rather than relying solely on abstract principle-based oppositions (such as physician versus patient or expertise versus autonomy). We reason that although treating illness requires objective scientific evaluation, the person receiving treatment is a subjective, embodied, feeling, and meaning-making individual. As Heidegger stressed, people exist in fundamentally different modes of being, which inevitably lead to varied responses and decisions.

We therefore utilized IPA, a qualitative approach grounded in phenomenological and hermeneutic philosophy and strongly influenced by the works of Heidegger and Gadamer. At its core, IPA investigates how people interpret and give meaning to major life experiences—such as illness, loss, or critical decision-making—within their specific lifeworld [10]. This method highlights context, personal experience, and the dynamic interpretive relationship between researcher and participant. We aimed to create a space for mutual understanding through semi-structured interviews conducted with both the patient and the physicians.

IPA employs a two-stage interpretive process:
In the first stage, our primary focus was on capturing how participants themselves understood and described their personal experiences, staying as true to their own stories as possible. We drew on Heidegger's idea of Dasein [11] — the characteristically human way of existing that is invariably embedded in a meaningful world (being-in-the-world). Heidegger's concept of Geworfenheit ("thrownness") captures the reality that Dasein is always already situated in factual circumstances beyond one's control, including physical condition, disease course, family obligations, social expectations, cultural background, religious beliefs, institutional rules, and limited resources. Thrownness represents a core ontological feature of "having to exist" within these given realities rather than a mere momentary event. In medical settings, both doctors and patients operate within this facticity: physicians must navigate established care paths, protocols, tight schedules, and resource constraints, while patients' choices are constrained by co-existing illnesses, economic realities, family responsibilities, and deeply held values. Effective SDM, therefore, begins by fully recognizing this thrown condition before addressing projection (Entwurf) — the possibilities that can still be pursued — and carefully weighing the ethical consequences involved. Consequently, a clinician's idea of the "right decision" may not align with the patient's sense of a "good decision," since the latter must feel sustainable within the patient's actual lived constraints.

Heidegger further reinterprets temporality by showing that human life unfolds not in neutral linear time but through an integrated temporal unity in which past experiences and future anticipations actively shape the present moment. For patients facing serious illness, current choices are never isolated reactions to the immediate situation; they are shaped by recollections of past hardship and incomplete life goals as they reach toward an expected future. This temporal dynamic adds profound existential depth to every clinical decision and demands that SDM account for this extended "already–toward" perspective.

Building on Aho's interpretation [2], we approached Dasein as an ongoing process of becoming rather than a fixed self, constantly influenced by illness, time, and relationships. Accordingly, we used semi-structured interviews to investigate how participants constructed meaning around their illness within the specific realities of their everyday lives [10]. As Conrad [6] maintains in his exploration of "illness as experienced," patients' personal understandings of their condition hold unique epistemic and ethical worth. Listening closely to this insider viewpoint reveals how illness profoundly alters a person's identity and life trajectory [11-15].

The second stage involved what Gadamer [8] describes as the "fusion of horizons," where we conducted a dialogical reading of the participants' accounts to uncover deeper values and existential significance. This phase highlighted the researcher's own standpoint and interpretive duty — how to respectfully engage with context, structure, and ethical layers without altering the participants' voices. We focused closely on the meanings expressed through language, as well as on subtle, often unstated existential elements essential to healing. This approach echoes Morgan's [16] notion of "alternative stories" in narrative therapy, which frequently remain hidden beneath the main illness narrative. Here, the purpose of interpretation is not to create full agreement on values but to discover pathways for mutual respect and ethical acknowledgment even when important differences persist.

*Supplement: operationalizing the double hermeneutic*

In practice, we implemented the double hermeneutic that lies at the core of IPA. Step 1 centered on the participants' own meaning-making: immediate post-interview memos were created, and transcripts were read repeatedly to notice specific language, metaphors, emotional tone, and meaningful silences. Step 2 consisted of the researcher's active interpretive layer: applying Gadamer's fusion of horizons as a methodical approach to perspective-taking, we moved back and forth between the patient's and the physician's viewpoints. We examined emerging ideas through repeated dialogical questioning. For example, we explored how a physician's choice could appear both reasonable and ethically responsible within certain institutional or risk-management settings, or how a patient's decision might serve as an effort to restore personal meaning within a different horizon. After each perspective shift, we returned to the original transcripts to verify phrasing, tone, and silences, remaining cautious against excessive interpretation. Areas of tension were treated as disconfirming evidence and helped refine the developing analysis. Themes took shape not through standard coding procedures but through ongoing hermeneutic dialogue, memo writing, and deliberate horizon-shifting.

Furthermore, the researcher's own background substantially influenced the interpretive work. The primary author is trained in philosophy, specializing in medical ethics, and has taught medical humanities and medical ethics in a medical school for more than ten years, with a sustained research interest in physician–patient dynamics. She has also conducted 14 direct observations in clinical settings and over 40 interviews with doctors and patients, which have sharpened her awareness of the ethical and existential dimensions of medical encounters. At the same time, she remained mindful that this philosophical lens could lead her to overemphasize the patient's existential viewpoint. For instance, when first reviewing Ms. M's description of Hospital A's decision not to operate, she initially viewed it as emotionally distant. Through systematic reflexive journaling, she actively worked to understand the situation from the physicians' perspective, considering how the refusal might be justified within professional standards and institutional realities. This deliberate horizon-shifting did not produce immediate methodological outcomes but became a key influence in forming the final themes. Continuous reflexive notes and repeated returns to the raw transcripts helped reduce the risk of imposing personal biases and allowed corrections of early assumptions when inconsistencies emerged. In this way, the researcher's positionality functioned as both a valuable asset and a constant methodological challenge, with the entire analysis maintained through openness and self-reflection.

### *Participants and data collection*

IPA places strong value on detailed, individual-level understanding and contextual interpretation, usually working with limited numbers of participants [10]. We therefore chose Ms. M's story as the central case for close examination. Her cervical cancer moved rapidly from stage I to terminal within just seven months. In that short time, she navigated two very different hospitals and contrasting styles of medical decision-making at Hospital A and Hospital B. Her account offers a powerful lens for understanding why some patients continue seeking active treatment even when medical experts consider it futile. It enriches our grasp of how patients think during shared decision-making processes.

The three physicians who cared for her at Hospital B — experts in cardiology, cardiac surgery, and gynecologic oncology — brought distinct professional viewpoints. From a strictly evidence-based standpoint, stopping aggressive therapy might seem clearly warranted, whereas continuing it raises more difficult ethical questions. The decision by these physicians to proceed with treatment, even while aware of its slim chances of success, reveals the wide range of ethical interpretations that "futility" can take on in everyday clinical work.

All interviews were formally approved by the institutional ethics committee (IRB). Every participant gave informed consent, including agreement to allow their anonymized information to be used in research and publications. The interviews were conducted in person and typically lasted 25-40 minutes. Because IPA demands rich exploration of lived experience, the questions were crafted to support open yet guided conversations. In total, eighteen questions were used — ten directed to the patient and eight to the physicians — covering topics such as decision-making processes, emotional experiences, personal values, and the communication of information. The full set of questions appears in an additional table.

Please note that any doctor–patient conversations reported in the Results & Discussion come from Ms. M's personal recollections shared during her interview, rather than word-for-word records of the original clinical discussions. This approach is consistent with a hermeneutic perspective, which treats participants' own ways of remembering and framing events as meaningful data.

## Results and Discussion

Because this study follows a hermeneutic approach, the analysis did not proceed in a straight line. Instead, it involved repeated cycles between the interview material, the researcher's own reflections, and relevant theoretical ideas. For this reason, we have combined the Results and Discussion sections. Each theme is supported by direct participant excerpts, followed by interpretive commentary and links to existing literature and philosophical concepts that help situate the findings within their clinical and ethical setting.

By closely studying the participants' words, personal stories, and described interactions, we distilled three central themes. These themes illuminate the deeper reasons and ethical logic that motivated both the patient and the physicians to keep pursuing treatment despite the medical determination of futility.

*Theme 1: Entering the horizon—the patient as a whole person being seen*

In shared decision-making, patients frequently yearn to be recognized as complete individuals — people whose full life stories, personal values, and unique existential realities are genuinely understood and valued [14]. This deeper form of "being seen" involves more than surface-level attention. As Gadamer [8] explains, real understanding happens as an event when one person willingly opens their own perspective to include the other's situated reality. When clinicians truly hear and respond to the existential plea within a patient's story, the care relationship itself becomes an expression of genuine concern. As Cassell [4] famously put it, "It is the person who suffers, not the body." Medicine must therefore respond not only to biological measurements but to the whole person experiencing distress.

During her interview, Ms. M mostly spoke with calm determination as she described her journey. Nevertheless, she cried on two separate occasions: first when remembering the physician's comments about treatment futility at Hospital A, and later when recalling the supportive behavior of a doctor at Hospital B right before her operation.

Let us return to Ms. M's own words to understand these emotional responses better. The first tearful moment occurred as she described her consultation at Hospital A, where the doctor judged further aggressive treatment pointless and advised moving to palliative care:

Ms. M remembered asking the physician, "Does this mean I don't even have the chance for surgery?"

She recalled his reply: "Yes, there is a chance. But if you undergo surgery, it would be in vain. I would not perform it unless something happened and you were brought to the emergency room."

As she relived this memory, her voice tightened, and she became visibly upset. She continued, "When he said that, I felt they were so cold. How could a doctor say something like this to a patient? … I felt as though they had given up on me! I… I wasn't untreatable. I was just harder to treat."

The tears that surfaced during this recollection show the lasting emotional damage of that encounter. Ms. M was not refusing to accept her prognosis. What wounded her most was the profound sense of abandonment — the feeling that she had been written off and removed from active care. As Kleinman [12] has observed, the narrow biomedical idea of disease cannot capture the wider social, cultural, and existential pain that illness brings. Doctors should avoid reducing a patient's illness experience to a mere disease category. Toombs similarly reminds us that the body is not just a physical object but the lived foundation of a person's world: "I am embodied not in the sense that I have a body — as I have an automobile, a house, or a pet — but in the sense that I exist or live my body." [17]. Patients want to be seen as full human beings living in particular circumstances, not simply as symptom carriers. Ultimately, medical practice should be understood as a profoundly ethical and relational encounter, not only a technical activity.

The second emotional moment relates to Ms. M's memories of working with the cardiologist after her transfer to Hospital B.

During the interview, Ms. M described: "His regular clinic time had finished, but he stayed behind in the room with me, waiting for my test results to come back… At last, I felt I had met a doctor who truly cared. He really looked out for me…".

Ms. M kept returning to this experience, stressing that these small acts of staying present held powerful symbolic weight for her. They showed that during serious illness, the simple feeling of "being cared for" and "stepping into the doctor's world" could mean far more than medical staff might expect. Fighting back tears, she then described what happened the night before her operation:

Ms. M remembered: "The night before the procedure, he came by my room in the ward. He said he wanted to pray for me. No one had ever done that for me before… I broke down crying once he left… He gave me real strength, because I was so frightened. I had never been through heart surgery; this was completely new to me."

What moved her most deeply was not the prayer, but the doctor's warm presence and kindness. It was a genuine way of standing with her that confirmed she mattered as a complete human being. In that instant, Ms. M felt fully recognized — not merely as a medical case, but in her worries, vulnerabilities, and desire for human connection. The physician's support reached beyond medical procedures and offered important emotional and existential comfort. This bond grew not from technical expertise, but from shared emotional understanding and mutual respect.

Her tears revealed something deeper than simple emotion: they expressed her core human longing—to be acknowledged and supported as a person who deserves care and companionship.

The study suggests that patients become more willing to trust and follow medical advice during shared decision-making when they sense the doctor honestly cares about their safety and overall welfare. When physicians offer steady emotional support and stand beside patients, it can greatly strengthen the patient's courage and optimism in unexpected ways [18]. The doctor at Hospital A focused primarily on managing risks while intending to protect the patient. In contrast, the team at Hospital B began from Ms. M's personal existential reality — placing priority on empathy and genuine connection [19-25].

As Charon [5] has observed, compassionate emotional care is the bedrock of trust in clinical relationships. Schneiderman and Jecker [26] remind us that while particular treatments can lose their usefulness, caring itself remains valuable. They stress that medicine involves far more than carrying out procedures — it centers on providing care, forming relationships, and acting with moral responsibility. This understanding prompts a more profound question: in clinical choices, should we aim for the right decision or the good decision?

### *Theme 2: Fusion of horizons—from the right decision to the good decision*

Following the patient's wish to be understood as a complete person, we maintain that once the physician truly enters the patient's perspective, an essential ethical step must occur: the fusion of horizons between doctor and patient. This process opens the door to truly joint clinical decisions. Here, the main ethical aim shifts toward making a good decision rather than settling for a merely right one.

Medical publications classify futile interventions in several ways — including physiologic, quantitative, and qualitative futility [21, 22] — yet these categories tend to reveal value clashes rather than resolve them. They especially fail to explain how different types of futility should be balanced. As Lemmens [13] and Müller and Kaiser [17] have noted, rigid adherence to universal rules often overlooks the importance of patients' personal histories and individual priorities.

This situation clearly demonstrates the issue. The very same patient labeled as a case of futile care at Hospital A later received heart surgery and continued treatment at Hospital B. The contrast cannot be accounted for by clinical data alone; it stems from different ethical outlooks and interpretive worlds. Hospital A made the right decision based on evidence-based risk assessment and statistical prognosis. Hospital B, however, responded directly to the patient's expressed hopes and values, working to craft a good decision from inside her personal lifeworld.

This difference raises a central question for medical decision-making: Should we pursue the right decision, defined by statistics, safety, and clinical standards, or the good decision, rooted in sensitive attention to the patient's inner world, relationships, and existential situation? In some instances, the two may overlap, but in others they can separate or even clash. As Pellegrino [18] writes:

"Each participant is a moral agent and as such is bound to uphold, and be accountable for, their own conception of what is right and good. Making morally defensible decisions in the face of substantive differences in conceptions of patient good has become, therefore, one of the urgent procedural problems in medical ethics."

Contemporary medical ethics has built upon this insight [27-30]. Sulmasy [30] maintains that sound clinical choices must rest on both scientific evidence and the patient's existential and relational reality. Pellegrino and Thomasma [19] suggest that true medical goodness combines technical accuracy, ethical suitability, and personal values. This outlook transforms medicine from a purely professional duty into a deeply ethical response to another person.

In our research, the three physicians at Hospital B demonstrated efforts to provide exactly this kind of ethical response through their fusion of horizons with the patient:

The cardiologist commented, "Even if this operation only helps her approach the end of life with dignity, I consider it meaningful," — showing concern for honoring the final chapter of life.

The cardiovascular surgeon stated: "I focused mainly on the medical details… If she accepts the surgical risks, what actual benefit will she receive from taking them?" — underlining the need for worthwhile gains in life quality.

The gynecologic oncologist noted: “If we can give a cancer patient three or six more months, that is valuable to us,” — stressing the deep importance of extra time.

Although these positions appear varied at first, they all reflect sincere ethical efforts to view treatment options from the patient’s own perspective. Each doctor moves beyond simply pursuing the right decision to imagining a genuinely good one. As Gadamer explains, understanding develops not by forcing agreement but by the broadening that happens when different horizons come together. Physicians retain their clinical knowledge but willingly enter the patient’s lived experience to engage with her hopes, fears, and quest for meaning.

Fusion of horizons does not require physicians to give up their expertise. Rather, it encourages them to expand their ethical outlook. Clinical choices should not be dictated only by numbers and risk charts; they must also respond to the patient’s moral and emotional reality. In this light, decision-making turns into a moral conversation rather than a purely technical task.

Gadamer [8] additionally challenges modern scientific thinking for cutting experience off from its historical roots, wrongly suggesting that standardized information can apply equally everywhere. Yet every patient exists as a unique Dasein — an individual with a personal story, specific background, and distinctive sense of time.

This perspective echoes the classical Greek understanding of medicine as a true art (techne). Plato [20] cautioned:

“You should not attempt to cure the eyes without the head, or the head without the body, nor the body without the soul.”

This comprehensive outlook feels especially relevant in our time, as advanced medical technologies can extend bodily life yet sometimes intensify existential distress. Callahan [3] warns of the risk of “a cruel kindness”—keeping someone alive while stripping away the meaning of their existence.

Therefore, labeling a treatment as “futile” should not be decided solely by clinicians using evidence-based medicine (EBM). Instead, it should emerge through an open, collaborative, and interpretive dialogue with the patient. While physiologic futility can serve as a useful technical guide, qualitative futility more closely aligns with our ethical commitment to whole-person care.

Ms. M’s experience shows that her decision to proceed with surgery was not rooted in denial of her prognosis. Rather, it stemmed from her deep wish to complete unfinished personal goals, repair important relationships, and face death according to her own values. For some people, three extra months might seem insignificant. For her, those months represented an opportunity for purpose, dignity, and peaceful closure.

In situations like this, the central clinical question shifts from “Is this treatment effective?” to a more human one: “Is this meaningful to her?”

### *Theme 3: Practicing shared decision-making—a hermeneutic framework*

Although evidence-based medicine (EBM) provides an essential scientific foundation for contemporary clinical decisions, its emphasis on averages often falls short when dealing with the unique realities of individual patients [28]. The challenge of “medical futility” explored in this study clearly highlights this difficulty, since such judgments usually involve intertwined physiological, psychological, ethical, and existential layers [29]. Because patients — not physicians — ultimately live with the consequences of these decisions [7], assessments of futility cannot depend exclusively on scientific data. They must also fully consider the patient’s broader existential reality as a complete person. Only when physicians and patients reach a shared understanding of each other’s horizons can Shared Decision-Making (SDM) truly deliver on its ethical potential.

The struggle to define medical futility often arises from insufficient communication and a lack of mutual understanding between doctors and patients [30]. For this reason, combining EBM with a value-based medicine (VBM) approach is vital to strengthening SDM. The idea of “Value-Based Health Care” (VBHC), first introduced by Porter and Teisberg [22] and later expanded by Porter [21], focuses on improving patient outcomes while controlling costs. By contrast, our concept of “Value-Based Medicine” describes a hermeneutic model that prioritizes the patient’s existential, ethical, and personal narrative dimensions, thereby balancing the mainly physiological orientation of EBM.

In the five-step EBM model developed by Guyatt *et al.* [9], the initial three steps (Ask — Acquire — Appraise) concentrate largely on the patient’s physical condition. The final two steps (Apply — Assess), however, need to be broadened to include the patient’s psychological and existential realities. Only through this fuller evaluation can genuinely holistic healthcare be realized **(Figure 1).**

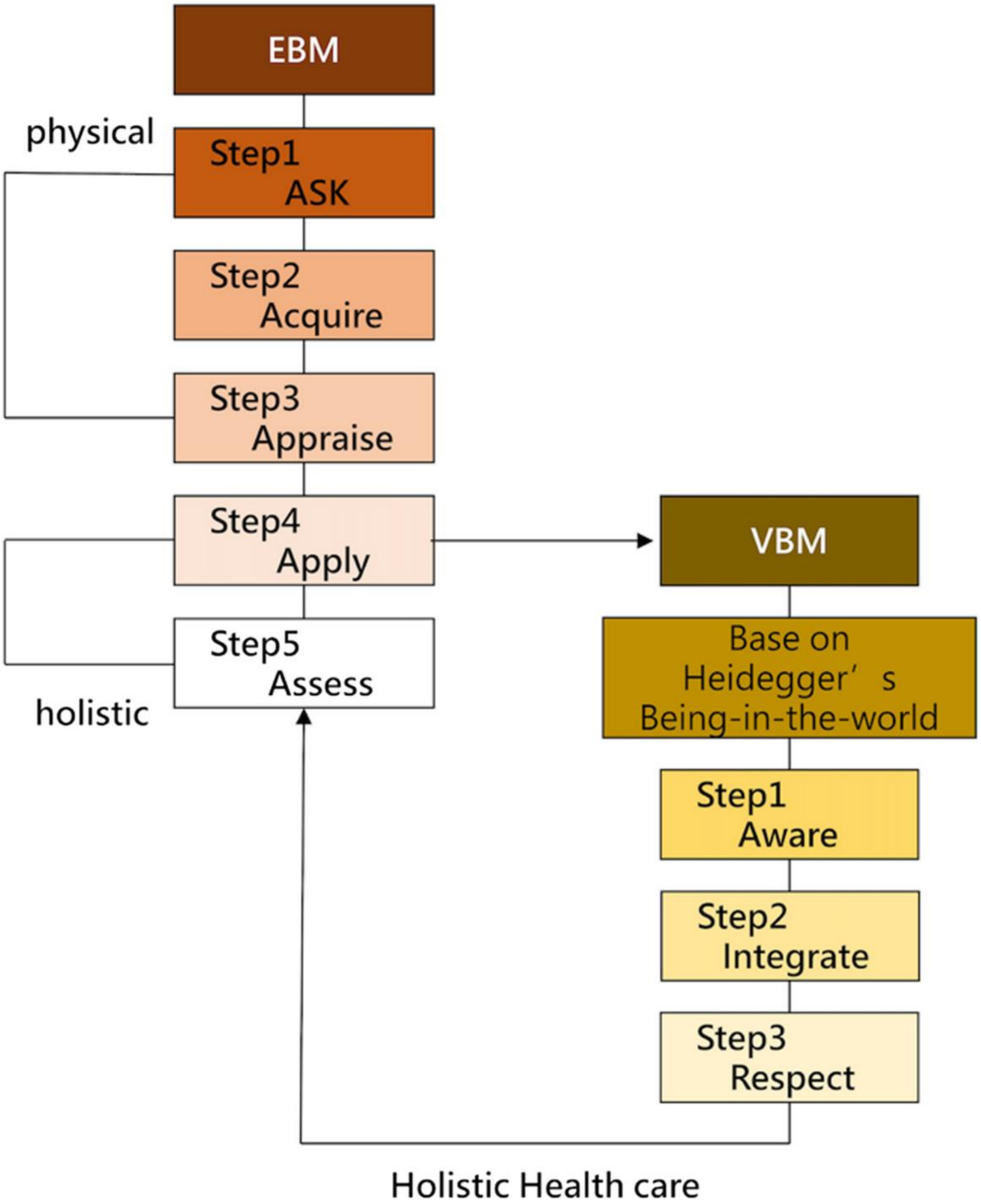

**Figure 1.** An integrated model of evidence-based medicine (EBM) and value-based medicine (VBM) in shared decision-making. From: Medical futility and the ethics of continuing treatment: a hermeneutic inquiry into patient and physician perspectives

The left side of **Figure 1** displays the standard five-step EBM process, while the right side shows our proposed VBM framework. This VBM model was developed using a hermeneutic lens informed by Heidegger's concept of being-in-the-world and Gadamer's idea of the fusion of horizons. Unlike the policy-focused VBHC approach found in the literature, our VBM highlights the holistic and existential aspects of patient care, effectively complementing EBM's primarily physiological focus.

*Step 1: aware*

The idea of a horizon describes a person's pre-existing framework for interpreting the world, influenced by their cultural roots, personal experiences, convictions, and historical setting. According to Gadamer [8], horizons are never fixed or sealed off; they can grow and blend via meaningful conversation. At the beginning of shared decision-making (SDM), doctors need first to recognize the contrasts between their own lifeworld and the patient's, while identifying any possible divides separating these horizons. For instance, a clinician evaluating clinical risks may judge a certain intervention as pointless because of its elevated risk. In contrast, the patient might regard it as their last chance to mend important relationships or resolve unresolved personal matters.

*Step 2: integrate*

Merging horizons does not mean the doctor must give up their own deeply held values; on the contrary, it involves creating a connection of understanding that spans those differences through attentive listening, morally grounded discussion, and compassionate involvement. Rather than judging the patient's choice solely by medical standards, the physician ought to explore the reasons behind the decision the patient is making right now. In the research we conducted, doctors at Hospital B honored Ms. M's choice to proceed with high-risk surgery even when it conflicted with what evidence-based medicine (EBM) considered the best course. They understood that "for her, this was a journey of living alongside death while rebuilding the meaning of her life." Such comprehension arose not from trying to convince or override her, but from a hermeneutic approach rooted in the merging of horizons.

*Step 3: respect*

Even if full alignment of horizons proves impossible, doctors should still prioritize what the patient sees as a good decision. This approach does not mean neglecting their professional duties; instead, it means accepting that the purpose of healthcare extends beyond simply prolonging physical life to enabling a life filled with personal significance [31-33]. Physicians continue to bear responsibility for delivering precise information and supporting the decision process, yet they should not act merely as tools carrying out the patient's wishes. Through this process, SDM combines the validity of EBM with the patient's personal value, thereby preventing the reduction of the doctor's role to a mere instrument [34] and reducing the ethical strain often experienced in situations involving futile treatment [5].

These three steps do not function as rigid techniques but as moral attitudes and interpretive practices. Whereas the standard five steps of EBM (Ask, Acquire, Appraise, Apply, Assess) focus mainly on physical and evidence-based aspects, our SDM framework emphasizes a more human-centered understanding. Medical information can become genuine practical wisdom only when doctors are prepared to step into the patient's horizon and when patients truly sense that they have been heard and understood. As Marcel points out, the real objective of medicine is not just to deal with abstract ideas about a condition, but with the actual reality—the very existence of the individual.

By adopting value-based medicine (VBM), we uphold the complete integrity of the patient's being and draw on the philosophical insights of Heidegger and Gadamer to strengthen the ethical dimension of SDM. Moreover, we recommend enhancing education in ethical conversation as part of medical training—for example, through programs focused on narrative skills—so that future doctors can learn to access the patient's horizon, identify clashes of values, and engage in truly significant exchanges. In this manner, the clinical environment can shift from a place centered on technical procedures to one centered on shared healing and the joint creation of ethical significance.

In addition, when differing values arise among healthcare team members, open communication across professions and efforts to reach agreement become just as vital. The variety of viewpoints within medicine should be viewed not as a problem but as a valuable opportunity to advance more comprehensive, whole-person patient care. By actively addressing these differences, medical teams are better able to examine and define what genuinely represents goodness in the practice of medicine.

## Conclusion

This research emphasizes that evidence-based medicine (EBM) and our hermeneutic understanding of value-based medicine (VBM) ought not to be regarded as opposing or incompatible systems. Instead, they function as mutually supportive elements that together form a truly patient-focused approach to shared decision-making (SDM). It is worth noting that the version of VBM presented here differs from "value-based health care" (VBHC), as it places greater emphasis on the existential aspects of patient care.

Nevertheless, the study also carries notable constraints. Because it centers on a single patient case and conversations among a limited number of physicians, the outcomes are not intended to apply broadly across medical settings. Rather, the results demonstrate the usefulness of interpretative phenomenological analysis (IPA) and hermeneutic methods in revealing the moral and existential issues associated with medical futility, thereby drawing attention to layers of significance that could easily go unnoticed.

We maintain that the most appropriate medical choice arises from harmonizing the objective correctness provided by EBM with the subjective goodness perceived in the patient's own decision. Practicing SDM demands that physicians show not only moral awareness but also skill in interpretation, going past a purely technical process of "presenting choices" to a deeper ethical process of "jointly building meaning." For this reason, we urge medical schools and ongoing clinical preparation to foster doctors' abilities in ethical discussion, sensitivity to personal stories, and insight into human existence. SDM can only fulfill its potential—not simply as a routine method, but as a truly ethical endeavor and a manifestation of humanistic insight—when physicians can enter the patient's lived horizon and participate in authentic, shared interpretation.

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