Shared decision-making: enhancing the clinical relevance

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DECLARATIONS

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Shared decision-making is increasingly advocated to enable patients to participate in decisions that affect them, to protect patients from insufficiently individualized supply-driven care, and to reduce health care costs and waste by avoiding the provision of unwanted interventions.[1–3]

The concept of shared decision-making can be understood in several ways. A number of definitions and descriptive models have been offered, emphasizing different aspects of clinician-patient interaction and decision-making.[4] Most definitions and models can be variously interpreted when considered in relation to the complex realities of healthcare provision. Clinicians' understandings of shared decision-making can have important implications for clinical practice.[5] They can diverge, for example, over questions of whether, when and how it is appropriate to recommend a particular treatment or challenge a patient's expressed preferences.

This paper considers the practical and ethical implications of, 'narrow' and 'broader' ways of thinking about shared decision-making. It illustrates how narrow understandings of shared decision-making, which focus on informing patients so they can choose between options, can make it hard for many patients to share meaningfully in decision-making that affects them. It then outlines how broader understandings, which allow for more clinician influence and extend the relevance of shared decision-making to diverse situations, can be justified in principle and appraised for appropriateness.

Table 1 compares the key features of narrow and broader understandings of shared decision-making.

Narrow understandings: practical limitations

Narrow understandings of shared decision-making are characterized by an emphasis on engaging patients in choice by informing them about healthcare options then eliciting and respecting (not interfering with) their preferences. Narrow understandings are encouraged by policies that promote patient choice to 'correct' the biases of professionally or commercially driven healthcare supply. They also reflect prevailing ways of thinking about an ethical principle of respect for autonomy in healthcare, which require clinicians to abide by the autonomous choices of competent patients. Autonomous choices are defined as those made intentionally, and with sufficient understanding and freedom from controlling influences.[6] This discourages clinicians from intervening beyond information provision if this might be construed as steering patients' choices.

Narrow understandings of shared decision-making promote a division of labour in which clinicians supply information about healthcare options and patients work out which option they prefer.[5] Implicitly they rely on the idea that clinicians' non-interference in patients' preference formation will protect patients from clinicians' conflicting interests.

Practice consistent with narrow understandings of shared decision-making can work well when there are several reasonable treatment options, and patients are adept and confident at processing information and identifying and expressing their preferences. It might be facilitated by the use of decision aids. But the applicability of narrow understandings of shared decision-making is limited.

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The three authors have discussed issues relating to patient involvement in treatment decision-making for a number of years. VAE drafted this manuscript and AC and ISW both contributed significantly to the content and to improving clarity

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Table 1
Key features and implications of narrow and broader understandings of shared decision-making

Narrow understandings of shared decision-making	*Broader understandings of shared decision-making*
Reflect and are congruent with notion of respect for autonomous choices.	Reflect and are congruent with notion of support for a person's autonomy (understood relationally).
Scope of concern of shared decision-making is primarily task-oriented communication for decision-making.	Scope of concern of shared decision-making includes communication relating to decision-making, but also emphasizes the relationship in which communication is embedded, and the motivations and experiences of both clinician and patient participants.
Emphasizes protection of patients from inappropriate paternalism and relies on a division of labour to achieve this: –Clinician brings research-based information about options and outcomes –Patient 'independently' brings or forms their individual preferences	Emphasizes enablement of patients' participation and requires clinicians to interact responsively and flexibly to support this. Provision of research-based information and attention to individual patients' needs, values and preferences are important, but attention is also paid to clinicians' attitudes towards patients and softer communication and relationship building skills. Division of labour is less strict. Dialogue is more open ended.
Patients' sharing in decision-making is understood primarily in terms of their role in selecting a healthcare option from a menu of at least two options.	Patients' sharing in decision-making is understood in multiple senses. Their perceptions of involvement and inclination to 'own' decisions are recognized aspects of sharing, as well as their contributions to option selection and other stages of healthcare decision-making.
Clinician respects (stands back and abides by) patient's preferences/choices.	Clinician respects (affirms and supports) patient as person in broader sense. This involves taking patient's expressed preferences seriously, but not necessarily abiding by them without discussion. Support for autonomy-capability becomes salient.
Any challenging of patients' preferences is restricted to checking patient's factual understanding and reiterating or providing more information.	Respectful treatment of the patient may involve challenging patient's expressed preferences or choices to check their congruence with personal values and life plans. It may even involve contributing to the formation or revision of preferences - as a friend or mentor might when supporting decision-making.
Require patients to (1) understand information about options and outcomes and (2) 'independently' formulate and express preferences about these.	Are less demanding on patients' information processing and decision-making skills. Accept that a person's preference formation and expression may be achieved in collaboration.
Can sometimes protect some patients from inappropriately paternalistic clinical influence BUT may not facilitateindividually appropriate forms of involvement AND may not allow sufficient clinical support to enable all patients to participate appropriately.	Enable more patients to share in decisions in a variety of senses by virtue of a fuller range of forms of decision support AND facilitate individually appropriate forms of involvement BUT in practice require high levels of clinician skill and virtue if they are not to degenerate to inappropriate paternalism.
Can be assessed by observing communication in consultations.	Require attention to context and subjective perspectives of clinicians and patients, as well as communication between them.

Narrow understandings make the concept of shared decision-making seem inappropriate for situations in which there is only one reasonable course of action or clinicians believe, on the basis of their research-based knowledge about the likely effects of different treatments and their familiarity with the situation and concerns of a particular patient, that one option is probably better than the others. In these situations, it seems that there should be scope for clinicians to take 'decisional priority' and make recommendations.[7,8] But narrow understandings that lead clinicians to respect patients' autonomous choices in a 'stand-back and don't interfere' sense, do not readily sanction recommendations. Instead they seem to support the communication practices that generate the numerous lamentable anecdotes in which patients who have been told they must choose between options describe becoming anxious and frustrated when clinicians' refuse to use their expertise to guide them. (Table 2 Column 1).

Narrow understandings render shared decision-making difficult for people who struggle with information appraisal and choice. Many people fall into this category, especially when

Table 2

A scenario and illustration of narrow and slightly broader approaches to shared decision-making

John has been found to have an abdominal aortic aneurysm. The specialist who identified it briefly explains what it is, and why it is a cause for concern. He outlines three options: no repair, open repair and endovascular repair, and summarizes the main outcome probabilities associated with each.

Narrow understanding of shared decision-making	*(Slightly) broader[a] understanding of shared decision-making*
The specialist asks John which he would prefer. John says he doesn't know. He asks which the specialist recommends. The specialist says he shouldn't recommend one. They're all on offer, so they're all reasonable, but they have different benefits and risks. John must choose, but the specialist will give him more information that he can take away to help him think about his choice. He can let him know by phone what he's decided. John visits his GP, tells her what the specialist said, and confesses he is undecided. He thinks that now he knows about the aneurysm he probably wants to have something done about it, but he can't choose between the open and endovascular repair. In fact, he is getting so stressed about the choice, perhaps he'd be better not having either. The GP acknowledges that it is a difficult decision, but says that her preferences are probably different from John's, and she isn't well placed to advise him. Reflecting on their consultations, both doctors recognized John's difficulties and felt a bit uncomfortable about them. But they reasoned that they shouldn't have helped him any further with decision guidance because he was a competent adult and to respect his autonomy, they should not interfere with his preferences.	The specialist asks John what he thinks about those options and whether he has any questions. John says that now he knows about the aneurysm, he'd probably rather something was done about it. And maybe the overall survival rate makes the endovascular repair the better option? But the complications sound worrying. The specialist says he also tends to favour repair, and the endovascular repair in particular because of the overall survival rate. John is right to be concerned about possible complications, though, and they can discuss those a bit further. The specialist outlines the kinds of complications that can arise, and how these might be dealt with. He asks about John's family and work and what support he might have after an operation. The specialist asks John what he's thinking now. John says the endovascular repair seems to be the way to go, although he's still a bit anxious (but he can see that the anxiety should be short term). The specialist says that sounds like a good decision, and he will reserve a slot for surgery. He gives John information about the condition and both kinds of repair to take away and share with his family. He invites John to contact him if he has any further questions or concerns. The specialist reflected that John seemed to understand the key issues and express his thoughts and concerns well. He felt confident that the plan of action was mutually agreed and appropriate.

[a]This illustration of enactment of a slightly broader understanding is an interpretation consistent with many extant definitions and models of shared decision-making. A clinical example involving a less able patient and greater clinician influence would require a more detailed description and extensive commentary to clarify whether and why the clinician's approach could be considered appropriate and supportive of the patient's autonomy capability.

experiencing the situational stresses of poor health and complex healthcare options with uncertain and unfamiliar but significant life implications. People with limited education and/or health literacy, and people with learning disabilities will rarely be able to engage well in shared decision-making if this is narrowly understood. And even knowledgeable and usually assertive clinician-patients occasionally want guidance or stronger decisional recommendations from experienced and trusted clinicians.[9]

Not surprisingly, narrow understandings can lead conscientious clinicians to develop concerns about shared decision-making as an ideal, even though in practice they strive genuinely to treat patients 'as persons' and to involve them in decisions that affect their lives. We have been struck by conversations with clinicians who evidently (1) care about their patients, (2) are strongly committed to providing effective and personally appropriate treatment, and (3) are extremely skilled at enabling diverse individuals to understand and influence decisions about their care, but who worry that they have not 'done' shared decision-making or respected patients' autonomy because they have not provided detailed information about all remotely reasonable options and/*or* because they have made recommendations or otherwise influenced patients' treatment selection. The problem, we believe, lies not with what these clinicians are doing when they find ways of guiding without imposing upon patients within mutually responsive discussions about potential treatments. Rather, we suggest, narrow understandings of shared decision-making and/or respect for autonomy can inappropriately idealize 'uninfluenced' patient choice and, by doing so, undermine common-sense recognition that preferences developed independently are not necessarily better than treatment preferences developed in collaboration.[10,11] Although clinicians have interests that potentially conflict with their patients', they also often have much to offer as decision guides.[7,10,12]

Narrow understandings of shared decision-making obscure the value of respectful and emotionally supportive interpersonal relationships that patients – especially those with serious illness, limited education and/or literacy – often see as key to their involvement.[13–15] While thoughtful and skilled proponents of shared decision-making acknowledge that relationships are important, and recognize that patients often need more than information about treatment options and encouragement to choose for themselves,[16] a focus on autonomous choice tends to marginalize the potential of supportive healthcare relationships.

Broader understandings: justifying and appraising diverse forms of decision support

Compared to narrow understandings, 'broader' understandings of shared decision-making take a more expansive view of what 'sharing' might mean and how it might be achieved. They look beyond information and preferences relating to a menu of healthcare options and consider communication relating to decision-making (broadly interpreted) in the wider context of clinician-patient relationships. Broader understandings can accommodate more diverse forms of patient involvement (not just in making selections between options)[7,17] and decision support from clinicians.

Some clinicians, including those who advocate shared decision-making, already adopt broader understandings of shared decision-making and/or reflect them in highly flexible communicative practice. However, they are not always able to provide ethical justifications for their practices. The assessment of appropriateness is a key challenge for broadening understandings of shared decision-making.[5]

Diverse forms of decision support, including recommendations, *can in principle* be justified as respectful of personal autonomy *if* we adopt relational theories of autonomy.[5,8,18] Relational theories recognize that socio-cultural and interpersonal variables influence all our values and preferences.[19] They direct attention to social influences on individuals' capabilities for self-discovery, self-definition and self-direction, and they use ideas of identity, responsibility, and authorization and ownership in decision-making to show how people, while socially intertwined, can shape their own lives in meaningful ways.[19]

The *possibility* of ethical justification for broader forms of decision support, however, does not constitute a general license. Relational theories of autonomy encourage consideration of *how*, in

specific situations, clinical support impacts on individuals' autonomy capabilities, identity, responsibility, decisional authorization and ownership.[18] An analogy can illuminate these ideas.

Prosthetic feet enable amputees to walk, run or cycle by compensating for physical impairments. 'Good' prostheses are tailored to individuals' particular impairments (below or above knee amputations etc.) and well designed for required functions (blade feet work well for running but not cycling).[20] Crucially, good prostheses are controlled by the people they are intended to enable: we can meaningfully say it is the people, not the prostheses, who walk, run or cycle, and amputees can own their actions and identities as walkers, runners or cyclists although responsibility for their performance is somehow shared.

In analogous ways, the imagining, reasoning and communicative skills of clinicians (and family members and other personal supporters) might be used to overcome the varied impairments and challenges that can affect people's decision-making, and to enable people to form and express their own views of what is good for them.[20] Although there are important differences between inanimate prostheses and human helpers, and between walking, running or cycling and choosing, the analogy suggests that 'good' decision support will be tailored to individuals' particular capacities for reasoning, imagining and communicating, and will facilitate their participation in decision-making in ways they can control.

This resonates with the recognition that 'good' friends and mentors can influence our preference formation but *without* precluding our ownership of our preferences. Good friends and mentors sometimes challenge our expressed preferences, query apparent inconsistencies between our proposed choices and overall aims and commitments, suggest alternative ways of thinking or recommend particular courses of action. Their interventions reflect their knowledge of our particular strengths and limitations, and are supportive of our developing and maintaining our own values and identity. They are oriented towards achieving what matters to us, and they bolster rather than detract from our capability for autonomy and decision-making agency. They can encourage us to take responsibility but will provide more support and take more responsibility when we need that.

Broader understandings of shared decision-making, underpinned by relational understandings of autonomy, open up scope for clinicians to use at least some of the supportive strategies associated with friends and mentors. There can, however, be no specified universal prescriptions for particular forms of communication and decision support. What is appropriate depends significantly on the individual patient and situation - including the particular clinician-patient relationship. Some situations will require clinicians to lay out detailed information about options and encourage patients to choose (in the ways usually associated with narrow understandings). But recommendations and other forms of support may legitimately feature in clinicians' communication repertoires, albeit with caveats about how these are provided.[8] In general, patients with lower health literacy and more cognitive impairment or emotional stress are likely to need the most flexible and intensive support.

When underpinned by relational understandings of autonomy, broader understandings of shared decision-making do not give clinicians licence to omit careful exploration of reasonable options or to re-engineer patients' preferences to suit their own. They require relationships within which clinicians get to know patients as persons, assess their (changing) needs and abilities, and offer responsive support that facilitates involvement in decision-making without imposing particular forms. This renders external assessment of the appropriateness of clinicians' decision-making with patients difficult. It implies that rounded judgements will require complex, contextually sensitive consideration of clinicians' motivations and responsibilities, as well as various features and consequences of clinician-patient interactions and relationships, including the identification and fulfilment of patients' specific support needs, and the senses in which patients were enabled to share in processes and to authorize and own decisions. Existing means of assessing shared decision-making will need further development if they are to reflect the range of issues that broader understandings render salient. Neither observations of communicative behaviours nor self-reports will suffice alone.

Concluding comments

Attempts to enact shared decision-making as narrowly understood, might sometimes protect some patients from insufficiently individualized supply-driven care, but in many clinical situations it is unrealistic to simply inform patients about options and insist they choose 'independently'. Narrow understandings of shared decision-making can discourage clinicians from providing forms of decision-support that enable and are valued by patients.

Broader understandings accommodate more diverse forms of patient participation and clinician decision support, including guidance and recommendations. They expand the possibilities for more people in more diverse situations to share in meaningful ways in decisions about their care, and they allow clinicians to draw on their professional expertise and experience in ways patients value. They enhance the relevance of shared decision-making for clinical practice. Relational theories of autonomy can help justify and differentiate between more and less appropriate forms of decision-sharing by clinicians, but they render broader understandings of shared decision-making highly demanding of clinicians' skills and virtues.

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