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Editorial

SRIKANT SARANGI

Aalborg University, Denmark

This issue marks the continuation of the forum discussion paper by Lauris Kaldjian, titled *Concepts of health, ethics and communication in shared decision making*, which appeared in the first issue of this volume (*Communication & Medicine* 14 (1): 83-95 [2017]). The discussion paper has attracted four rejoinders which are included in this issue, accompanied by an extended response from Kaldjian. Like the original paper, these contributions will also be openly accessible from *Communication & Medicine's* website.

The four rejoinders – by Angus Clarke, Larry Cripe/Richard Frankel, Martin Richards and Peter Scalia/Glyn Elwyn – attest the fact that conceptual and practical issues surrounding shared decision making (SDM) are current and remain contentious. A main challenge concerns our baseline understanding of what counts as a ‘shared’ decision and how to differentiate a ‘shared decision’ from a decision that is ‘un-shared’ from the perspectives of those for whom the decisions are real and consequential.

Metaphorically speaking, there seem to be many flies in the SDM ointment. For instance, how can we map agreements and disagreements to the process of SDM and the decisional outcomes? If a clinical encounter ends in a disagreement, does it still qualify as shared decision making? When does an SDM trajectory run the risk of bordering on professional indifference as opposed to simply indexing differential preferences among professionals and

patients/families? In situations where decisional outcomes are the result of ‘unethical persuasion’ on the part of the healthcare providers, or of ‘undesirable demands’ on the part of patients and families, how does one go about labelling such processes in relation to outcomes? Likewise, to what extent does professional expertise/autonomy to be aligned with or compromised by patients’ autonomy vis-à-vis their needs and rights for a decision to be considered shared or unshared? ‘Goals of care’ are bound to be nuanced and contested in interpretive terms, both in the short term and in the long term as well as for individual patients on the one hand and their carers on the other. In addition, can the provision of available choices/options be straightforwardly equated with SDM?

Questions as the ones listed above – and many more unasked questions – impinge on the uniquely contingent situation of a clinical encounter. From a situational communicative perspective, the practical implementation of the SDM framework in a standardised format is as challenging as arriving at a consensus at a conceptual level. The ontological and epistemological divides between what ‘shared’ and ‘unshared’ means or looks like for professionals and patients/families will no doubt persist. Socio-cultural variables underpinning health beliefs and healthcare delivery will inevitably add a layer of further complexity.

The more one considers the situated contingencies of SDM in life-changing environments

such as cancer, end-of-life or genetic counselling the harder it becomes to arrive at a 'shared understanding' of the circumference of SDM as far as researchers and practitioners are concerned. We seem to be running two parallel risks: one concerns accepting a range of decision-making scenarios as 'shared' in the absence of clear-cut parameters at conceptual and operational levels; the other concerns a lack of attention given to the preconditions of what might constitute shared decision making, independent of the decisional outcomes. Such preconditions could include the communicative manifestations of participation structure, negotiation of understandings, division of responsibility, joint exploration of options/choices, goals of care, compliance with treatment regime etc.

Coincidentally, there are two papers included in this issue (Joy Lee and colleagues and Donna Duffin / Srikant Sarangi) which address the topic of shared decision making empirically from a communication perspective. The two titles are

provocative: Lee *et al.* ask: 'What does shared decision making look like in natural settings?' Duffin and Sarangi pose a nuanced sequential interrelation by altering the word order – the process of 'shared decision' is juxtaposed to that of 'decision shared'. Both the empirical papers draw attention to the fact that there exists enormous variability in appraising the complex phenomenon of shared decision making, both for SDM researchers – whether theoretically or empirically minded – and for healthcare practitioners. Models and philosophical viewpoints have their limitations, as do praxis-based accounts.

It is evident that themes such as shared decision making, individual autonomy, patient-centredness and professional expertise necessitate not only interdisciplinary and interprofessional engagement but also the involvement of those who stand to benefit or be affected by such concepts and processes. A communication perspective on the matter promises to offer useful insights.