

Shared decision making is an ethical imperative, but implementation challenges persist: A rejoinder to ‘Concepts of health, ethics, and communication in shared decision making’ by Lauris Kaldjian

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The physician is the medical expert, but the patient is an expert on his or her own sense of well-being. Shared decision making is a clinical approach that aims to bridge the gap between the two parties by providing the physician with the tools to enable the patient to communicate their values or goals of care. Kaldjian (2017) indicates that patient preferences are embedded within their ‘concept of health’ framework; each individual has a unique definition of *flourishment* in the context of healthcare. This ‘concept of health’ can serve as the foundation for the interaction and provide the physician with a window into the factors (physical, psychosocial, cultural) that make up a patient’s perspective. From Kaldjian’s point of view, if a physician can tap into the patient’s ‘concept of health’, he or she can better understand the patient’s decision making – particularly when there is disagreement regarding the best treatment option. In this circumstance, a physician can only communicate the medical and ethical reasoning behind their recommended therapy, while respecting the patient’s autonomy. Shared decision making enables this two-way communication, so even when disagreement arises, both parties understand each other’s reasoning.

We agree with Kaldjian’s ethical assessment of the shared decision-making approach – an approach which has long been considered the pinnacle of patient-centered care, and an ethical imperative (Drake and Deegan 2009; Barry and Edgman-Levitan 2012). For decades, the

paternalistic model has predominantly been practiced in medicine – a model that solely emphasizes the principle of beneficence. The doctor must do no harm, and choose the best possible treatment pathway for the patient. However, as early as the 1970s, medical ethicists described the importance of emphasizing patient autonomy, and eliciting patient preference in a model that stressed patient–physician interdependence (Veatch 1972) – a model that encouraged the exchange of information between both parties in the clinical encounter, making the values of the patient the focal point of the decision-making process (Stiggelbout *et al.* 2015). To be autonomous, one must ‘act with understanding’ (Gulbrandsen *et al.* 2016).

Physicians have a duty to not only provide information, but to ensure patients understand it. Creating that sense of partnership is especially important in cases where there are discordant beliefs about which is the best treatment decision, or the patient feels the burden of having to make a decision. According to Gulbrandsen *et al.* (2016), a by-product of sharing information is an increased level of patient vulnerability and uncertainty. Complex medical information may lead to cognitive overload and a feeling of unpreparedness to make a decision in some patients (Gulbrandsen *et al.* 2016). Ensuring understanding helps the patient make a more informed decision, and indicates a willingness to form a partnership, and help guide the patient to a decision, if need be.

The emphasis on patient autonomy, however, may pose a challenge in terms of ‘conceptualizing and operationalizing’ decision making, according to Clayman *et al.* (2017). Patients do not make decisions in a vacuum. They consult the individuals around them (e.g. family members) when considering the information (Clayman *et al.* 2017). Kaldjian touches on the biopsychosocial element of the individual’s concept of well-being. Clayman *et al.* extend this notion by suggesting that we should avoid viewing patients as singular entities and that patients’ families need to be included in the decision-making process. They also argue that the decision-making process is fluid, so we should not just see medical encounters as isolated incidents, but rather as part of the patient’s story, each encounter building off the last. The ‘narrow focus’ on patient autonomy also does not consider the access patients currently have to information outside the medical encounter (Clayman *et al.* 2017). Patients turn to the internet for much of their medical information.

Various shared decision-making blueprints have been created for physicians to help them practice the shared decision-making approach, such as the framework of Charles *et al.* (1999), the multi-step plan of Makoul and Clayman (2006), and most recently, the ‘three-talk’ model of Elwyn *et al.* (2012). These models provide a guide to discussing the information and providing the treatment options, forming a partnership with the patient, and eliciting and integrating the decision in the treatment plan. Despite these shared decision-making guides, though, it is still a challenge to implement this approach in clinical settings (Légaré *et al.* 2008). We know that ethically it is sound clinical practice, and there is evidence that patients prefer the shared decision-making model (Chewning *et al.* 2012). The question remains: how do we implement shared decision making in clinical settings?

Medical students often are not taught this approach to medicine, and therefore have no knowledge of shared decision making or how to practice it (Durand *et al.* 2017). The lack of training and awareness of shared decision making makes it challenging for physicians to alter the way they practice, in some cases leading to negative attitudes towards its implementation (Boland *et al.* 2016). There is also a perception that shared decision making increases time pressures, although there is

a paucity of evidence to support this claim (Elwyn *et al.* 2013). Some physicians point to the ‘lack of applicability due to patient characteristics or clinical situation’ (Légaré *et al.* 2008). These factors all contribute to the lack of a shared decision-making culture at the clinical level (Joseph-Williams *et al.* 2017). Creating an environment where this approach is not only accepted, but is the norm, begins at the organizational level, but very few organizations have made the necessary investments to integrate this clinical approach in their clinics (Joseph-Williams *et al.* 2017). Barriers continue to exist at every level in healthcare organizations, making the implementation of shared decision making evermore challenging (Joseph-Williams *et al.* 2017). We know that this approach is ethical. Our efforts now need to be focused on formulating strategies to overcome these implementation barriers so that more patients can feel empowered by an increased sense of agency and autonomy.

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