

Shared Decision Making, Paternalism and Patient Choice

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Abstract In patient centred care, shared decision making is a central feature and widely referred to as a norm for patient centred medical consultation. However, it is far from clear how to distinguish SDM from standard models and ideals for medical decision making, such as paternalism and patient choice, and e.g., whether paternalism and patient choice can involve a greater degree of the sort of sharing involved in SDM and still retain their essential features. In the article, different versions of SDM are explored, versions compatible with paternalism and patient choice as well as versions that go beyond these traditional decision making models. Whenever SDM is discussed or introduced it is of importance to be clear over which of these different versions are being pursued, since they connect to basic values and ideals of health care in different ways. It is further argued that we have reason to pursue versions of SDM involving, what is called, a high level dynamics in medical decision-making. This leaves four alternative models to choose between depending on how we balance between the values of patient best interest, patient autonomy, and an effective decision in terms of patient compliance or adherence: Shared Rational Deliberative Patient Choice, Shared Rational Deliberative Paternalism, Shared Rational Deliberative Joint Decision, and Professionally Driven Best Interest Compromise. In relation to these models it is argued that we ideally should use the Shared Rational Deliberative Joint Decision model. However, when the patient and professional fail to reach consensus we will have reason to pursue the Professionally Driven Best Interest Compromise model since this will best harmonise between the different values at stake: patient best interest, patient autonomy, patient adherence and a continued care relationship.

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Introduction

Background

Patient centred care (PCC) is gaining ground as a leading ideology of modern medicine and health-care and is increasingly advocated as a guide for how diagnose, consultations, treatment, and care should be performed [17]. Within PCC shared decision-making (SDM) is considered to be one of the characteristic features. SDM has been contrasted against other medical decision-making models like paternalism, informed (or patient) choice, interpretative decision-making, the model of the physician as perfect agent, etc. [2–4, 8, 24].

In a developed and much referred to characterisation of SDM [3, 4], the emphasis is on *active participation from both patient and professional* in the decision-making process, and *agreement on the decision*. Moreover, both patient and professional is supposed to bring preferences and facts into the decisional process and there deliberate together in order to reach a joint or shared decision. In case of less initial agreement Charles et al. claim that ‘...a process of negotiation is likely to occur’ (Ibid, p. 656). This decision might involve a compromise between the parties and it is claimed that ‘...both parties are [not] necessarily convinced that this is the best possible treatment for the patient, but rather that both endorse it as the treatment to implement.’ [3], p. 688). This is contrasted against paternalism, where the professional makes the decision based on what she finds to be in the patient’s best interest; against informed choice, where the patient makes the decision based on information received from the professional; against interpretative choice, where the professional helps the patient to interpret his preferences in relation to the situation and then leave it to the patient to make the decision; and finally against the physician (or professional) as perfect agent, where the professional makes the decision based on the preferences of the patient and with no interference of her own preferences [3]. Since these competing models will either result in the professional making the decision or the patient making the decision, we can see them as versions of either paternalism or patient choice (see the developed characterisation of these models below).

It is far from clear, however, that SDM is in fact a distinctive decision-making model in this way. Several of the aspects of SDM are possible to incorporate into the competing models, hence making them more ‘shared’ whilst still retaining their basic feature of being either paternalistic or a case of patient choice. In order to see whether there is room for a distinctive competing version of SDM, the concept of SDM needs to be further analysed. Furthermore, this is necessary in order to evaluate whether we have reasons to adopt such a competing model (or alternatively modify any of the existing models in a more shared direction). The purpose of this article is to provide such an analysis and then evaluate the reasons for and against these different decision-making models. Thus, as a first step, conceptual analysis

will be used to shed light on how the idea of shared decision making can be understood. On this basis, a normative argument will be made in relation to these different understandings, based on relevant basic values of the health-care context. One important result of a general nature is that the sharing in any model of SDM should involve what we call a high-level dynamics. The argument for this claim is developed throughout the text.

More specific, we will argue, first, that versions of both paternalism and patient choice can incorporate high degrees of sharing and a high-level dynamics in this sharing (*Shared Rational Deliberative Patient Choice* and *Shared Rational Deliberative Paternalism*, respectively). Second, we will describe two distinctive versions of SDM that are not reducible to paternalism or patient choice (while still containing the element of high-level dynamics), *Shared Rational Deliberative Joint Decision*, and *Professionally Driven Best Interest Compromise*. Depending on how we balance the values of patient best interest, patient autonomy and patient adherence we will have different reason to adopt the four models. On the basis of such a balancing, we will argue that ideally we have reason to adopt *Shared Rational Deliberative Joint Decision*. However, we also acknowledge *Professionally Driven Best Interest Compromise* as a strong competitor, since ‘joint decision’ (i.e., consensus) may often not be forthcoming even when a high-level dynamics of sharing is in place. This last model harmonises the balance of patient best interest and patient autonomy with attention to the value of securing adherence to the decision and a continued care relationship.

Wirtz et al. [28] have criticised the characterisation of SDM made by Charles et al. for not being sufficiently specified with regard to two different aspects: (1) the framing problem—the construction of the option-set which both frames decision-making and is, in part, a product of decision-making, (2) the nature of reasoning problem—the nature of the reasoning-communication represented in any process of joint decision-making [28]. In particular, they criticise the reference to ‘negotiation’, claiming that it obscures more than clarifies the idea of the sort of reasoning supposed to be going on in SDM. Wirtz et al. focus more on the framing problem and only explore the nature of reasoning problem to some extent. However, it seems obvious, that the nature of reasoning problem is the more fundamental one for coming to grips with SDM. In this context, the issue is about what idea about *sharing* that should be operating in SDM in the first place. The framing problem seems to be actualised only to the extent that certain ways of framing may undermine the sort of sharing one strives for, but in order to inquire about that one will need a clear idea of what this sharing is supposed to amount to, and how that specific sort of sharing may be undermined by framing effects.

Nevertheless, both problems highlight a general lack of clarity as to how exactly the patient and/or professional can take part in and share in medical decision-making. The model of SDM could be interpreted in different ways regarding the aspect of sharing and these will amplify or tone down differences in relation to other models, as well as have different implications for how, in more concrete terms, the decision-making process should be performed and what it should result in. Thus, there is a basic uncertainty as to how SDM actually differs from other decision-making models when these are used in a clinical setting.

Since PCC supporters advocate SDM as the decision-model to be preferred, it is essential to be clear over exactly what it is that should be preferred and if it can be supported by stronger reasons than contrasting alternatives. If the competing models can be modified in ways that would incorporate the alleged advantages of SDM and still retain other advantages, it is less clear why there should be a *shift to SDM from* other decision making models.

Our starting point will be the characterisation of SDM found in articles by Charles et al. [3, 4]. A review of different concepts of SDM used in the scientific literature showed this characterisation to be the most common, used in about 20% of the cases where a specific definition was referred to [19]. Based on this, two well-established competing ideas as to who should be making or determining the actual decision (the paternalistic and the patient choice model, respectively) will be explored as to what their distinguish features are and how they may incorporate the sharing aspect of SDM. Doing this, different interpretations of SDM will be brought in to check if any of these makes a difference. The critical issue in this context is if there is any version of SDM that cannot be so incorporated and, if so, why it should or should not be preferred. As indicated above, the reason for focusing on the paternalistic and the patient choice models is that most decision making models could be seen as version of them, since they either result in the patient or the professional making or determining the final decision. Moreover they connect strongly to different ethical ideals about the goals of health care and clinical decision making that may be used for assessing the pros and cons of SDM, i.e., patient best interest and patient autonomy.

In order to contrast SDM against the allegedly competing models of decision-making we will start by presenting characterisations of SDM, paternalism and patient choice. Paternalism and patient choice will here be somewhat developed to make them into more worthy competitors of SDM.

Characterisation of SDM

As SDM has been portrayed by Charles et al. [3, 4], the focus is explicitly on two main aspects: First, *sharing*: the decision making is being shared, or involves sharing. Second, *consensus*: the final decision is mutually agreed upon. In Charles et al. [4] this is described as a process over time in the following way:

1. At a minimum, both the physician and patient are involved in the treatment decision-making process.
2. Both the physician and patient share information with each other.
3. Both the physician and the patient take steps to participate in the decision-making process by expressing treatment preferences.
4. A treatment decision is made and both the physician and patient agree on the treatment to implement (p. 652).

As Wirtz et al. [28] note, nothing is said about the framing of the situation and very little is said about the nature of reasoning in the decision-making process. In fact, the description seems to allow that no reasoning at all takes place! In Charles et al. [4] there is a step between 3 and 4 involving joint deliberation, or if ‘wider apart in

their views' (Ibid, p. 656) a negotiation. If a step is inserted between 3 and 4 where the parties reason with each other on the basis of shared information and preferences, the process becomes less negotiation-like and can be made to approach something more resembling, e.g., an intellectual discussion. Variations in this respect, as well as in other aspects, will be considered further on. For instance, one interesting issue is whether consensus is (or should be) a necessary component of SDM, or merely considered to be an expected positive side-effect (or 'bonus') of sharing in many cases. Other characterisations of SDM have not explicitly demanded mutual agreement on the decision [19].

Paternalism and Patient Choice

In this section, the models of paternalist decision-making and patient choice will be described and discussed in some detail, straightening out some ambiguities under way. Embedded in this, we will also demonstrate how these models connect to underlying ethical ideals of different (and potentially conflicting) sorts.

Paternalism

Generally, the idea of medical or health care decision making as paternalistic has its roots in the Hippocratic ideal of the physician (and, today, the nurse or other staff) as the caretaker of the patient's interest. Accordingly, medical decision may very well fail to involve the patient in the process, and may also go against her wants, or ignore the perspective of the patient in other ways, as long as the patient is benefited. It is this last aspect that makes the decision-making *paternalistic* rather than something else. This since it to some extent ignores to see or treat the patient as autonomous and/or rational. Rather, the patient is handled in analogy to how a parent typically handles a (small) child; seeing to the child's best interest but making the decisions independently of the child.

As a starting point for developing a more exact definition of paternalism, the following suggestion by VanDeVeer [27] may be considered:

'A's doing or omitting some act X to, or toward, S is paternalistic behaviour iff:

1. A deliberately does (or omits) X
2. A believes that his (her) doing (or omitting) X is contrary to S's operative preference, intention, or disposition at the time A does (or omits) X [or when X affects S—or would have affected S if X had been done (or omitted)]
3. A does (or omits) X with the primary or sole aim of promoting a benefit for S [a benefit which, A believes, would not accrue to S in the absence of A's doing (or omitting) X] or preventing a harm to S [a harm which, A believes, would accrue to S in the absence of A's doing (or omitting) X]' (p. 22)

Central to this suggestion is clause 2, i.e., the idea that paternalism has to involve *knowingly and willingly going against the wants* of the patient (for the patient's sake). In view of the general characterisation of paternalism above, however, this seems too strong in several ways. First, consider the following situation.

Leila, an oncologist, decides on mastectomy for Sara, who has been diagnosed with breast-cancer—without consulting Sara as to her preferences in the situation. Leila's decision on mastectomy *happens* to be in line with the preferences of Sara.

It seems clear that Leila acts paternalistic, since she treats her patient as someone whose point of view or opinion she does not need to consult. In effect, a decision may be paternalistic in a relevant sense even if it does not go against (or is believed to go against) the wants of the patient. If the decision is made in a way that actively ignores to take into account the perspective of the patient, it still fails to treat the patient as an autonomous and/or rational being. Now, consider the following situation:

Leila, after having asked Sara about her preferences, decide on a mastectomy—which is in line with Sara's preferences. Sara is however not given the opportunity to further influence this decision and has not authorised Leila to make the decision.

Here, the patient is indeed consulted and her point of view seems to be taken into account; at least, the decision conforms to her wishes. Nevertheless, also this case seems to be a case of paternalism in the relevant sense. Leila still supremely controls the reasoning process and is the one who makes the decision. Sara has not explicitly authorised Leila to exercise such control, and neither has she delegated decision-making authority to Leila. More generally, if a person, knowing someone's preferences, acts to fulfil his preferences, without him either participating in the reasoning process leading up to the decision and partaking in the decision or having authorised the other person to make the decision on her own, she would act paternalistic. Hence, **if my mother decides to sell my car, which is what I want, without my permission (to save me the bother)—she would be acting paternalistically.**

It may be objected here that the paternalistic feature can be counteracted if I would consent to my mother's act after the fact. At least, such a retrospective approval may be suggested to remove any ethical ground for complaint [27]. This idea seems to form the core of the model of *the professional as perfect agent* [9], the idea that medical professionals should strive to approximate as closely as possible the decision that would have been made by the patient, had she been as medically informed as the professional. For what would be the point of this idea if not to secure an after-the-fact content patient? Had the point been simply to achieve a well-informed choice based on the patient's perspective, it would be more straightforward to apply some model of patient choice (to be explained below)—i.e., handing over decisional authority to the patient.

However, in the practical context of clinical decision-making, whether or not retrospective authorisation would be forthcoming, or if attempts at approximation of a well-informed patient choice would be successful, is very difficult to predict. **Playing it safe against acting paternalistic, therefore, would require that authorisation is a part of the actual decision making process,** at least as long as the patient can give it. These points highlight a central feature of the concept of autonomy: for

others to care for my autonomy, it does not suffice that they act so that my goals are achieved. It is a crucial part of the notion of ‘self rule’ that it is *me* that achieve my goals [14]. In effect, autonomy requires others to act so that I am helped to take such steps that promote whatever it is I care about. For this reason, lack of control over the decision making process reduces my autonomy, and if it does so to my benefit, we have a case of paternalism. In light of this, Van de Veer’s idea of retrospective authorisation as a factor that may counteract the paternalistic nature of a decision thus seems to require an appeal to some other value than autonomy. What happens later can never be a part of me controlling what happened at an earlier point.

The upshot of all this is that clause 2 above needs to be qualified. Our suggestion for a new definition is that A’s decision, D, with regard to S is paternalistic if, and only if, (a) D benefits S, (b) S is not involved as a reasoning party and partaker in making D, and (c) A is not authorised by S to make D by herself. Here it is important to point out that it is somewhat open to what extent and in what sense a person needs to partake in a decision not to make it paternalistic. This will be explored in the following discussion.

The suggestion is made in relation to the context at hand, and is not claimed to suit any imaginable circumstances. For instance, if my wife buys me the suit I have been (what I thought) secretly longing for to my birthday—without me having authorised her to do so, she is clearly not acting paternalistic in any relevant sense. The question of paternalism only arises within certain fields of conduct, i.e., in relation to fields where I have legitimate authority [27]. Many share the intuition that we have legitimate authority over our own body, our own life and our own possessions—but we do not have legitimate authority over what someone should buy for our birthday etc. Luckily, such considerations need not trouble us in the context of health care and our further discussions of SDM.

We might need to say a few words about two other points, though. First, the notion of *authorisation* may be understood in different ways. However, in the context where the paternalist model is contrasted against respecting autonomy it seems obvious that in order for the authorisation to be ‘valid’, it should at least be **voluntary, non-coerced and well-informed**—all of which are features of standard ethical guidelines for health care and medical research [1, 5, 10, 29]. Simply handing over the decisional authority on a whim or as an impulsive way of reducing anguish cannot suffice as authorisation. Moreover, S should have a choice as to whether S should authorise A to perform the decision or act, and the choice should not be a result of illegitimate threats. Hence in a situation in which A is in formal control over the decisional situation, as in a medical consultation, the alternative of allowing S to reason around the decision and then make the decision must be a real option—if the decisional situation should not be inherently paternalistic. This implies that S should have the possibility to withdraw his authorisation without negative consequences due to actions taken by health care staff. Moreover, S needs to make the authorisation before the decision is made (or the process initiated) and this authorisation should be explicit.

Second, the relevant notion of paternalism obviously presupposes that the patient actually has a capacity for autonomous and rational decision making in the sense

that we regularly take normal adults to have. In effect, it does not apply when the patient is incapable to make her own decision in an autonomous or rational way. Chief cases here are small children, unconscious adults, psychotic, severely mentally retarded or gravely intoxicated people, etc. It is quite possible to act in such people's best interest without their authorisation without therefore acting paternalistic. The reason is simply that, in these cases, there is no valid authorisation or lack of authorisation to be had, so talking about paternalism would be a misnomer. The point of mentioning this is that, presumably, everyone agrees that SDM is not a model for decision making regarding patients in this category. Thus, SDM may be close to or incorporated into the paternalistic model without being open to the accusation of laying claim to an obviously illegitimate area of application. However, it may also remove itself far from this model and similarly escape such criticism.

Patient Choice

The idea about patient choice is sometimes called the informed choice or the consumer model of medical decision-making [7]. However, since these labels are often used in a more limited, vulgar or even pejorative sense, we will talk broadly about patient choice, and take this to cover a variable collection of decision-making models. Despite the variation within this collection, all of these models differ from the paternalistic model in the following way: patient choice implies that the patient somehow remains in authority over the decision as to what should be done. Hence, in the end, regardless of how the actual process leading up to the decision looks like, the patient makes the final choice among existing alternatives.

This idea about medical decision making connect strongly to ideas within health care ethics about the moral valence of autonomy, that have been assigned increasing importance in post World War 2 debates [1]. Central to these ideas is the notion of a right of patients to make their own choice of whether to accept or decline offers of health care, and the accompanying right to be well-informed about these offers as a preparation for making such a choice. That is, in contrast to paternalism, this model allows for patients not only to make choices, but to choose options against their own best interest—as long as they are well-informed.

Still, as will transpire below, patient choice can be implemented in a number of different ways, based on different ideas about what should be taken into account in such choices, the responsibilities of health care staff to assist, and resulting ideas about how the decision process should look like. Moreover, since the professional is in formal control over the care and treatment that is to be decided on, the idea of patient choice calls for a certain **framing of the decisional situation**. This framing normally includes the professional (or the institution which she represents) having decided on the range of alternatives that the patient can choose between. This is an important part of patient choice in order to contrast it to a 'pure market model' of buyer and supplier. By controlling the framing of the decisional situation, health care professionals can accept the decision of the patient without **having to sacrifice ethical and professional standards of 'best practice'**. Choosing the framing so that no option would go against such a standard, patient choices that would be

unacceptable from the perspective of professional health care ethics can be safeguarded against. Obviously there is an area of variation here, and SDM raises questions about whether the patient could influence where the lines are drawn. We will return to this below, as we will to variations regarding ideal decision processes within patient choice.

As with paternalism, an obvious condition of patient choice is that the patient is capable of making an autonomous and/or rational decision. If not, a simple ‘best interest model’ applies, just as it does from the point of view of paternalism. As said, however, in relation to the task of making SDM more clear, this does not have to worry us any more than pointing it out.

The Room for Sharing in Paternalism and Patient Choice

After having established how SDM and its main competitors paternalism and patient choice can be characterised we now move to analyse whether we can find versions of paternalism and patient choice that incorporate some (or even all) of the aspects of SDM. As hinted above, the primary importance of the question of where SDM is to be situated in relation to paternalism and patient choice has to do with the intimate connection between these respective decision models and basic health care ethical ideals. These ideals can be seen as partly complementing, partly competing with each other. Paternalism connects to an ideal of acting in the best interest of the patient, sometimes spelt out in terms of beneficence and non-maleficence [1], while patient choice connects to an ideal of respecting patients as autonomous and rational beings. Thus, making clear how the ‘sharing’ supposed to take place within SDM can be combined with these models will also give us information on the extent to which SDM may respect and/or promote the underlying ideals. In effect, we will be able to see how different specific variants of SDM connect to underlying ideals about the goals and limits of health care, thus informing us of connected problems with regard to the balancing of competing considerations. If, as a result of this, we find some variant of SDM that fits neither within paternalism, nor within patient choice, further inquiry is needed in order to understand what the goals and limits of such a model might be.

Structural Preliminaries

In health care ethics, the potential conflict between the ethical ideals underlying paternalism and patient choice are often stressed. Obviously, acting in the patient’s best interest may itself require disregarding the patient’s wants, ignoring the patient’s subjective perspective and/or denying the patient access to the decisional process. Similarly, respecting the patient’s wants, promoting her ability to make a well-informed rational decision and handing over the authority to make the final choice to the patient may require accepting a result that is not in the patient’s best interest (from the professional perspective). However, seen from a broader perspective, these conflicts should not be overemphasised. In the concrete clinical setting, ways of setting up the decisional process that make use of the patient’s

perspective and promote the authority and participation of the patient may many times also promote her best interest by, for instance, being instrumental for adequate diagnosis and choice of treatment and long-term adherence as well as satisfaction with the end-result. That is, aspects of paternalism and patient choice might be mixed in various ways in clinical practice.

On the basis of this, SDM may initially be seen as a vehicle for achieving such mixes in the clinical setting, and the interesting question becomes how different interpretations of ‘sharing’ affects what sort of mix is achieved.

In the following, we will investigate this matter by sliding bit by bit along a scale, the endpoints of which are extreme versions of paternalism and patient choice, respectively. None of these extreme versions are seen as compatible with SDM, while the variations in between them may be so compatible.

The extreme versions are united by taking the cognitive, communicative and evaluative shape of a monologue. In the paternalist case, the health care professional applies predefined standards of what is of relevance to find out, what is the goal of treatment, what information needs to be sought on the basis of that, and how the result of the findings is to be evaluated in terms of a clinical decision, that is then to be communicated to the patient. For instance, in order to set a diagnosis and find an appropriate treatment according to state-of-the-art, a number of biomedical tests are carried out, and on the basis of the result of these, a decision is made as to what treatment to use. In the case of patient choice, the roles are reversed in that the patient has a predefined idea of what is of relevance to find out, how that is to be achieved, what is the goal of treatment and what decision regarding treatment that is to be made on the basis of that. In this case, we have a ‘demand driven’ or ‘pure consumer’ model of health care. Our initial assumption, then, is that neither the professional monologues, nor the pure consumer model, are compatible with SDM in any form.

However, we also assume that the next step on the scale (from either end) is incompatible with ‘sharing’ in any interesting sense taking place. In this case, the professional (in the patient choice case) and the patient (in the paternalist case) are both authorised to ‘veto’ the decision made by the other party. In other words, just having a right of patients to decline offers of health care, and a right of professionals to insist on some minimal professional standard does not make for any SDM. In the following, therefore, we will assume these features to be in place, and investigate how elements of ‘sharing’ may be introduced as amendments to that. We will do this, starting from the paternalist end of the scale (where we thus assume, that the patient has a right to reject any treatment proposal made by the professional). The interesting question is whether such additions will force the clinical set up out of the paternalist model and into the patient choice camp. After that, we will approach the matter similarly, but from the patient choice end of our imagined scale.

Sharing as a Part of Paternalist Health Care

According to Emanuel and Emanuel [8], an essential quality of the relationship between professional and patient, is the quality of caring for the immediate and/or salient needs of the patient in the very moment of interaction—something which is

evidently missing in a strictly monological paternalist decisional approach *just because* it is a monologue. Now, the patient can be allowed to share in different ways: ranging from simply venting his concerns, over having these concerns affirmed, to having his concerns cared for in the sense of being provided support and comfort in relation to these concerns. Consider therefore:

1. *Sharing as venting* The professional talks with the patient about his situation and listens to his thoughts and concerns about what is going to happen and how this is going to affect his life.
2. *Sharing as affirmation* The professional talks with the patient about his situation and listens to his thoughts and concerns about what is going to happen and how this is going to affect his life. The professional does her best to affirm and endorse the patient's thoughts and concerns.
3. *Sharing as caring* The professional talks with the patient about his situation and listens to his thoughts and concerns about what is going to happen and how this is going to affect his life. The professional does her best to affirm and endorse the patient's thoughts and concerns and, at the same time, tries to comfort and reassure him, in a way as realistically as possible given the prognosis.

These different sharing models connect to the value (beneficence) underlying paternalism, since the professional acts as she does for therapeutic reasons with regard to the patient's immediate (and possibly also long-term) well-being. However, these types of therapeutically driven sharing models can actually be added whatever decisional process is applied and whatever decision is made with regard to diagnosis, treatment, etc. They are hence compatible with both paternalism and patient choice.¹ In any case, if paternalism is combined with these therapeutic sharing models, especially in the form of sharing as caring (and the latter thus not influences the decision process or decision), this seems to be the cliché of the paternalistic, but caring and good hearted physician of the 'good' old days.

The 'sharing' going on in these cases of sharing is about the professional listening to messages from the patient and responding to these, as well as attending to perceived immediate emotional needs thus communicated. But other variants of 'sharing' may directly be a part of or affect the decision process. Consider:

1. *Patient Adapted Paternalism* The patient tells the professional about how he leads his life in different areas, what is generally important to him and his former experiences around health-problems. The professional incorporates this information into the decisional process and adapts the decision about treatment

¹ Since Emanuel and Emanuel [8] criticises the patient choice model (which they call the informative model) for its lack of caring ingredients, it appears that they believe the venting, affirmation and caring models of sharing to be better suited to paternalism. Possibly, this may be due to a confusion of the (true) fact that all of these models of sharing connect to beneficence (which may conflict with autonomy) with the (false) assumption that beneficence can never be combined with a concern for autonomy. There is, as they note, a possibility of the professional to some extent influencing the decision of the patient by showing an interest and/or attending to his emotional needs. However, this in itself does not make for any paternalism—as long as the professional does not exploit these needs of the patient in order to covertly assume control over the decision making process.

to what she has been told, in order to arrive at a result that suits this particular person's circumstances.

In this case, the professional still acts paternalistic, since **she is the one who interprets the information from the patient, reason from this to a decision and then makes the decision—all done without the patient explicitly authorising her to do so.** The patient is then informed about the decision and he could also be informed about why the decision was made. The way in which a decision is assessed to suit the patient's circumstances is furthermore assessed from the professional's concern for acting in the best interest of the patient, taking into consideration factors revealed by the patient of relevance for getting the diagnosis right, avoiding inefficient treatment options and securing compliance and retrospective satisfaction. Essentially, the 'sharing' in patient adapted paternalism thus brings information communicated by the patient into the decision process by treating it as an instrument for arriving at an optimal decision on the basis of the professional's own standards.

Going one step further would require the professional to incorporate the patient's preferences into her decision-making not only as a factor to consider instrumentally, but as an actual part of the basis from which options are evaluated and selected. Consider:

2. *Patient Preference-Satisfaction Paternalism* The professional explores the preferences of the patient by listening to his opinions and motives, and then reason from these preferences and other relevant information in order to arrive at a decision that best satisfies the preference-set of the patient.

It might sometimes be an overstatement to assume this sort of process to involve exploration or elicitation of a pre-existing preference-set of the patient. It could as well, as described by Emanuel and Emanuel [8], be that the professional by listening to the patient, helps him to work out these preferences and their mutual priority—what they call the interpretative model.² Then, eventually, this set is incorporated into the reasoning and results in a decision made by the professional.

The versions 1 and 2 can be combined in various ways. In some particular instances there may be a conflict between them—namely when the patient's preferences go against the view of the professional as to the goals of treatment (the patient may, e.g., be willing to accept a worse prognosis). Still, even in those cases when they can be and are combined (for instance, so that the professional adapts the set of options to the situation of the particular patient), the professional remains in authority over the decision and the decision process. In line with what was said earlier, therefore, even a combination of 1 and 2 would be paternalistic. That is, as long as the 'sharing' involved in SDM does not imply handing over decisional authority to the patient, SDM is quite compatible with paternalist health care. The only problem involved in this seems to be that, in practice, different aspects of 'sharing' may in some cases pull in opposite directions, since patients may prefer treatment options that are not optimal from the professional's point of view (e.g.,

² Emanuel and Emanuel [8] see this as strength of the interpretative model over patient choice. As will transpire, however, this aspect may perfectly well be incorporated in the patient choice model.

since they will risk compliance and therefore and more essential, the outcome of treatment).

The potential for irresolvable conflict between 1 and 2 has its roots in a ‘static’ feature of the process, where one party (the patient) serves purely as a provider of information, while the other (the professional) handles the actual decision making and thus exclusively serve as evaluator of the provided information. This actualises the idea of introducing a dynamic element by having the professional and patient engaging in systematic discussion in order to have the chance to trade information back and forth as well as accommodate their respective ideals and preferences. Either part of this element may result in the conflict being resolved, but it may also serve other purposes mentioned earlier, such as securing compliance and forming clear preferences. Consider, therefore:

3. **Shared Rational Deliberative Paternalism** The professional and patient both engage in a rational discussion or deliberation, trying to get all the relevant preferences, facts and reasons relating these aspects together on the table. In the end the professional decides on what option to choose.

Sharing as a Part of Patient Choice

A standard opinion on the patient choice model is that it is not to be recommended unless it involves health care professionals sharing some information with patients (beyond the mere naming and explanation of available options) that the latter may use for deciding on what to do [1, 10]. Thus, consider:

4. *Informed Patient Choice* After having laid out the available options for the patient, the professional also explains relevant facts about these options (e.g., regarding risks and benefits). The patient then decides on what option to choose.

This version of SDM assumes **the patient to have clear preferences on which he can base his decision with the help of the information shared by the professional**. However, as mentioned in the former subsection, the patient may sometimes need to work out his preferences in tandem with receiving information about the options. Going one step further as regard the ‘sharing’ involved, therefore, we may consider [8]:

5. *Interpretative Patient Choice* With the help of presented information and the patient’s opinions with regard to the options on the basis of that, the professional describes different ways of interpreting what the patient says in terms of lines of argument, expressing different preference-sets. The patient then decides on which of these to take into account in what way, and makes his decision on the basis of that.

Just as, in the case of paternalism, the professional can take into consideration the preferences of the patient, within patient choice, the patient may do the same with regard to the professional. Thus, in the spirit of the classic notion of a counsellor or advisor, the professional may inform the patient of his opinions, reasons and preferences as regard the options without transforming the model into paternalism. Hence, we also can consider:

6. *Advised Patient Choice* On top of what has been mentioned earlier, the professional also voices his opinion on what option she prefers, and why that is so. The patient then makes his decision on the basis of all that has been said.

All of these variants of SDM within patient choice have the sort of ‘static’ feature mentioned at the end of the former subsection, only with reversed roles (the professional is the information provider, while the patient handles the decision making). Just as in the case of paternalism, this gives rise to a potential for irresolvable conflict arising out of differences in the respective ideals and preferences of the patient and the professional. However, also here, the process may be made more dynamic by having the parties enter into a joint rational discussion or deliberation [8]. Brock and Wartman [2] describes a process in this vein and actually dubs it shared decision-making. Thus, consider:

7. *Shared Rational Deliberative Patient Choice* The professional and patient both engage in a rational discussion or deliberation, trying to get all the relevant preferences, facts and reasons relating these aspects together on the table. In the end the patient decides on what option to choose.

Taking ‘Sharing’ All the Way: The Case for High-level Dynamics in SDM

It can be concluded that there is considerable room for different variants of ‘sharing’—and thus SDM—within both paternalism and patient choice. As demonstrated, for most of these variants, the sharing is limited to the provision of information of different kinds in one or the other direction (on top of that, all other variants may be complemented by the therapeutic forms of sharing mentioned at the outset of the former section). Two variants (3 and 7, respectively) however, stand out by extending the sharing to a *high-level dynamics* in the process. The other variants introduce some dynamic elements, since the information provided might in various ways affect the decision-making party. However, there is a static element in that no party has any necessary incentive to reconsider his or her evaluative basis (ideals, preferences, values, etc.). Variants 3 and 7 introduce such an incentive by having the parties engage in a discussion where arguments and reasons have to be presented, compared and evaluated, thus making for a high-level dynamics where their evaluative basis may be revised and accommodated in the light of this. Unless we make the implausible assumption that the patient or the professional necessarily gets it right from the start, such a reasoning process will have obvious benefits.

There are reasons to claim that these two variants of SDM (3 and 7) are both the most interesting from a theoretical perspective and urgent from a practical point of view to consider in greater depth. First, the presence of high-level dynamics provides an instrument for conflict resolution that may be of value for many different aims (ethical, intellectual and practical). Ethical, since it provides a better ground for a continued care relationship where the professional can continue to care for the best interest of the patient. Intellectual, since this implies that the decision made is as rational as possible given the preferences and situation. Practical, since a continued conflict can cause difficulties in the continued administration of

treatment. Second, both variants take sharing a long way, even if remaining within the models of paternalism and patient choice, respectively. From the perspective of an emphasis on patient best interest (paternalism) this implies giving the patient more room to influence the final decision by bringing in preferences and reasons to support that the understanding and wants of the patient should be taken into account into the reasoning process. From the perspective of an emphasis on patient autonomy (patient choice) it gives room for the professional to reason around what is really in the patient's best interest, giving the patient an opportunity to critically assess his preferences and the reasons around different sets of preferences and how they can be satisfied in the situation. This holds even if, in the end, the patient's autonomy will be respected and he will make the decision. Since both patient best interest and patient autonomy are values that should be taken into account, both these models are better suited to do so than the more pure paternalistic and patient choice alternatives. And it will depend on how we prioritise between these values in case of conflict whether the *Shared Rational Deliberative Paternalism* or *Patient Choice* model will receive strongest support. Third, both these features (high-level dynamics and taking sharing a long way) have the upshot of reducing the practical and theoretical 'distance' between paternalism and patient choice, thus opening up for a version of SDM that transcends the framework of every model of clinical decision making having to be categorised in terms of two incompatible and mutually exclusive medical ideologies.

In order to explore this possibility, as well as the idea of SDM, further, we will in the next section compare alternative ways of 'modelling' the idea of a 'shared' or 'joint' *decision* (and not only a reasoning process) where sharing is taken 'all the way'.

Negotiation, Deliberation and Joint Decision Making

There are two different reasons for engaging in 'sharing' in the form of joint decision-making. The first is to arrive at a well-founded decision—in which case we call the process *deliberation*. The second is to resolve conflicts of interest—where the process is often referred to as *negotiation* [3, 4, 19]. In both cases, the ideal is to reach a consensus; however, the implications of failing to reach this aim are rather different.

In the deliberation case, the upshot of failure will be intellectual disagreement as to what decision would in fact be best (perhaps because there is disagreement on what evaluative basis should be applied to the facts at hand). In the negotiation case, the upshot will be loss of the practical opportunity of (an optimal) joint venture. It is of some importance to note that, while the failure to agree on what decision would be well founded *may* also bring loss of a practical opportunity, it *need* not do so. This since, although a person does not agree that a certain decision is the best one, she may still find it to be in her interest to comply with it. This also works in the reverse way: even if she does not find compliance to a decision to be in her interest, she may still recognise it as the best one. In other words, there is no necessary connection

between consensus and failure to reach a consensus in the deliberation and negotiation models, respectively.

In the following, after some further conceptual preliminaries, we will first comment on the negotiation model of joint decision making (for a further exploration see Sandman forthcoming³), noting a number of weaknesses, and concluding that it is not very well suited to the idea of SDM. After that we will move on to the deliberative model, noting some strength in relation to the negotiation model, but also a number of problems.

Joint Decision Making as Negotiation

As noted at the outset, it is rather common to describe what is taking place between the professional and the patient in SDM in terms of a negotiation [4, 19]. However, in many instances the use of this notion seems to be mainly metaphorical, indicating rather something closer to what has been termed deliberation above. In academic usage, this is a rather common way of using the term ‘negotiation’ as a loose label for all sorts of social processes where people gradually adjust and accommodate their beliefs, preferences, behaviour, etc. to each other. Thus, linguists and sociologists may talk about people ‘negotiating concepts’, for instance. In this loose sense, the notion of negotiation may perfectly well be applied to social patterns of coordination of which the participants are completely unaware. Presumably, many of the descriptions of SDM in terms of negotiation apply this sort of usage. However, as has already been indicated, and as will be further supported below, a sharpened understanding of SDM needs more precise conceptual tools. For one thing, coordinating processes of which the participants are completely unaware seem to be outside the scope of interesting interpretations of what the idea of SDM is about. After all, the idea of SDM is the idea of an elaborate strategy that is consciously applied in the clinical situation. Perhaps a side-effect of such application will be some behavioural coordination of which the parties are unaware, but this is exactly that: a side-effect of SDM rather than a part of what SDM is.

The terminology introduced above delimits the meaning of the notion of negotiation even more narrowly, however. This since there is a need to separate coordination processes that aim for different things (consensus regarding intellectual well-foundedness vs. mutually rewarding practical joint ventures), and ‘negotiation’ seems to be better suited for denoting processes having the latter aim. This is often described as a ‘mutual gains bargaining’ [21]—the typical case being a straightforward business negotiation.

In a mutual gains bargaining, the parties come to the negotiation with different stakes and different negotiation or bargaining positions. That is, both parties want something from the other party and also have something to offer the other party. But the position of the parties are different as to how much it is worth compromising with their interests before the prospect of a joint venture loses its attractiveness, and how high costs in terms of time and effort it is worth to chisel out an agreement (what is called reservation price [25]). Bargaining with a car dealer may be a case in point.

³ Sandman L. The Concept of Negotiation in Shared Decision Making, *Health Care Analysis*, accepted.

Initially, the *oddness* of describing the dealings between a health care professional and a patient in a medical consultation in this way may be pointed out. It is clear, of course, that the patient has a self-related interest in the situation—in terms of having his suffering relieved, his quality of life promoted or life prolonged, etc. However, as is argued in Sandman (forthcoming), it is difficult to see what the self-related interests of *the professional* have to do with proper provision of health care and medical consultation or decision-making, let alone the idea of SDM. This given that the consultation takes place within the context of a health-care system, where the patient does not simply pay the professional for providing whatever service he may desire.

A minimally plausible version of the negotiation model of joint decision-making thus needs to be constrained with regard to what sort of interests and stakes are permitted to enter the process. The most plausible suggestion is that the interests and/or stakes entered by the professional need to enjoy *institutional sanction*. That is, the professional cannot transcend the limits of what is considered important considerations set by the internal goals of the institution of health care, its ethical constraints, formal placing in the larger societal apparatus, etc. There are two basic ways of incorporating this sort of constraint into the model: (a) the professional is assumed to have self-interest in advancing such stakes, or (b) the professional is viewed as a representative of the institution of health care. Of these, the latter seems to be the more realistic route, allowing that, in real life, a professional may sometimes stray from her professional role.

Now, is this idea of a negotiation a fitting model for the sort of joint decision-making supposed to take place within a version of SDM that takes sharing ‘all the way’? There are several reasons to deny this. First, even constrained in the way just described, the idea of negotiation still embodies the phenomenon of *bargain*. This means that even if the stakes of the professional are worthwhile stakes from the point of view of health care, the model involves the possibility of selling these out in exchange for a price paid by the patient. In other words, the negotiation model seems to be incompatible in an essential way with the idea of a set framework of values, such as professional or ethical standards regarding the risk-benefit profile of acceptable treatments. As mentioned early on, it is a presupposition of the general ideal of SDM that such standards remain untouched by SDM.

Second, the negotiation model will systematically put the patient in an extremely weak position of bargain. The professional obviously has a very strong bargaining position—having access to and the instruments to interpret relevant information, having the power to effectuate the decision, not being in any way dependent on the individual patient, being in charge of what the patient wants and needs (i.e., medical treatment and care), etc. As an upshot, there does not seem much left of ‘sharing’ of the actual decision-making. In practice, the patient is left with accepting what the professional offers, or going home. The idea of ‘taking sharing all the way’ thus shrivels into a formal opportunity of the patient to voice his opinion that in many cases will seem completely pointless.

Third, the negotiation model seems to fail achieving the property of high-level dynamics noted to be of such importance above. The process of bargaining back and forth provides no salient incentive for any of the parties to reconsider and

accommodate their respective basis of evaluation (i.e., their basic preferences). All that is introduced is the psychological logic of one or the other party realising that she may have to go for second or third best in order to get anything at all. The fact that she accepts this outcome in no way implies any ‘sharing’ in the decision making process, other than having to accommodate to the fact that she receives this or nothing. In light of all this we conclude that the concept of ‘negotiation’ is not suitable to characterise SDM and hence move to consider the concept of ‘deliberation’.

Joint Decision Making as Deliberation

Savulescu [23] and Savulescu and Momeyer [24] have argued for the claim that health care professionals, in the process of seeking informed consent, have reason to enter a rational discussion with patients. The thrust of the argument is that the professional have reason to secure as far as possible that decisions made by the patient rest on rational beliefs (and, presumably, valid patterns of reasoning). The starting point for this argument is a patient choice perspective (from where the idea of informed consent originates). Hence, the professional should not accept what at face value seems like an irrational or unfounded standpoint of the patient. Instead the professional should argue for what, according to the professional and the values the professional represent, is most rational to do, given the situation. Still, having done so, the professional should accept the decision of the patient. That is, they seem to argue for what above was called *Shared Rational Deliberative Patient Choice*.

Now, since the right of the patient to opt out is presumed in our discussion, the aspect that makes this suggestion appear as one of patient choice rather than paternalism may be ignored in the present context. However, the rest of Savulescu’s and Momeyer’s idea may be retained.

Their basic thought is that the decision of the patient should be as rational as possible, in order for the patient to be as autonomous as possible (the connection between autonomy and rationality is explored in the context of medical ethics, e.g., in [14], Chap. 3, and [20], Chap. 6). At the same time, however, they seem to claim that the professional should represent the values of medicine (whatever they are) and argue for the most rational option based on these values. This, of course, makes for the possibility of internal conflicts in the evaluative basis of the professional (in case where a patient strive for something not conforming perfectly with the values of medicine). To resolve this conflict, the professional would seem to be forced into reconsidering this basis and enter into a process of argument, where those considerations valued highly by the patient are compared to the considerations of relevance from the values of medicine. Moreover, as was observed in connection to variant no. 1 of SDM (*patient adapted paternalism*), in order to be rational, the professional may need to consider information and arguments provided by the patient. In some cases, the patient may even be better placed to assess the quality of an argument from medical premises. Moreover, both will need assistance of the other to clarify relevant concepts, descriptions, etc. So, in the end, it would seem

that both parties are in need of each other's assistance to safeguard against mistakes in matters of fact, logic or values.

Beyond Paternalism and Patient Choice?

The situation thus described reminds very much of the standard ideal picture of scientific discourse. All participants—the professional and the patient—bring beliefs, conceptual tools, preferences and values to the decisional situation, but the process thus initiated is not about bargaining in the search of an equilibrium of price and merchandise. It is about working together in order to find a consensus on what is the most rational or well-founded decision. This implies, e.g., a strong need for sharing as much of the information brought into the process, making effort to explain it, getting rid of conceptual misunderstandings, etc. So far, the process described is compatible both with variants 3 and 7 of SDM. It could also involve 'taking sharing all the way'—where the patient and professional really has to work together, continuously communicating, to reach a joint decision—and a high-level dynamics; real incentives to reconsider the evaluative basis from which a decision is to be reached. As described, even if the professional has strength in her professional skill and knowledge, the patient need not be in the sort of weak and completely dependent position as in the case of the negotiation model. Let us call this model:

8. *Shared Rational Deliberative Joint Decision* This model has affinities with the idea of practical discourse within the discourse ethical paradigm [12, 15] which exemplifies what Habermas calls communicative action. Communicative action aims at consensus between the parties—not necessarily in line with the predetermined goals or interests of any of the parties. In order to achieve this the discourse should be surrounded with a number of constraints (which to a large extent are applicable on the *Shared Rational Deliberative Joint Decision Model*: 1) All parties concerned by the decision should be given the opportunity to take part (generality constraint): 2) All the parties should be able to express whatever they find as relevant needs, interests, suggestions, reasons etc. (autonomous evaluation constraint): 3) All parties should be open to seriously consider the interest of the other party and allow their own interests to be radically questioned (role-taking constraint): 4) No goal or interest should be given more weight due to the position of the party (power neutrality constraint): 5) All interests, goals and reasons should be openly displayed (i.e., there should not be a hidden agenda) (transparency constraint).

In practice, of course, this rosy picture is dependent on the presupposition that the professional does not exploit her initial authority as medical expert in order to manipulate the patient into compliance. In reality, this may happen a lot. But SDM is not thought to be a description of reality, but an ideal that should be applied. Nevertheless, it should be observed that practical application of SDM as Shared Rational Deliberative Joint Decision-Making may never be perfect due to factors as this one.

Another obvious drawback of this model is that it seems to be expensive. It takes time and effort to perform the sort of task described, and professionals would have

to be duly educated to set up the consultation situation in a way fitting efficient implementation of this idea of SDM.

Last, the model so far described is undecided on how, more exactly, a decision is to be reached. Sometimes, of course, consensus may be reached swiftly. If the consensus is a result of the kind of rational deliberation described, this will imply that the parties agree upon the best possible decision given the situation. If so, the paternalistic and patient choice models converge, and would seem to allow us to benefit from the values of both models, not having to choose at the expense of some values.

But in other cases, such consensus might not be reached, resulting in a persistent conflict, even after having straightened out misunderstanding and presented reasons to convince each other. As has been presented above, in such a case, we might resort to either the paternalistic or patient choice model, depending on how we balance between the values of patient best interest and patient autonomy. Given the value of patient best interest we should also take into consideration the potential for reaching an effective decision (i.e., a decision the patient would adhere to), which will be a reason against adopting the paternalistic version. What if we want to continue to pursue the shared decision making model further? In Charles et al. [3, 4] we saw that in case of conflict, they advocated a model of negotiation, resulting in consensus on a compromise. In the following we will describe how this should be understood.

Above we came to the conclusion that negotiation in terms of mutual gains bargaining was not a suitable model to describe the situation and obviously the rational deliberation has here come to an end. What makes this situation look like a mutual gains bargaining are a couple of factors. First, both the professional and the patient have a reservation price [25], meaning that they have limits for what kind of compromise they could accept. Second, in order to arrive at a decision, the parties are willing to accept a sub-optimal decision from their perspective. Third, they both have stakes in the situation, even if they cannot be viewed as the kind of self-interested stakes needed in a mutual gains bargaining (Sandman, forthcoming).

Since the negotiation model is unsuitable, we propose that this situation should be viewed as a case of strategic decision making, mainly on behalf of the professional. A background assumption is that the professional is in control over what the decision is about and hence must be committed to allow the patient to take part in decision making to different extents. Another assumption in the SDM model of Charles et al. [3, 4] is that the professional legitimately bring preferences around what is in the best interest of the patient to the decision-making situation. Based on this, the professional will both have an institutionally sanctioned idea about a lowest acceptable limit for what could be offered to the patient, but also an idea around what would ideally benefit the patient *the most*. Realising that the patient is not willing to accept what is ideally viewed as in the patient's *best* interest, and still aiming at consensus, the professional is motivated to accept a compromise within these limits.

The reason why the professional is motivated thus is partly due to the motive of finding a decision that, as far as possible, sees to the best interest of the patient, and the interest in securing adherence connected to that. But it is also based on

professional ideals of caring for the autonomy of the patient. Given this, the professional may act strategically, using persuasive means (such as riding on the authority of the white coat) to get the patient to accept a decision that as far as possible adapts to the professional ideal. If the professional is genuinely interested in the patient's best interest, she will not push it further than what the patient could be expected to adhere to. However, the concern for patient autonomy could make her stop even before reaching that point. The extent to which the professional tries to strategically get the patient to accept a decision will be due both to what will be an efficient decision, but also due to how patient autonomy is balanced against the patient's best interest. Here, considerations not primarily related to the individual patient could also be taken into account, e.g., regarding institutional legitimacy, general patient trust, public health, etc. The patient might also try to act strategically to get the professional to accept what the patient wants. However, given the position of the professional, the professional's strategic measure is likely to be more successful than the strategic measures used by the patient. In distinction to the *Shared Rational Deliberative Joint Decision Model* where the best interest and autonomy of the patient harmonise, here we find these values to be potentially in conflict with each other. Also depending on a conflict between different perspectives on what is in the best interest of the patient.

This version of SDM should still achieve consensus between the patient and professional, since the parties should find a compromise both parties can agree on. Hence it is not purely paternalistic as to the making of the decision (since the patient partakes in decision making and the decision needs to be authorised by him) and neither a pure case of patient choice (since the professional applies some pressure and persuasion). However, it can be viewed as driven by a central feature of paternalism, i.e., the professional perspective on the patient's best interest. In line with this we call this model:

9. The *Professionally Driven Best Interest Compromise Model* Using Habermasian terms again we can claim that in moving from the *Shared Rational Deliberative Joint Decision Model* to the *Professionally Driven Best Interest Compromise Model*, we move from communicative action to strategic action [12]. Strategic action aims to reproduce meaning (in the sense of a certain way to understand things) or to achieve a predetermined goal or interest of a person or system/structure. The strategic action can be open or latent. The open strategic action openly displays its agenda as to what it wants to achieve, whilst the latent strategic action have 'goals and interests whose effectiveness require their not being shared' [15]. The latent strategic action either works through one of the parties manipulating the other, or through self-deceit by what is called systematically distorted communication. In positioning the strategic action involved in the *Professionally Driven Best Interest Compromise Model* as openly strategic action in distinction to latently strategic action, we emphasise the weight assigned to patient autonomy and respect for the patient. That is, the patient should be aware of when the professional acts strategically and in what way to be able to relate to this.

We have touched somewhat on the effect of framing in the above. One of the frames of the decisional situation is the respective limitation to what the parties could accept, where we said that the professional limitation should be institutionally sanctioned. However, in the shared rational deliberation models of decision-making (3, 7 and 8) the ideal is that apart from this, there should be no framing. That is, there should be an open communicative attitude, where both parties try to arrive at a well-founded decision. A problem is that even given such an ideal, implicit and unintended framing effects (mainly from the professional) might occur [6, 11], something that perhaps could be minimised if the professional is made aware of this. On the other hand, in the *Professionally Driven Best Interest Compromise Model*, in being strategic, the professional is required to (openly) frame the decisional situation so as to achieve what she wants to achieve, although, at the same time, involving the patient in the decision making and ‘taking sharing all the way’ (thus caring for patient autonomy as far as is practically possible).

Depending on the weight given to patient best interest and patient autonomy, respectively we may have more or less strong reasons to pursue this last version of SDM in the case when *Shared Rational Deliberative Joint Decision* fails. If caring for patient autonomy is very demanding (excluding not only paternalism, but any sort of deliberate influence, such as persuasion) and in the end always trumps patient best interest, we should resort to *Shared Rational Deliberation Patient Choice*. If, however, patient best interest (from the professional perspective) in the end always trumps patient autonomy, it seems that we should resort to *Shared Rational Deliberative Paternalism*. However, since evidence show that paternalistic decision-making is less efficient in actually resulting in patient best interest, due to lack of compliance or adherence [18], a commitment to the patient’s best interest over patient autonomy would give us reason to adopt the *Professionally Driven Best Interest Compromise* model. **Here the professional is given the opportunity to achieve a compromise that as far as possible sees to the patient’s efficient best interest (from the professional perspective) and at the same time is open to accommodate this to the value given to patient autonomy.**

Conclusions

Apart from the inaptness of modelling sharing as negotiation, SDM may be readily accommodated or amended to the paternalistic as well as the patient choice model of clinical health care decision making in several ways. Most of these possibilities, however, are not very interesting, theoretically or practically. We have argued that SDM becomes a potent and exciting clinical decision-making model only if it includes what we have called high-level dynamics. In this case, there is also a prospect for SDM to actually become an arena where the polarised relation between paternalism and patient choice is transcended. Firstly, high-level dynamics is an incentive for ‘taking sharing all the way’ and reach a consensus that fully satisfies both paternalism and patient choice through mutual adaptation of beliefs, ideals and values. That is, ideally we should strive to use the *Shared Rational Deliberative Joint Decision* model where both parties agree on a decision found to be optimal

given the situation. However, obviously this might be an ideal, impossible to reach. If so, we are left with the three remaining high-level dynamic decision models: *Shared Rational Deliberative Paternalism*, *Shared Rational Deliberative Patient Choice* and *Professionally Driven Best Interest Compromise*. Above we have argued that *Professionally Driven Best Interest Compromise* is to be preferred to *Shared Rational Deliberative Paternalism*. First, the latter is likely to be less efficient in reaching a decision the patient will adhere to. Secondly, the *Professionally Driven Best Interest Compromise* model illustrates how, when consensus is not achieved spontaneously, paternalism may be avoided, while there is still room for health care professionals to persuade patients to accept an option closer to what the professional believes is in the patient's best interest than what would otherwise have been the case.

Whether the *Professionally Driven Best Interest Compromise* model also trumps *Shared Rational Deliberative Patient Choice* is a more difficult matter to establish, since it draws on the role we assign to patient autonomy in relation to patient best interest. First, it may strike someone as somewhat *disrespectful* to behave strategically vis-à-vis the patient in the way allowed by the *Professionally Driven Best Interest Compromise* model, and this may be taken as a reason for applying the sort of demanding autonomy standard that would exclude the sort of persuasion taking place in this model. Second, allowing to strategically influence the patient thus risk opening up for a more problematic influencing from the professional. Third, in the *Shared Rational Deliberative Patient Choice* model the decisional role of the patient is clear from the beginning, the decision will in the end rest with the patient. Fourth, the minimal standard accepted by the professional can be safeguarded by framing the decisional situation in a way that sets a limit to what can be accepted. However, such framing then needs to be transparent from the outset of the decisional process.

This said we would still like to make a case for the *Professionally Driven Best Interest Compromise* model. With openly displayed strategic action, the professional maintains a respectful attitude towards the patient and allows the patient to autonomously assess whether to compromise with the professional or not, given the strategic stance of the latter. She may simply tell the patient that the option they agree on is not what she would want the most, but that she is concerned about adherence and therefore understands that she has to accommodate to what the patient wants. Moreover, if the patient is adamant about his standpoint, the compromise will at worst converge with the frame for the decisional situation. This is not different from the 'worst' decision (given the professional perspective) in the *Shared Rational Deliberative Patient Choice* given its framing. Trying to find a compromise, which both parties are committed to agree on, will give a better ground for a continued care relationship, than simply allowing the patient to make the decision on his own. Furthermore, since the professional will state the concerns she has with the patient's decision, the patient will know the professional's standpoint and be able to take this into consideration in her future dealings with the professional. Finally, since the patient can always fail to adhere to the decision made, a professional commitment to patient best interest should make the professional committed to find a treatment solution the patient will accept and

adhere to. That is, in the end patient autonomy should be given an important role even within the *Professionally Driven Best Interest Compromise* model.

A possible concern remains here. The *Professionally Driven Best Interest Compromise* model assumes that there is a range of options available between, on the one hand, the limit for what the professional can accept on the ground of professional minimal standards of care, and on the other, the action that the professional holds to be in the patient's best interest. Now, whether there in fact is such a range available would seem to depend on the relationship between the professional minimal standard and the best interest option. In particular, it may be suspected that the idea of good clinical practice means that applying anything less than the best available treatment would in fact violate the professional minimal standard. In some situations, this may indeed be the case—for instance, if a less than optimal dose of a drug would provide almost no therapeutic effect, but significant risks of side-effects. In most cases, however, we believe that there is in fact such a range available. This since the best interest concern needs to acknowledge the need for taking the prospect of adherence into account, while the determination of good clinical practice does not as a rule do so. If it *is* taken into account, what would otherwise look as the best interest option may in fact not be in the patient's best interest to insist on (since the patient would not adhere even if he accepted the decision). In fact, as long as risks of serious side-effects are not present, it may even be a good idea to accept a very ineffective option just in order to get the patient 'into the program', with the hope that he may eventually change his mind and be prepared to adhere with decisions closer to the best interest option.

As PCC have gained ground as a leading ideology of health-care in the recent years, a large number of PCC influenced interventions have been made. See e.g., reviews by [13, 16, 17, 22, 26]. When these interventions involve shared decision-making there is little or no explicit discussion around the exact model of sharing that is implemented and evaluated. As we have argued, different models are likely to further different types of values, hence given what values are important to achieve, the relevant model of shared decision making should be chosen. Furthermore, since these models might have different empirical effects on aspects like health outcomes, satisfaction with care, experience of participation etc. suggestions for further research involve comparing and evaluating different models of shared decision making in a clinical context.

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