Medicine, Health Care and Philosophy (2024) 27:1–2
https://doi.org/10.1007/s11019-024-10196-w

EDITORIAL

Emerging perspectives in the shared decision making debate

Bert Gordijn[1] · Henk ten Have[2,3]

Published online: 14 February 2024
© The Author(s), under exclusive licence to Springer Nature B.V. 2024

A philosopher wielding Ockham's razor might maintain that the very notion of shared decision making (SDM) is superfluous in the context of medicine. Does it not suffice to have the principle of *respect for autonomy* in place, which requires *informed consent*, thus already guaranteeing ample involvement of patients in medical decision making? Have these notions not been doctrinally ingrained since the promulgation of the Nuremberg Code and the Helsinki Declaration? The prominence of patients in medical decision making has since evolved to a point where the issue of patients assertively demanding certain medical treatments prompted debate on bolstering the position of physicians by stressing their *professional autonomy* (Jochemsen and Ten Have 2000), the idea being that physicians cannot be forced by patients - or frankly anybody – to engage in treatments that are deemed futile or unprofessional. Our fictitious philosopher might contend that this dialectical development has produced a sufficiently robust normative groundwork accommodating both patients' and physicians' engagement in medical decision making.

However, this would be an example of top down thinking from first principles gone awry. Whilst the generic notions of (professional) autonomy and informed consent represent important doctrinal innovations, they only stipulate certain entitlements and obligations without specifying how to organise and structure mutual involvement of patients and physicians in decision making. Hence the continued relevance of the debate about SDM in healthcare.

In his analysis of this debate, Engelsma (2023) argues that the discussion has thus far mainly focused on the process character of SDM whilst neglecting the analysis of its intended product, i.e. the shared decision. To address this oversight, he maintains, it is imperative to explore the nature of shared decisions more thoroughly. Putting words into action, he develops a sophisticated metric to assess shared decisions. More specifically, his metric is meant to ascertain the degree to which a decision to implement a particular medical option amongst alternative options is shared. The metric involves six considerations centred around how the physician and the patient rank the alternatives, their preference scores of the alternatives, and the concessions they make (see Engelsma (2023) for a detailed analysis).

In the course of his investigation, Engelsma highlights that his proposed metric gives rise to a variety of intricate issues: How can the six considerations be properly scored and quantified? How should they be weighted amongst themselves? What is the relative importance of the result features as compared to the process dimension when assessing the overall SDM? How should maximizing shared decisions be valued in scenarios where it conflicts with other values such as the patient's wellbeing or survival chances? What are the obstacles to the implementation of the proposed metric in clinical practice? How should the metric or its implementation be adjusted in scenarios going beyond the traditional physician-patient dyad, in which more patients or healthcare workers need to be involved in the shared medical decision (Engelsma 2023)?

Given all these unresolved challenges, Engelsma admits that it might seem enticing to downplay the significance of the shared decision and exclusively focus on the process features of SDM. Yet, he argues there are solid reasons not give up on shared decisions that easily. First, SDM resulting in a robustly shared decision seems intuitively better than SDM producing a poorly shared decision. Second, strongly shared decisions might very well produce beneficial effects for the patients involved. Finally, highly shared decisions are more in accordance with the notions motivating SMD in the first place, i.e. avoidance of paternalism and respect for patient autonomy (Engelsma 2023).

For these reasons, Engelsma makes a case for further investigation of the nature and value of shared decisions as well as the practicalities of boosting the extent to which they

✉ Bert Gordijn
bert.gordijn@dcu.ie

[1] Institute of Ethics, Dublin City University, Dublin, Ireland

[2] Duquesne University, Pittsburgh, USA

[3] Anahuac University, Mexico City, Mexico

are actually shared. With his contribution, Engelsma opens up new and thought-provoking perspectives in the SMD debate.

References

Engelsma, C. 2023. Sharing a medical decision. *Med Health Care and Philos*. https://doi.org/10.1007/s11019-023-10179-3.

Jochemsen, H., and H. Ten Have. 2000. The autonomy of the health professional: an introduction. *Theoretical Medicine and Bioethics* 21(5): 405–408.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.