

ARTICLE

Patient involvement and shared decision-making: an analysis of components, models and practical knowledge

Alan Cribb BA PhD^a and Sara Donetto MBBS PhD^b

a Professor, Centre for Public Policy Research, Department of Education and Professional Studies, King's College London, London, UK

b Research Associate, National Nursing Research Unit, Florence Nightingale School of Nursing, King's College London, London, UK

Abstract

Patient involvement and shared decision-making are prominent ideas in healthcare policy discourses and the focus of extensive analysis in health services research and social sciences scholarship. In this paper, we reflect on the different kinds of knowledge that might help professionals to more fully translate these ideas and the broader ideals of collaborative healthcare, into everyday clinical practice. To do this, we offer a brief account of 8 components of involvement and indicate the ways in which the plurality of these components highlights the complexity of and dilemmas inherent in, patient involvement practices. We also present various models of involvement as 'summary pictures' which foreground specific constellations of these components. We argue that if we are to engage with involvement seriously, we require conceptions of knowledge that recognize and reflect the inherent tensions within and across models of involvement. That is, we need to pay attention not only to technical knowledge - the question of 'what works' - but also to 'practical wisdom' - the question of what *counts* as working from case to case.

Keywords

Health communication, patient involvement, person-centered medicine, practical wisdom, professional-patient relations, quality of healthcare, shared decision-making

Correspondence address

Professor Alan Cribb, Centre for Public Policy Research, Department of Education and Professional Studies, King's College London, Franklin-Wilkins Building, Waterloo Road, London SE1 9NH. Email: alan.cribb@kcl.ac.uk

Accepted for publication 3 September 2012

Introduction

The idea of shared decision-making is, for good reasons, of central importance in contemporary health policy [1]. This notion - along with closely analogous ones such as 'partnership' - arguably represents the focal point of a whole set of interlinking shifts and reforms related to the changing roles of and relationships between, doctors and patients. This is because it conveys a picture of doctors (or other professionals) and patients *working together* and thereby points to a 'middle path'- a path which moves away from any presumption of medical domination or professional paternalism, but does so without reducing health professionals to mere purveyors of services in response to unmediated patient demands.

Shared decision-making (SDM) is not only prominent in policy discourses but has also been the focus of extensive theoretical consideration and of much high quality health services research and social sciences scholarship [2-8]. One of the recurring themes in this literature is the theory-practice gap in SDM (or professional-patient partnership more broadly) - that is, clinical practice does not conform as closely or as often, to

models of SDM as its many influential advocates would like. This gap provides the starting point for this paper. In broad terms we will reflect upon the kinds of knowledge that might help us to do better in translating the ideals behind 'partnership working' into clinical practice. Through setting out some of the complexities and 'open-endedness' that attach to the challenge of patient involvement, our goal is to recognise both the value of and the limitations of, 'technical' conceptions of knowledge.

Here we are focussing on the professional-patient dyad rather than on broader forms of patient or public involvement and we are interested in placing SDM in the context of a broader set of 'clinical involvement' models and practices. After a brief and indicative review of some of the knowledge base related to SDM, we will proceed by offering a heuristic listing and summary discussion of 8 'components' of involvement and use this list of components to review the complexity of and dilemmas inherent in, patient involvement practices. This account of components will also enable us to summarise and 'unpack' key involvement models and finally, to argue for the need for 'practical wisdom', in addition to technical knowledge,

if we are interested in understanding and realising the possibilities of patient involvement.

We will leave ‘definitions’ of models aside for now. We will begin by relying on the assumption of some very loose commonsense consensus about the meaning of ‘patient involvement’ in general and ‘partnership working’ in particular. Initially, we will treat the notion of and the work on, SDM as broadly representative of this set of concerns about professionals and patients working *with* one another, but we will then move on to make some of the necessary differentiations between and within models.

The knowledge base relating to SDM: an indicative summary

There is now a large quantity of published research relating to SDM.¹ In addition to individual research studies, there are a number of systematic reviews on various SDM themes and indeed at least one very carefully constructed overview of systematic reviews first authored by Angela Coulter, a leading figure in this scholarly field [9].

This body of work has provided considered and empirically well grounded answers to a key set of questions, including: (a) how widely is SDM practised in a range of healthcare contexts; (b) what are (some of) the reasons why SDM is not practised; (c) what kinds of interventions and practice initiatives show evidence-based promise for promoting greater use of SDM and (d) what are (some of) the benefits of SDM when it is practised?

It is not our intention to review this substantial literature here, nor do we have the space to do it any kind of justice, but a few indicative examples will serve to indicate the value and importance of this evidence base. For example, Stevenson *et al.*'s work which reviewed 134 observational studies of professional-patient communication, looking at and for the ‘building blocks’ of SDM in practice, sheds light on both (a) and (b) [10]. The observation studies showed, amongst other things, that patients were willing, in principle, to share their perspectives and concerns with professionals, but were often effectively discouraged from doing so by interactions in which they were typically cast into a passive role. They also showed that there was a mismatch between professionals’ *perceptions of the importance* of ‘2-way’ communication including the need to, for instance, check patients’ understanding of information and explanations and the *actual habits* of professional practice. If we focus very specifically on some of the details of these kinds of studies, it is possible to make assessments of which aspects of SDM are more or less likely to be practised and to identify some of the major obstacles to SDM. For example, Braddock *et al.*'s study, which looked at 3,552 clinical decisions, taken in both primary care and surgical settings, showed that while patient preferences were discussed in

21% of cases, uncertainties associated with treatment decisions were only discussed in 4% of cases and the level of understanding of the patients was only assessed in 1.5% of cases [11]. These kinds of studies highlight the many challenges to SDM. They confirm the relative lack of penetration of SDM in most healthcare contexts, but they indicate that this is not simply a product of a lack of interest or willingness on the part of either practitioners or patients. Rather, this lack of penetration needs to be understood as arising from a compound of barriers relating to the overall challenge of reorienting patterns of expectations, roles, habits and routines in the many institutional and social interactions that make up healthcare. In coming to grips with the specifics explored in depth in the literature, we move away from what could otherwise be a rather easy endorsement of the ideals behind SDM, towards a grounded appreciation of how hard it is to change healthcare practice and what is involved in such change. Nonetheless, the literature on SDM should not be seen as primarily negative. Many studies make a contribution to answering questions (c) and (d) above, that is, to providing evidence about the potential for and benefits of, SDM.

One section of the 2006 Coulter and Ellins overview paper brings together the lessons from 22 systematic reviews (and a handful of related RCTs and Technology Appraisal studies) under the heading of ‘Shared decision-making: what works?’ [9]. Their overall summary of findings includes the following bullet points on the theme of ‘what works’:

- Communication skills training should be the main mechanism by which clinicians learn about and gain competencies in the principles and practice of shared decision-making, but the extent to which it is explicitly included in medical curricula is not known. There is evidence that such training can be effective in improving communication skills.
- Coaching for patients in communication skills and question prompts can have a beneficial effect on knowledge and information recall. These interventions also empower patients to become more involved in decisions, but there is no evidence of effect on satisfaction, mood or treatment outcomes.
- Decision aids for patients improve knowledge and information recall and lead to increased involvement in the decision-making process. Patients using decision aids experience less decisional conflict. Decision aids have also been shown to have some impact on health service utilisation leading in some cases to reduced cost but no effect on health outcomes has been demonstrated.

This summary is backed up by a wealth of research evidence which – as is even evident in the summary – is reported in a suitably sober and balanced way with strengths, weaknesses, satisfactory and unsatisfactory outcomes (and absences of evidence) all duly represented. The body of research on ‘what works’ that is brought

¹ See, for example, the lengthy elaboration of SDM and supporting resources at the Foundation for Informed Medical Decision Making (FIMDM) website – <http://www.informedmedicaldecisions.org/>

together here provides one set of very useful and credible answers to the question signalled above – namely, how to translate SDM ideals into practices. At least under certain circumstances and given some carefully designed and implemented interventions (and properly specified outcome measures), it is possible to succeed in strengthening SDM processes with measurable benefits. Not surprisingly, given that SDM depends upon mutual understanding and dialogue between practitioners and patients, the interventions which hold promise are those which support the communication skills of doctors and patients or tools – such as decision aids – that promote understanding and communication in other ways.

What we have presented here is an indicative summary of the research base relating to SDM including a very simplified account of the Coulter and Ellins overview paper. We have no desire to diminish the significance or usefulness of this body of research, still less to be critical of its quality. But we do wish to highlight the dominant genre and epistemological style of this body of work and to suggest that other genres and epistemologies also have an important role to play in this area [12].

The emphasis in most of the published work is on the drawing up of careful descriptions and measurements, the making of causal inferences and on the production of explanatory models which can inform the design of interventions which can, in turn, be ‘tested’ in the same fashion. Of course, embedded within this kind of research knowledge there are also references to practical ‘know-how’; notions of practical strategies or even protocols for enacting SDM. That is, the kinds of generalisations that are discussed as part of the research literature depend upon some broad characterisations of forms of practice. (For example, characterisations such as “coaching, when it takes the form of x (the enactment of a,b,c practices in circumstances d,e,f) can have the desirable effect of y”.) The central argument set out in the concluding section of this paper is that this broadly technicist approach to theoretical and practical knowledge needs complementing by another conception of knowledge – ‘practical wisdom’. But in order to justify and present this argument it is first necessary to analyse the nature of patient involvement in much more depth.

Components of patient involvement: a conceptual unpacking

To illustrate the complexity of patient involvement practices - and to explain the need for complementary conceptions of knowledge - we will abstract out some of the different components of patient involvement in clinical practice. This particular way of ‘unpacking’ patient involvement is designed to be heuristic and is certainly not meant to be definitive or exhaustive. It is simply a rough ‘headline’ list of the kinds of activities that a professional who wants to strengthen their involvement practices can be undertaking individually or collaboratively. The approach here is therefore necessarily and knowingly ‘professional-centric’ – it represents ‘involvement’ as a something

‘sponsored by’ professionals and as a qualification of or a ‘moving away’ from, a historical norm of relative professional domination. The components are:

- (i) creating the conditions for communication
- (ii) informing and educating patients
- (iii) promoting self-management
- (iv) being responsive to patient perspectives
- (v) joint agenda-setting
- (vi) joint decision-making
- (vii) relationship building
- (viii) re-working relationships and systems.

As will become clear, these components are not straightforwardly discrete from one another – they overlap and interpenetrate one another in complex ways. It is rather that they each ‘foreground’ some aspects of involvement. The account presented here is essentially conceptual rather than empirical; however, the underlying analysis is based upon empirical fieldwork.²

Not least, setting out this list of 8 components makes it evident that involvement is inherently diverse and complex. For a professional to ‘involve’ a patient can mean, for example, that they must engage with them, inform them, encourage and support them, listen to them, work collaboratively with them on defining problems and determining solutions, build rapport and trust with them and, at least some of the time, break out of the moulds which typically shape the ways in which professionals and patients interact. In what follows, we will reflect on these components in 3 different ways: first, we will reflect on the components individually to show how they each raise questions about both practicalities and purposes and their inter-linkages; second, we will show how the components and associated purposes, roughly map onto diverse models of patient involvement, including SDM and, third, we will use these reflections to further draw out the inherently dilemmatic nature of patient involvement, including SDM and the need to transcend both technical conceptions of knowledge and the prevailing emphasis on communication skills and tools.

Creating the conditions for communication

Of course, nearly all professional-patient interaction involves communication (not all because, for example, patients can be unconscious), but this does not necessarily include meaningful dialogue or engagement. But if communication is not to consist of simply ‘telling’ patients what to do, then an element of engagement with patient subjectivity is needed. Opening up channels of communication – as with all aspects of involvement

² To be clear in this paper we are not citing the fieldwork to attempt to demonstrate the validity of our analysis, but only to explain its origins – the fieldwork and its methodological basis and rigour claims are presented elsewhere [12] – here we are purely interested in demonstrating the heuristic value of the resulting analysis of components and models.

practices: (a) involves considerable practical challenges and (b) can be done to serve a range of different purposes. Indeed, it is important to recognise that communication does not come about effortlessly. Patients and professionals are not always on the 'same page' or the 'same track' and, for a variety of reasons, it is not always easy for patients and professionals to talk to one another – for example, as noted above, embedded patterns of relating or the norms and constraints built into professional settings may effectively close down channels such that patients don't feel 'allowed to' or confident enough to share their perspectives. Achieving meaningful communication requires the right levels and kinds of time, space, skills, attitudes and trust and all of these things require significant investment of thought and effort if not financial resources. However, talking about developing 'communication' in a general way does not really make much sense. As we will go on to elaborate, communication takes multiple forms and can be for a variety of different purposes – for example, to help inform or provide education, to show and embody respect or empathy, to negotiate treatment options, *etc.* and the exact resources and practices needed are a function of purpose.

Informing and educating patients

At the simplest level, communication involves 2 'directions' – professional to patient and patient to professional. We will say something about the latter under the next 2 headings. Both of these directions can include what can be thought of as the 'transmitting' and 'receiving' of information and, in richer versions, 'educating'. Informing and educating patients – whether, for example, about diagnoses, conditions, treatments, risks *etc.* – is a core dimension of clinical work and could be seen as the most pervasively practised form of 'patient involvement' in 2 respects. Most obviously it is 'including' or involving patients in clinical understandings and agenda. However, in addition, unless educating is to be equated with the crudest and most rudimentary forms of basic information transmission, it entails taking an interest in the conceptions of the relevant 'learners', including, in this case, engaging with patient beliefs and attitudes (whether these are constructed as misconceptions, alternative perspectives or lay 'expertise'). In other words, education, except in the most impoverished sense, is inherently dialogical. As with all the components reviewed here, there is, therefore, considerable scope for 'practical failure' – for example, for making false assumptions, for gauging both the quantity and content of substance incorrectly and generally for working at cross-purposes with patients. Education can also be practised for a range of purposes including both intrinsic and instrumental purposes. Patients may simply wish to understand some aspects of their experience as an end in itself, in the same way that they may wish to understand something about the movement of the planets or the music of Bach. Nonetheless, it is the instrumental possibilities of patient education that are most often highlighted and these are diverse – for example, education can be advocated as an underpinning for SDM, but also for

ends that are much more circumscribed such as 'reassurance' or 'adherence'.

Promoting self-management

Involvement, like communication, could be said to have 2 'directions'. Just as there is the challenge of 'involving' patients in clinical agenda, there is also the challenge for professionals to 'involve' themselves (in various respects) in patient agenda. Important currents of patient education and health promotion more widely, are geared towards helping patients 'look after themselves' and it is increasingly understood – especially in the area of chronic illness – that most of the day-to-day burden of illness management is shouldered by patients (and families/carers) themselves. Patients are, in this respect, already and necessarily 'involved' in their own care, but it is possible for professionals to help support these forms of patient involvement. In this context, patient education can become a very significant dimension of healthcare and much more than a strand in professional consultations. This can involve not only a shift in scale, but also a shift towards broader educational approaches and activities including, for example, structured courses and peer-led group work. More generally, the promotion of patient self-management entails a systematic re-thinking and 're-tooling' of healthcare systems and relationships and entails very substantial practical and organisational challenges. Both patients and professionals have incentives to fall back upon traditional scripts sometimes, with patients sometimes not wanting to assume responsibility and professionals sometimes being more familiar with 'prescription' (even when it is ineffective), than with the 'messy' and potentially compromising process of negotiation and support.

Being responsive to patient perspectives

When professionals attend to the perspectives of patients, they do not just encounter 'information' – accounts of patients beliefs or opinions about things – but the whole of the 'first person' experience and point of view; what is sometimes called the patient's 'lifeworld'. This includes encountering and somehow responding to the emotional dimension of patients' lives and the strong emotions that often accompany many stages in an illness trajectory. In short, involving and supporting patients means attending to the whole person and cannot be understood as simply a rational-technical process. The support that is offered may include information exchange and use practical tools, but it can also include emotional support or care. Accompanying and helping someone on an illness journey calls for dispositions which reach into the core of carers and which, for very good reasons, are not always available from professionals. Nonetheless, it is crucial to recognise that some degree of responsiveness to and accommodation of patient perspectives is essential if involvement is to be more than 'lip service' and also to see that responsiveness

to patients' lifeworlds can – just as with patient education – serve intrinsic and not merely instrumental purposes. Thus far, the accounts of the listed components have emphasised the importance of dialogue for more effective clinical and illness management. But, sometimes listening, attending and caring are ends in themselves. Professionals need to strike very difficult balances here, for example, the balance between accepting and challenging patient narratives or between encouraging independence and acknowledging dependence.

Joint agenda-setting

'Dialogue', if it is to extend to 'partnership', entails not only responsiveness to patient subjectivity, but also responsiveness to patient agency. It is one thing for professionals to take the ideas and concerns of patients seriously, but a subtly (yet importantly) different thing for a professional to see a patient as someone they are self-consciously 'acting with'. The richer the idea of partnership, the broader and deeper the scope for joint working will be and this certainly must extend beyond joint decision-making (discussed below) to include joint agenda-setting. There is, of course, no sharp distinction between agenda-setting and decision-making. But there is a useful commonsense distinction between the processes of exploring and discussing the option set or 'menu' of care and treatment possibilities and the processes of 'closing off' the options by coming to an agreement about what should happen. Joint agenda-setting is difficult to accomplish. Think, for example, of mundane examples such as when one finds oneself having to spend a few days with people one does not know – how does one decide what to do, where to start, how to frame the conversation, how to devote time to different potential discussion items *etc.*? How does one avoid one party dominating the process or, on the other hand, being overly flexible? As with all of the components discussed here, it is easy to use joint agenda-setting as a slogan, but very difficult to operationalize it.

Joint decision-making

This is, by definition, the component of patient involvement that is foregrounded and stressed in SDM. Although – as we discuss more fully in the next section of the paper – models of SDM typically incorporate the other listed components also. As with the previous component, this one highlights the agentic nature of patients and has therefore become emblematic of some degree of 'reorientation' towards or even 're-conceptualisation' of, patients as active partners, rather than passive objects of concern. The broad principle of joint decision-making is widely accepted and there are many examples of clinical decision-making where it has compelling relevance, for example, where there are important treatment choices that have 'clinically equivalent', but 'biographically contrasting', outcomes (sometimes labelled 'preference sensitive' decisions). In addition to the moral importance of enabling people to participate in decisions that are

crucial in their lives, advocates of joint decision-making can point to other benefits, including the benefits of feeling 'ownership of' and 'valued in' healthcare processes. But there are myriad complications in interpreting and enacting joint decision-making. Some of these complications have been summarised already – this kind of joint working requires appropriate kinds of settings, time availability and attitudes and capabilities on the part of both professionals and patients. Other complications raise difficult issues of principle – for example: what if patients do not want to share responsibility? What if patients want to choose options that professionals think are damaging to the public health or public interest more broadly (e.g., needlessly expensive)? How can professionals share responsibility while maintaining professional accountability? The ways in which we answer these questions will determine the particular interpretation and ultimate purpose, of the joint decision-making we have in mind.

Relationship building

The increasing focus both upon patient subjectivity and patient agency, entailed by involvement practices, amounts to an increasing engagement with the personhood of patients. Even considered in wholly pragmatic terms, the conditions necessary for professionals to effectively 'connect with' and 'work with' patients entails treating patients more as *persons*. Although there are severe constraints in modern health systems for developing those richer forms of personal relationships that both take time and extend over time, this is certainly still a possibility, not least in services for individuals who are experiencing and managing chronic illness. The longer-term and often deeper nature of such relationships can substantially increase the potential for rich forms of 'joint working'. Also, there is nothing to preclude the possibility of more limited but perfectly respectful and meaningful relationships being forged in relatively short-term encounters. Of course, patients may not want to engage with health professionals or to co-operate with health systems, but that does not mean that professionals cannot be flexible and imaginative about maintaining some kind of relationship; nor, above all, does it mean that professionals cannot make an effort to understand patients' lives, including their social and psychological lives. Talking about relationships here, rather than simply 'decisions' and *persons* rather than just 'patients', is very significant. It serves as a reminder that there is more to healthcare than optimum clinical treatment trajectories. In other words, relationship building can be seen in instrumental terms, but it need not and arguably should not, be seen in this way alone.

Re-working relationships and systems

Once the potential open-endedness of professional-patient relationships is acknowledged and responded to through less restrictive professional 'scripts', then more

fundamental kinds of relationship change become visible and possible. Healthcare relationships and associated health systems can be, and are being, re-designed and re-worked in a variety of ways. Some of these changes are already quite widely embedded across many areas of healthcare. For example, the idea of multi-professional or inter-professional ‘team-working’ is now widely accepted, as is, increasingly, the notion of somehow including patients and lay caregivers into constructions of ‘the team’. The fostering and delivery of patient involvement needs to be seen in the context of a shift away from thinking of healthcare as about the professional-patient dyad and towards networks of care relationships. The focus on patients not just as persons, but as potential collaborators in service and policy analysis and re-design, also increases the chance of professionals working with patients outside of specific ‘care episodes’. This broader set of interfaces strengthens the opportunities for and likelihood of, more fully ‘human’ and ‘equal’ encounters between professionals and patients. Again, it is important not to be glib about these possibilities which can be hard to realise and bring new tensions and dilemmas of their own. There are, for example, well known tensions around how far patient groups should align themselves with professional service contexts or how far they should define themselves as being, in some respects, ‘combative’ with professionally organised services, although these 2 positions are not necessarily exclusive. There are also associated worries about ‘representation’ and the fact that some patient voices will get heard and not others, that is, that variations in patient access or involvement or wider health inequalities, may not be addressed and may even be reinforced by some forms of patient representation.

Models of involvement

The summary account of the components of involvement offered here illustrates the internal complexities and challenges in this area. It also shows why we have described patient involvement and SDM as sets of *activities* and not just as *behaviours*. We stress the idea of *activities* not only because they entail practical complications and effort, but because these efforts are aimed at a range of complex and sometimes competing purposes. We cannot begin to understand involvement unless we pay regard to these complications and contestations. This, in a nutshell, is why non-technical conceptions of knowledge are also needed here. The challenge of patient involvement is not simply one of finding the correct techniques or tools to do the ‘right thing’, but also one of judging what the ‘right thing’ is from case to case. Enacting patient involvement depends critically upon being able to recognise and manage fundamental value dilemmas and these core capabilities transcend both technical-rational approaches and the idea of communication skills (at least on normal interpretations).

Patient involvement has to be translated into practices in different sectors and settings, for different professionals

and patients and for different kinds of health conditions and treatments. What patient involvement can and should look like will vary from case to case. It partly depends, for example, upon the immediate setting and the dominant ‘function’ of the encounter between professional and patient. Some institutional settings and consultations lend themselves to richer forms of engagement and involvement than others. Equally important, different settings and functions suggest different involvement *purposes*. To return to the components of involvement listed above, it seems sensible to suggest that these components might need to be prioritized (and interpreted) in different ways on different occasions. If the immediate job at hand is to support the patient’s self-management of their chronic condition, for example, through the most effective use of already prescribed medicines, then – crudely – components 1 to 4 are arguably the most salient. If the principal task is initially to identify a suitable treatment regime (or to review and rethink a regime), then components 4 to 6 are obviously central. Similarly, if professionals and patients are likely to have a more long-term and open-ended relationship – for example, either working on a treatment trajectory over a long period and/or collaborating on service improvements, then components 7 and 8 (along with others, depending upon the instance) become prominent.

These kinds of differentiation could be formalized by referring to different ‘models’ of involvement – some of which have been given names in the literature. Roughly speaking, as we move through the 8 components, we are moving from what have been called ‘informed adherence’ models [13,14], to ‘self-management’ models [15-17], to ‘shared decision-making’ models [2,7] and to ‘relationship-centred’ models [18-20] (we will say a little more about each of these types below). Each of these is an attempt to improve on a straightforwardly expert-based ‘compliance’ model. The first part of this process is to help patients ‘get on board’ with clinical agenda – to involve them, for example, through education. This can merge into another part of the process, which is to recognize patients’ involvement in, indeed ownership of, their own health-related practices (which can still include ‘adherence’ issues of course) and the need to focus on patients’ health-related perspectives and practices. This, in turn, merges into the process of making decisions, including treatment decisions *with* patients as is represented in the idea of ‘the meeting of experts’ assumed by partnership ideals. Through these various steps there is some re-negotiating of the boundaries between professional and patient roles and responsibilities and the development and potential reconfiguration of professional-patient relationships.

The later components might be seen in some ways as potentially (and increasingly) more radical steps, because they suggest the possibility of – at least to some degree – diminishing or even dissolving the boundaries that typically define the professional-patient relationship. However, it is worth cautioning against the simple idea that some components or models are inherently ‘lower’ or ‘higher’ in an involvement hierarchy or of seeing more unconventional professional-patient relationships as necessarily representing ‘more’ and therefore ‘better’

involvement. To repeat the point just made, what counts as appropriate or 'better' involvement and how the components (summarized above) should be interpreted and applied, depends very much upon the particularities of specific settings, cases and purposes.

Models of involvement, therefore, including SDM models, are no more than summary 'pictures' of these components; pictures which foreground specific constellations of components, interpretations and purposes. We talk about particular models foregrounding or stressing particular constellations of components, because we would suggest that advocates of all patient involvement models would probably be ready to embrace all of the 8 components, at least on some interpretation. Indeed, it is arguable that all of these components are necessary elements of any defensible notion of involvement; that is, moves towards greater patient involvement must *in some sense* require professionals to work dialogically, this entails engaging with both patient subjectivity and agency and this amounts to the forging of new kinds of relationships.

Interpretations of the exact force of and the relative weightings of, these ingredients produce different 'models' – whether explicit published models or more unconscious models that are embedded in practices. Some of these different stresses have been reviewed in the unpacking of the components above. Two recurring and fundamental dimensions are worth underlining: first, components can be valued as ends in themselves or as means to other ends; second, components can be seen in more or less 'reformist' or 'revolutionary' ways - either as ways of refining and enhancing traditional biomedical approaches or as ways of eroding, transcending or even dissolving such approaches.

On this account, SDM models are just one way of capturing the shift towards more dialogical working. SDM foregrounds components 5 and 6 and in so doing frames healthcare as a social process of agenda-setting and decision-making. SDM models, stress the purpose of ensuring that patients are not merely the 'objects' or 'recipients' of this decision-making process, but that they are an active party to it. All of the other components are relevant to SDM, but they can be seen as either conditions for SDM or beneficial 'effects' of it (or both). Other possible models produce different framings and stress different purposes. In the next and final section of the paper we will complete our argument that responsible and effective healthcare depends upon the capability of making practical judgements both within and between models (whether conceived of explicitly or implicitly) or, in short, on 'practical wisdom'. Before turning to this we will provide a brief summary of the importance of alternative models and framings as complements and counterweights to SDM.

Informed adherence and supported self-management models are valuable because they shine a light on the indefinitely large number of day-to-day 'decisions' that occur outside of clinical encounters – decisions and sometimes 'non-decisions' (e.g., habits, evasions, compulsions) that are equally determinative of the health experiences and outcomes of patients as the decisions taken by or with health professionals. Informed adherence

models are closest to conventional paternalist models, but they represent a significant development of or clarification to, them by stressing that 'compliance' - the following through of clinical recommendations – is not all that matters. It also matters that any treatment recommendation reflects dialogue in the sense that it is: (a) based on an understanding of the patient's values and objectives and (b) is understood and accepted by the patient. Although the ethical significance of these 2 criteria is frequently alluded to, their contribution to effectiveness is nearly always stressed – informed adherence increases the probability of recommendations being both 'appropriate' and followed. Supportive self-management models focus on the scope for professionals to engage with the perspectives, concerns and challenges of patients living with illness and to see how they can help foster and support effective practical and emotional coping. This is a useful 'gestalt switch', because it places professionals – given this frame of the everyday lifeworlds and practices of patients - in a position of secondary importance and plays up the agency, responsibility and capabilities of patients. These 2 models stress components 1 and 2 (informed adherence) and 3 and 4 (supported self-management), respectively. However and as we have argued, it is to be expected that they also 'point to' the other components in various ways - they embody aspects of the joint working stressed in SDM and they require and promote aspects of relationship building and reconfiguration.

Relationship-centred models also shift the emphasis away from clinical decisions, but in this case towards a more holistic emphasis on the deeper 'linkages' between professionals and patients. The idea of 'decisions' only captures one thread of the possibilities of professional-patient dialogicality. Professionals and patients *working* together presupposes and regenerates the possibilities of professionals and patients *being* together, of forms of mutuality that include but transcend decisional deliberation. Relationship-centred healthcare would thus encompass the full personhood of both professionals and patients, the emotional as well as the cognitive aspects of 'togetherness', the fundamental importance of reciprocity and 'presence' and – at least as an ideal – the ethical value of genuine or authentic forms of relating [19]. In short, the stress is shifted from the instrumentality of the caring process to the intrinsic value of care and connection. Components 7 and 8 are stressed and all of the other components are seen as elements of or expressions of, the business of strengthening and re-shaping the opportunities of relating.

Models are thus very useful as shorthand for communicating broad approaches. However, they risk losing this usefulness if they are not interpreted flexibly and imaginatively. The languages and lenses provided by the different models enable us to apprehend, be sensitive to and 'move between', different dimensions of and perspectives on healthcare. Embracing their diversity is part of embracing the open-endedness and contestability of patient involvement and SDM ideas and ideals.

The need for both technical knowledge and practical wisdom

We are arguing that the open-endedness inherent in patient involvement calls for an approach to knowledge that includes both technical and non-technical elements. When professionals are urged to adopt involvement or partnership practices they do not only have to overcome *barriers*, but they also have to address *dilemmas*. It is not simply about ‘what works’, but about what *counts* as ‘working’ from case to case. It is useful here to note the Aristotelian distinction between two facets of practical knowledge.³

Techné or technical knowledge, is the knowledge of how to bring about or bring into existence, certain objects or states of affairs. We need technical knowledge, for example, to be able to bring about valuable ‘objects’ whether these be concrete things like pots or ships or more complex ends such as health. There are obviously various forms of technical knowledge depending upon what is being produced, but in each case the type of practical reasoning required – as with all practical reasoning - is inherently complex because practice requires adaptation to different resources and circumstances. But it is characteristic of *techné* that we determine its success by the degree to which the object sought is achieved. In other words, *techné* is relevant when trying to determine ‘what works’ – that is, what physical resources, skills and operations produce the desired outcomes.

Phronesis or practical wisdom, is, by contrast, that form of practical knowledge which is concerned with the quality of activity itself and not only the quality of the products of activity. We are used to the idea of distinguishing between ‘good work’, in the instrumental sense of work that produces good results and ‘good work’ in the broader sense of ethical or ‘virtuous’ work. Obviously both ‘good results’ and ‘good actions’ are important if we are to judge a health professional to be good overall, but we can make sense of the distinction being made here. The former requires technical knowledge and the latter requires something more - practical wisdom. In the case of practical wisdom, the means-end rationality associated with technical knowledge directed at achieving certain results is insufficient. Rather than being determined by the specification of any instrumental object or end, what matters and what is being pursued in practical wisdom, includes the right kind of conduct. In trying to act with practical wisdom we must be ready to deliberate about both the means by which the ends of an activity are achieved and the ends themselves. This requires the capacity to make discriminations not only about instrumental claims, but also about what is most valuable case by case and - on that basis - to make judgements about the best forms of conduct and ways to act in each set of circumstances [21].

Practical wisdom is necessary to deal with the many choices and dilemmas between and within models

summarised in the preceding section. Of course, technical knowledge also has an important role in this area. As we indicated at the beginning of this paper, it can help us to specify and measure the benefits of and the associated evidence for, certain kinds of interventions. It can also help to specify the kinds of practices that support the effective implementation of models such as SDM. But there are limits to how far this process of specification can go. Unless we are committed to producing ever expanding algorithms to steer professionals (to the effect of “in circumstances xyz do abc, unless p also applies; in which case do abq etc.”, *ad infinitum*), we need to embrace the fact that professional interpretation and judgement cannot be avoided (and that such algorithms are in any case only crude distillations of practical wisdom).

Conclusion

A balance between technical and non-technical perspectives needs to be struck when it comes to describing and working with, models of patient involvement such as SDM. In this paper we have reviewed the components of involvement and some of the tensions and dilemmas within and across involvement models. In doing so, we have sought to illustrate the sense in which healthcare practice is deeply embedded in – and, it might be said, actually constituted by - open-endedness and contestability and to argue, thereby, that it is essential to pay some attention to conceptions of knowledge that recognise and reflect this fact. In short, we have argued for the need to complement attention to the technical modelling and measurement of involvement with attention to practical wisdom. This means, we would suggest, broadening the epistemological frames of reference that are typically used to think and write about important policy ideas such as patient involvement.

Acknowledgements and Conflicts of Interest

This paper draws upon a research study that was made possible thanks to the support of the Arts and Humanities Research Council’s Knowledge Exchange Programme (Grant No. AH/F008678/1). The authors report no conflict of interests.

References

- [1] Salzburg Global Seminar. (2011). Salzburg statement on shared decision making. *British Medical Journal* 342, d1745.
- [2] Charles, C., Gafni, A. & Whelan, T. (1999). Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. *Social Science & Medicine* 49 (5) 651-661.

³ Practical knowledge is knowledge about how to do things (or make things) as opposed to purely theoretical knowledge.

- [3] Edwards, A. & Elwyn, G. (eds). (2009). Shared decision making in health care: achieving evidence-based patient choice. Oxford: Oxford University Press.
- [4] Edwards, A., Evans, R. & Elwyn, G. (2003). Manufactured but not imported: new directions for research in shared decision making support and skills. *Patient Education and Counseling* 50, 33-38.
- [5] Godolphin, W. (2009). Shared Decision-Making. *Healthcare Quarterly* 12, e186-e190.
- [6] Gravel, K., Légaré, F. & Graham, I.D. (2006). Barriers and facilitators to implementing shared decision-making in clinical practice: a systematic review of health professionals' perceptions. *Implementation Science* 1 (1) 16 doi:10.1186/1748-5908-1-16.
- [7] Makoul, G. & Clayman, M. (2006). An integrative model of shared decision making in medical encounters. *Patient Education and Counseling* 60 (3) 301-312.
- [8] Stevenson, F.A., Barry, C.A., Britten, N., Barber, N. & Bradley, C.P. (2000). Doctor-patient communication about drugs: the evidence for shared decision making. *Social Science & Medicine* 50 (6) 829-840.
- [9] Coulter, A. & Ellins, J. (2006). Patient-focused interventions: a review of the evidence. London: The Health Foundation.
- [10] Stevenson, F.A., Cox, K., Britten, N. & Dundar, Y. (2004). A systematic review of the research on communication between patients and health care professionals about medicines: the consequences for concordance. *Health Expectations* 7 (3) 235-245.
- [11] Braddock, C.H., Edwards, K.A., Hasenberg, N.M., Laidley, T.L. & Levinson, W. (1999). Informed decision making in outpatient practice: time to get back to basics. *Journal of the American Medical Association* 282 (24) 2313-2320.
- [12] Donetto, S. & Cribb, A. (2011). Researching involvement in health care practices: interrupting or reproducing medicalization? *Journal of Evaluation in Clinical Practice* 17 (5) 907-912.
- [13] Horne, R., Weinman, J., Barber, N., Elliott, R. & Morgan, M. (2005). Concordance, adherence and compliance in medicine taking. London : NCCSDO, National Co-ordinating Centre for NHS Service Delivery and Organisation R&D.
- [14] Bond, C. (ed.). (2004). Concordance: a partnership in medicine-taking. London: Pharmaceutical Press.
- [15] Jones, F.R. (2010). Working with self-management courses: the thoughts of participants, planners and policy makers. Oxford: Oxford University Press.
- [16] The Health Foundation. (2011). Evidence: Helping people help themselves - a review of the evidence considering whether it is worthwhile to support self-management. London : The Health Foundation.
- [17] Heisler, M., Bouknight, R.R., Hayward, R.A., Smith, D.M. & Kerr, E.A. (2002). The relative importance of physician communication, participatory decision making, and patient understanding in diabetes self-management. *Journal of General Internal Medicine* 17 (4) 243-252.
- [18] Tresolini, C.P. & Pew-Fetzer Task Force. (1994). Health professions education and relationship-centered care: report of the Pew-Fetzer task force on advancing psychosocial health education. San Francisco: Pew Health Professions Commission.
- [19] Beach, M.C. & Inui, T. (2006). A Constructive Reframing. *Journal of General Internal Medicine* 21 (Supplement 1) S3-8.
- [20] Suchman, A.L. (2006). A new theoretical foundation for relationship-centered care. Complex responsive processes of relating. *Journal of General Internal Medicine* 21 (Supplement 1) S40-44.
- [21] Hursthouse, R. (1999). On virtue ethics. Oxford: Oxford University Press.