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COMMENTARY

‘Pieces of eight! Pieces of eight!’ But where’s the treasure? A commentary on “Patient involvement and shared decision-making: an analysis of components, models and practical knowledge.” [Cribb and Donetto (2013). *European Journal for Person Centered Healthcare* 1 (1) 41-49]

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Introduction

A key component of person-centred medicine is shared decision-making. Although this model of decision-making has its critics [1] and is not appropriate in all clinical situations [2], it has become the default position in modern health policy, as reflected internationally in the Salzburg Statement published in December 2010 [3]. When there is realistically more than one treatment choice, shared decision-making respects patient autonomy while leaving professional support intact. Although shared decision-making also appears safe and effective in improving patient care delivery [4], there is a continuing and common failure by health professionals to share decision-making with patients in routine clinical practice, even when these professionals voice support for shared decision-making in principle [5].

In this Issue of the *European Journal for Person Centered Healthcare*, Cribb and Donetto seek to narrow this gap between theory (and policy) and practice by reflecting on ‘the kinds of knowledge that might help us to do better in translating the ideals behind ‘partnership working’ into clinical practice. Specifically they offer a summary account of 8 components of patient involvement in decision-making. They suggest that each component is needed for dialogical working in all patient involvement models, including shared decision-making. In this context, they might usefully have considered how sharing spans patient-professional dialogues. There are different ways to share decision-making [6] and different ways for patients to incorporate high degrees of sharing in other forms of decision-making [7]. The authors explain that a balance between technical knowledge and practical wisdom is required for professionals to interpret and prioritize case-by-case the components of involvement as practices appropriate to particular health settings and purposes. The relative weightings of the individual components and their purposes, map to different models of involvement. This argument has merit, but its delivery raises concerns about the low level (a) of precision in describing the components, (b) of clarity regarding their identification and (c) of apparent commitment to values that are strongly person-centred.

Precision

Cribb and Donetto suggest that the model of shared decision-making foregrounds the components of ‘joint agenda-setting’ and ‘joint decision-making’. These labels are very general and contribute to what the authors acknowledge is an incomplete ‘rough headline list’ of components. They seek to justify this approach by pointing to limits in how far the ‘process of specification can go ... professional interpretation and judgement cannot be avoided.’ I agree with the stipulated need for interpretation between and within models, which should reflect a particularistic assessment of each case. However, interpretation by professionals – and patients – must be philosophically intentional. It must be *of* something they can grip, something less ‘slippery’ than joint agenda setting and joint decision-making. Otherwise, there is the danger that such components can mean whatever people want them to mean.

Increased specification of the components, to include action-guiding content, could have reduced uncertainty about the nature and purpose of involvement in models such as shared decision-making, since it is still unclear what shared decision-making means precisely [6] and how best to use it in clinical practice. Less vague prose could also have shed light on how to apply a balancing 'approach to knowledge' in order to choose from different patient involvement models. Increased specification of the individual components could have supported the development and subsequent use of criteria for balancing, for example, by helping to ensure situationally that the balancing is not too intuitive and open-ended.

Identification

I appreciate, nevertheless, the attempt to bring together some of the components of patient involvement, mindful of research [8] that points to the need to focus on how patients are involved in decision-making and not merely on who makes the decisions. However, I feel disappointed that the authors did not state how they identified the components that they list. They state only that the components are 'essentially conceptual rather than empirical; however the underlying analysis is based upon empirical fieldwork.' The list is apparently informed by the 2006 Coulter and Ellins overview of systematic reviews [9], but its components are not explicitly integrated with the literature on involvement. Hence, it is unclear how individual components were selected for inclusion or not. I wonder, for example, why the authors do not consider joint deliberative reasoning as a shared form of involvement in dialogical relationships, which may lead to joint decision-making or not. In the discussion of the components identified, it is also unclear which ideas are new, which ideas have research evidence underpinning them and, for those that do, what that evidence actually is.

Values

The main limitation of the paper is, perhaps, that before elucidating the 'kinds of knowledge' needed to translate patient involvement and the ideal of shared decision-making, into clinical practice, the authors do not really explicate and promote the kinds of *values* needed for such translation to take place. Although their espousal of practical wisdom, beyond technical knowledge, creates a space for and includes deliberation about, values for praxis, the authors appear largely to take for granted what those values are and assume 'some very loose commonsense consensus about the meaning (and implicitly the significance) of 'patient involvement' in general and 'partnership working' in particular.' This failure to delimit explicitly and specifically the conceptual axiology, scope and parameters of patient involvement may help to explain why some readers will feel disappointed that the description of the components of involvement is less person-centric than they would like.

Consider, for example, the relationship-building vision of 'treating patients more as persons' amid constraints in modern health systems to developing 'those richer forms of personal relationships.' This vision is problematic for two reasons. First, the need to relate to patients as persons is not a 'rich' practice any more than the right of all human beings to be recognized as persons before the law [10]. The authors are seeking to distinguish shared decision-making from relationship-centred models. However, in stating that all the components are necessary for each model, they appear themselves to recognize that the personhood of patients is fundamental to defining all care in medicine. More specifically, the objective and observable communicative event of shared decision-making is incomplete unless it is also a positive subjective experience. Saba and colleagues [11] described this combination in terms of an archetype of full engagement in decision-making, which implies here that if the process of shared decision-making is to be meaningful, it cannot be separated from respect for personhood and relationship-centred models of involvement. I also believe that person-centred relationships often, but do not always, 'take time' and that these relationships should not be described as 'certainly still a possibility'. The *European Journal for Person Centered Healthcare* is demonstrating, clearly and consistently, that person-centred relationships are emerging as a reality in many areas of health service provision internationally.

Second and more problematic is that the approach taken by Cribb and Donetto to develop their list of components is one that they themselves acknowledge to be 'professional-centric'. Largely ignoring the question of the extent to which patients want to be involved and, if they do, how they can grow both their own involvement and professionals' involvement in shared decision-making, the authors focus narrowly on activities that professionals can undertake directly to support patient involvement. They therefore neglect how professionals can indirectly support patients, for example, through practitioner self-care, despite opportunities to rehabilitate the personhood of the professional. For example, although shared care has usually been suggested to require 'involving the patient in decision-making, to the extent that they desire' [8], there is an unmet need to add the qualifier: 'so long as that preference does not compromise the moral agency of the professional in contributing to the achievement of shared goals in healthcare.'

Note how patients are presented here. Despite acknowledging that patients are already involved in their own care, the authors frame their set of components in terms of what is needed 'for a professional to "involve" a patient'. In the absence of recognizing that patients and not merely professionals, may sponsor increased patient involvement – and the involvement of professionals in practices such as shared decision-making – the authors therefore paint patients as rather passive partners whose involvement in decision-making depends on the behaviour of professionals. This portrait of patients weakens the authors' declared commitment to the value and practice of models of involvement, such as shared decision-making, that, note Cribb and Donetto, emphasize 'that patients are not merely the objects of or “recipients of”, this decision-making process, but are an active party to it.’

If Cribb and Donetto believe that patient involvement always depends on the readiness of professionals, I refer them to the Salzburg Agreement which calls on patients to recognize their ‘right to be equal participants in their care’ and speak up about what they want [3]. In failing to elaborate on this role, Cribb and Donetto miss the opportunity to explore how patient-led activities, such as caring about professionals, can dignify patients and professionals as persons, promote shared decision-making and remind professionals that they are valued [12]. It is thus unclear why the authors state that their approach is ‘necessarily’ professional-centric. Most of the components they identify, beginning with ‘creating the conditions for communication’, could and, I believe, *should* have been presented as ones that professionals and patients can lead in their relationship, alone or with one another.

Conclusions

In conclusion, I am attracted by the casuistic-sounding message of Cribb and Donetto, but do not accept that it justifies either the unsteady generalities that prop up their discussion or, more disconcertingly, what can be considered traces of paternalism in their paper. I agree there is a need for different conceptions of knowledge that recognize and reflect tensions within and across models of patient involvement. However, the paper does not back up its assumption that a common failure to grasp this point is a key reason for the theory-practice gap – even if there has been a ‘broadly technicist approach to theoretical and practical knowledge’.

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