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## Autonomy: What's Shared Decision Making Have to Do With It?

**Peter A. Ubel,**

Duke University

**Karen A. Scherr, and**

Duke University

**Angela Fagerlin**

University of Utah and VA Salt Lake City Center for Informatics Decision Enhancement and Surveillance (IDEAS)

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Ethicists have long promoted patient autonomy—the right of patients to make decisions about their medical care without experiencing undue influence from their health care providers. We have long believed that shared decision making promotes patient autonomy, in line with these ethical ideals. The shared decision-making movement was born out of realization among decision scientists that the “best” health care choice for a given patient often depends upon that patient’s preferences, especially in circumstances where the relative benefits of the treatment alternatives depend on a given patient’s attitudes toward those outcomes (Fleming et al. 1993; Ubel 2012). Like ethicists, shared decision-making experts recognize that clinicians should not tell patients what to do when patient preferences ought to determine treatment choice.

But as Childress points out in his response to our essay, the term shared decision making does not seem consistent with the idea of promoting patient autonomy—the “shared” in shared decision making appears to give some decision-making authority back to clinicians (Childress 2017).

Childress is correct. “Shared decision making” is a strange name for an approach toward physician–patient communication that is supposed to promote patient autonomy. But we contend that shared decision making does promote patient autonomy. Why? Because the word “shared” doesn’t refer to who makes the decision, but instead to the process by which patients and physicians make those decisions. The proper practice of shared decision making recognizes that clinicians often play a critical role in educating patients about their treatment alternatives, and in helping patients align their choices with their values. In effect, shared decision making is assisted decision making. It also allows for patients to have differing levels of responsibility for the final decision, according to their role preferences, rather than forcing all patients to be responsible for decisions that they wish to delegate to others. In effect, shared decision making is a process that promotes patients’ relational autonomy.

Sometimes in shared decision making, clinicians need to help patients understand the trade-offs relevant to their decision. These trade-offs, by the way, are not just medical—for example, quality versus quantity of life—but also include nonmedical factors, like financial and social issues. In his response to our article, Berger describes opportunity costs as being broader than the concept of trade-offs, and therefore more suited to the pursuit of authentic choices. (Berger 2017) We do not see a sharp distinction between trade-offs and opportunity costs, but understand both terms to describe the importance of recognizing the competing pros and cons of health care alternatives. In any case, we agree that when clinicians help patients make decisions, they should help patients recognize the broad set of interests relevant to their choices, not just the medical harms and benefits of their alternatives. To that end, we understand the goals of shared decision making to be the following:

- Help patients understand the pros and cons of their alternatives.
  - Which requires that clinicians assess patient understanding through techniques like teach-back.
- Help patients factor their goals/values into their choices.
  - Which means physician recommendations are consistent with simultaneously promoting autonomy and shared decision making, as long as those recommendations are mapped onto patient goals, and as long as patients understand the connection between the recommendation and their treatment goals.

We think that both SEED and REMAP are consistent with our characterization of shared decision making. (Ho, Jameson, and Eiser 2017; McKillip, Barnett, and Swetz 2017). Both approaches, described in the accompanying commentaries, engage patients and clinicians in the kind of productive communication that should increase the chance of patients choosing healthcare alternatives that reflect their values. As Dive points out in her commentary, shared decision making calls for decision-making processes that go beyond mere communication of information to patients, processes that “enhance a patient’s capacity to be autonomous” (Dive 2017).

Decision psychology teaches us that simplicity is important in motivating people to meet goals (Ratner and Riis 2014). For some, the SEED and REMAP acronyms will help them remember how to approach shared decision making, and thereby promote relational autonomy. For those who have a hard time remembering what the letters in those acronyms stand for, like the two oldest authors of the commentary you are now reading, we remind clinicians that they need to remember only three things:

- Help patients understand the risks and benefits of their alternatives.
- Help patients align their goals with those risks and benefits.
- Assist patients in making choices that promote their goals and reflect their autonomous right to decide.

Physicians and medical educators are finally accepting the term “shared decision making” as part of standard medical practice. We contend that it would do more harm than good to

question the legitimacy of the term “shared decision making” at this point. Perhaps in the future, as patient participation in decision making becomes the norm, we can refine the term. At this point, however, we believe that to do so could undo the precious progress that has been made in helping patients achieve relational autonomy.

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