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The open dispute of *interpretation* is key to shared decision making

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Healthcare providers may openly challenge factual claims, assumptions, and preferences that patients put forward. Munthe and colleagues argue that this behavior may be ethically required when providers face capable patients and pursue person-centered care, but that *how* to dispute patients remains in shadows, and whether it is appropriate in “less standard settings” such as with children or psychiatric patients under compulsory treatment, and for public health interventions. Interestingly, the appropriateness of openly disputing patients in shared decision making (SDM) has been underexposed in the literature so far.

The authors do not clearly distinguish propositions about person-centered care from those relating specifically to SDM though. That is, they describe SDM as one of the ingredients of person-centered care, namely the “collaborative process” between healthcare providers and patients relating to the definition of the problem and decision making. Indeed, SDM can be seen as part of person-centered care, but is not, in our opinion, a necessary part in all contexts or situations in which person-centered care may be an ideal to pursue.

Open dispute may have two different functions. First, healthcare providers may challenge patients’ assumptions and preferences to find out whether they are based on knowledge that is factually correct, i.e., are well-informed, and to ascertain whether preferences at least seem relatively stable. Preferences for healthcare options, especially in new decision situations, can be expected to change over time (Simon et al. 2008: 1e14). If patients’ views are to inform final decisions, these decisions will fit individual patients better the more ‘valid’ views are. This function fully aligns with the ideals of SDM (Stiggelbout et al. 2015: 1172-1179). A second function of openly disputing patients’ assumptions and preferences may be to wittingly or unwittingly induce a change in patients’ views and to harmonize them with those of providers, such as when providers think that they know what is best for patients. This second function undermines the principle of SDM. It is unclear what function Munthe and colleagues have in mind, but we contend that the second function is undesired, as we will clarify in the following.

We would argue that the essence of SDM is that for some healthcare decisions, biomedical evidence and clinical expertise is insufficient to select the best option for *this* patient. For these so-called *preference-sensitive* decisions (O’Connor 2003: 736-740), healthcare providers need to hear from each of their patients what the patient’s unique perspective is: what the patient considers important in her life, what her goals are, what she fears, and how she thinks about the tradeoffs between the benefits and harms of the options. That is, and differently from what Munthe and colleagues seem to propose, SDM is *not* about having open discussions about facts, but about their *interpretation*. Patients may have false ideas about the mechanism of disease, which providers should feel free to correct in respectful ways, rather than openly discuss them as beliefs that one may either agree or disagree with. Patients may further e.g., feel highly anxious about treatment harms in ways providers may find exaggerated. Discussions about the facts underlying these fears may demonstrate

that patients have misconceptions about potential harms. Correcting these misconceptions may help patients feel at least somewhat reassured. If patients' factual knowledge is correct, then still they may react much more strongly to the facts than providers consider reasonable. Then, providers may challenge the feelings to ascertain whether patients hold onto their interpretation in light of relevant information, such as how other patients experience harms. Note that this challenging should take place in highly diligent manners: presenting information with the aim to change patients' ideas, can steer patients towards options that are not necessarily most appropriate for *this* patient (Engelhardt et al. 2016:). The providers' intent should be to help patients gather correct knowledge and to support deliberation, regardless of patients' ultimate views. Using SDM to convince patients, be it to accept treatment for a psychiatric disorder or vaccination, is a *contradictio in terminis*.

Many decisions in healthcare are preference-sensitive, many others are not. For the latter, so-called *effective* decisions (O'Connor 2003: 736-740), healthcare providers do not necessarily need to know their patients' unique views – regardless of these, the biomedical and clinical evidence define the best option (O'Connor 2003: 736-740). That is, most people would agree that the benefits of a particular option outweigh the harms, and the option compares clearly favorably to alternatives. Note that patients should not be pressed to agree to that 'best' option. They may prefer an alternative that is expected to serve their health less well, but may suit them better for emotional, practical, or other reasons. The key point is that in case of effective decisions, patients' views are not required to select the option that is most suited from a medical perspective. Still, involving patients as much as possible in making these choices can be beneficial in terms of promoting or maintaining good therapeutic relationships, making it easier for patients to understand the tradeoffs underlying choices, and encouraging adherence to therapy.

In principle, we see no point in stating whether or not SDM is appropriate in specific contexts or with specific patient groups. We suggest that for preference-sensitive decisions, it is indicated to explore on every occasion the viability of involving patients in the decision. Children, similarly as other "fringe decision competent" patients, can tell about what is important to them. In general, the more difficult it is for patients to make tradeoffs between options, as it may be e.g., for children or patients suffering from dementia, the more healthcare providers need to deduce patients' views from patients' more general opinions, values, or goals of care and involve significant others in clarifying patients' opinions. The significance of discussing "less standard settings" is that decisions often will also be a function of third parties' interests, e.g., parents, partners, or the wider public. Significant others may help clarify patients' opinions but may also hold opinions that *depart* from patients'. Research on the role of third party values and how these should ideally be incorporated in SDM is still in its infancy.

We fully agree that in SDM, there is an ethical requirement of challenging patients' opinions and preferences, and that this may be a delicate endeavor. It should be made very clear to patients that the ultimate goal of such discussions is to make sure healthcare providers have explained the relevant

issues as clearly as possible; that providers can understand, if not necessarily agree to, patients' opinions and preferences; and that providers are assured that patients' opinions and preferences are informed and stable enough to be acted upon. In cases where other stakeholders have a legitimate role in making final decisions, how their opinions and preferences should be incorporated in SDM is open to debate and study.

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