



Exploring the Relationship between Shared Decision-Making, Patient-Centered Medicine, and Evidence-Based Medicine

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Abstract

Shared decision-making is a possible link between the best of patient-centered medicine and evidence-based medicine. This article seeks to describe the link between them. It discusses to what extent the integration of such perspectives is successful in assuring respect for the patient's autonomy. From the evidence herein, we conclude that if the doctor–patient relationship and communication are strengthened to cover all issues relevant to the patient's health and values, is it possible for him or her to achieve more autonomous decisions by this linkage of shared decision-making and patient-centered medicine?

Summary: Shared decision-making is a possible link between the best of patient-centered medicine and evidence-based medicine. This article seeks to describe the link between them.

Keywords

Bioethics, Patient-centered medicine, Personal autonomy, Shared decision-making

In recent decades, patient-centered medicine (*PCM*), evidence-based medicine (*EBM*), and shared decision-making (*SDM*) have all gained strength as perspectives for medical care. Several authors relate them as part of the same vision while others consider them conflicting positions (Tonelli 2001, 1440). In recent years, several *SDM* models have attempted to integrate them (Berwick 2009, 564–65).

The consensus statement promoted by National Institute for Health and Care Excellence (NICE) defines *SDM* as “a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counseling and a system for recording and implementing patients' informed preferences” (NICE 2020c, 1).

Bardes (2012) offers a concept of *PCM*: “As a form of practice, it seeks to focus medical attention on the individual patient's needs and concerns, rather than the doctor's” (p. 782).

According to Sackett et al. (1996), *EBM* is “the conscientious, explicit and judicious use of current

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best evidence in making decisions about the care of individual patients” (p. 71).

In this article, we examine the possible link between SDM, PCM, and EBM, with reference to the assumptions that underlie them. We will relate PCM and EBM with SDM, drawing out their inner harmony. Then, we will explain how SDM can leverage the best of PCM and EBM to facilitate greater patient autonomy, with the professional support of the physician. We will try to demonstrate that all three linked can promote a more effective autonomy of the patient and why we think that this is the more important relationship between SDM, PCM, and EBM.

“Autonomy” is a complex concept. Here, we adopt the concept of “substantive, perfectionist account of autonomy” that incorporates the notion of “normative competence” (the capacity for individuals to reflect upon their available choices in relation to their values, goals, and preferences) elaborated by Dive and Newson (2018, 191). According to these authors, patient autonomy is the patient’s capacity to decide about the different options available to him or her by reflecting upon the content or substance of his or her goals and preferences as long as the correct procedure has been followed. Although there are many concepts of autonomy, we consider this vision as the most complete and we will compare it with other views.

Method

A Proquest, Pubmed, and EBSCO search were performed by combining the following “key” words: bioethics, shared decision making, ethics and evidence based medicine, patient centered care, autonomy. To limit our searching and to show a recent perspective, we have included articles from 2016 to the present day. All the articles analyzing general bioethical fundamentals of PCM, EBM, and SDM were selected. Those who referred to any particular pathology were excluded. All papers fulfilling the above requirements were compared to find link-points. We show the results throughout this article.

SDM

SDM is a process involving both the doctor and the patient. The model aims to help physician and patient, by himself or herself or through his or her representative (Siddiqui and Chuan 2018, 853–54), to understand what is important to the other: that is, what the doctor proposes and what the patient wants. The patient is understood and encouraged to

make decisions based on the information received and is treated according to what he or she really needs, adjusted to his or her values and preferences (NICE 2020b). The participation of the clinician is such that the patient can better understand the scope of each treatment. Thus, the information is more effective when the patient can make an informed decision. The model presupposes collaboration between clinician and patient and has as one of its consequences, shared responsibility for the results (each one is responsible for his or her rightful part; Kraus and Marco 2016, 1670).

Elwyn et al. (2012) argue that the model tends to promote the *relational autonomy* of the patient, that is, an autonomy that is not absolute but is always conditioned by others. These authors affirm that “our decisions will always relate to interpersonal relationships and mutual dependencies” (pp. 1361–62). Good communication skills are needed from the professional to ensure that the patient understands the information well (p. 2).

According to Bomhof-Roordink et al., SDM is becoming the norm for patient-centered health decision-making. Health professionals are experts in medical evidence and practice, and patients are the experts in what matters to them (Bomhof-Roordink et al. 2019, 1). These authors carried out a systematic review of the various published models on SDM, looking for the aspects which were similar in all of them:

- describing the options,
- informing treatment options (this alone does not guarantee understanding), and
- seeking mutual agreement.

There are other elements, but they are not considered by all models. These authors do acknowledge that greater uniformity would facilitate further investigations. Blumenthal-Barby et al. (2019) hold the same opinion.

PCM and SDM

In the twentieth century, a series of changes took place, influenced by a more scientific and technical approach in Medicine, focusing attention mainly on the cure of the disease. During the second half of that century, the importance of the patient and his or her family was recovered, while still paying attention to the treatment of the patient’s illness (Mezzich 2012). The idea was that rather than for physicians to just heal a disease, they also must treat a patient who is sick (World Health Organization 2009;

International College of Person-centered Medicine [ICPCM] 2011).

Throughout this period and to this day, many authors have attempted to define and provide tools to this vision of medical practice (Lewin et al. 2001, 14; Dwamena et al. 2012). R. M. Epstein and Street (2011) point out that although it is clear that this approach is based on the deep respect of patients, there is still disagreement in several respects (p. 101).

Seeking to identify the different dimensions of patient centeredness described in the literature and to propose an integrative model of PCM, Scholl et al. made a systematic review; they identified fifteen dimensions of patient centeredness (Scholl et al. 2014). They formulated an integrative model, which highlights the centrality of the doctor–patient relationship and is based on the characteristics and abilities of both. We would note that six of them that are related to SDM (Table 1).

Regarding assumptions, PCM puts at the center a relationship between two subjects. Such a relationship has tended to blur over the past few centuries. “Paternalism” could be “most simply defined as deciding to act in an autonomous person’s best interests without taking that person’s will decisively into account (or deciding expressly against it)” (Specker Sullivan 2016, 439). The clinician appeared as an expert, supported by confidence in science (Kaba and Sooriakumaran 2007, 59). The birth of bioethics and the historical circumstances of the mid-twentieth century gave rise, as a reaction to paternalism, to the recovery of the value of the patient’s autonomy.

However, such emphasis on autonomy has in turn provoked a defensive attitude of professionals, who often limit themselves to making a diagnosis and offering therapeutic possibilities. This, in some way, blurs the role of the physician, who almost becomes a “*therapy dispenser*” that will later be chosen by the patient. PCM establishes a *therapeutic alliance* that recovers *medicine of two people*, that is, where both subjects can and should contribute for the good of the patient (Kaba and Sooriakumaran 2007, 62).

EBM and SDM

EBM was born in the last decades of the twentieth century. The origin of the expression is linked to the elaboration of medical practice guidelines. From there, EBM went to medical education and decision-making in specific cases. In a few years, it became a medical quality thermometer, incorporating research results into health policies and healthcare practice (Djulbegovic and Guyatt 2017, 420).

As Djulbegovic and Guyatt explain, EBM has progressed as a way to develop medical knowledge and optimize results from medical practice. In the evolution of this model, the Cochrane Library played a very significant role (Cochrane Collaboration 2016; Synnot et al. 2018, 344–45). Perhaps, while still recognizing the value of objective information, EBM’s main practical limitation is that it tends to lose sight of the subjective aspect of the patient’s needs and desires (Haines, Savic, and Carter 2019). The emphasis placed on the disease obscures patient’s preferences (Spatz, Krumholz, and Moulton 2017, 1309; Ceriani Cernadas 2018, 90).

Djulbegovic and Guyatt respond to some of these observations by stating that EBM has always been focused on the individual patient and that EBM’s emphasis on the use of replicable research results is complemented by the experience and reasoned clinical judgment of the physician. In the history of medicine, there are many examples of useless and harmful interventions routinely administered (Djulbegovic and Guyatt 2017, 420).

Regarding EBM assumptions, we can state that the recourse to evidence helps medical judgment. The level of knowledge that medicine demands, and the continuous advance of its various branches, make it necessary to have reliable information. We have been advancing in that knowledge and in a kind of “fight against disease” (Elsevier 1921). At the same time, we know that nature has its laws. That is, there is a reality that has its own dynamism and that, in some way, does not allow itself to be completely dominated by human beings (Mc Keown 2017, 195–96). Through the physician’s opinion, SDM tries to make the patient understand that the current therapeutic possibilities of medicine are limited.

PCM–EBM–SDM Relationship

Forte, Kawai, and Cohen (2018) propose a bioethical framework as a guide in the decision-making process in SDM, which tries to relate EBM to PCM (p. 1). They divide the process into four steps with its corresponding ethical content (Table 2).

We believe that SDM, PCM, and EBM have several points in common, which serve to create synergy between them. All three practices have been born alongside bioethics, seeking to improve patient care (Altamirano-Bustamante et al. 2013, 15). They have all tried to remove arbitrariness from medical care, recovering the importance of the patient as a person (holistic vision), the need to make decisions based on solid and updated knowledge (scientific

Table 1. Dimensions of Patient Centeredness Related to Shared Decision-Making.

Dimension	Brief Description
Clinician–patient relationship	Building a partnership with the patient through collaboration
Clinician–patient communication	General communication skills
Teamwork and teambuilding	This has relevance on different levels
Patient information	Sharing knowledge and information reciprocally
Patient involvement in care	Encouraging the patient to participate actively in the consultation
Patient empowerment	Encouraging the patient to take responsibility to solve health-related problems

Table 2. Forte et al. Bioethical Framework.

1. Safety: focusing on disease (evidence-based medicine)
2. Understanding: focusing on the person (patient-centered medicine)
3. Situational awareness: focusing on providers (evidence-based medicine)
4. Deliberation: focusing on the patient–provider relationship (shared decision-making)

vision), and to take advantage of effective communication (practical vision).

Sometimes, SDM, PCM, and EBM have been seen as opposites or at least as divergent (especially regarding PCM and EBM). But references to the aspects that each one highlights can be found in the recent literature. All three, in short, refer to medical care, that is, the doctor–patient relationship:

- The patient provides all the data (symptoms) that the doctor needs in order to make a diagnosis, but personal aspects are also important, since they will serve when deciding the most appropriate therapy.
- The professional must provide secure information to the patient, so that, in addition to knowing his or her situation, he can participate, taking this information into account.
- Both actors are relevant: they seek the same purpose (patient health), and the best possible outcome depends on good collaboration between the two. By entering this relationship, they both know that their autonomy is conditioned, for the good of the end sought. That’s what happens in any agreement. Neither can impose itself on the other, although it is true that the patient has the last word. Both must respect each other. And while there are always other interests that interfere, the goal to achieve is mutual trust that is not naive, but it is born through mutual knowledge and communication (Turnbull et al. 2018, 1635). These would be the assumptions of SDM.

Therefore, we conclude that PCM, EBM, and SDM have in common:

- a. the objective: the health of the patient, contributing to a greater whole: the goals of care;
- b. the motive: solving a defect in medical care; and
- c. the means: to improve some aspect of the doctor–patient relationship.

Not only are they related but each aspect is complementary to the other. In turn, each practice can be distinguished from the other, each emphasizing different aspects.

In our opinion, doctor–patient relationship is the key characteristic that connects SDM, PCM, and EBM. The doctor–patient relationship should be characterized by mutual respect and truthful communication. Precisely, the word *respect*, a value which is at the center of the spirit of convergence of these approaches, comes from the Latin: *respectus*. This term refers to *looking again, looking with special attention* (Etimología de Chile 2020b). By revaluing the importance of the doctor–patient relationship, both are invited to value what the other person is and what their dignity is (Sueiras et al. 2017, 8–11). When we say that both must be respected, we refer to a bidirectional relationship: the doctor respects the patient insofar as he or she seeks what is best and does not impose himself or herself. The patient does not impose himself or herself either: he or she recognizes that the doctor has a lot to contribute and wants to take care of her or him.

And the other important word, *communication*, also comes from Latin, *communicare*, and refers to *making a person share in what one has* (Etimología de Chile 2020a). Both parties offer something to one another. The patient, who is since sick and hence vulnerable, puts his or her care into the hands of the professional. The professional offers all his or her experience and effort to heal the patient (Osuji 2018, 103).

Respect for Autonomy in Doctor–Patient Relationship

In principle, SDM was born to facilitate patient autonomy (Cochrane Collaboration 2016). This is implied by NICE, one of the main global promoters of SDM (NICE 2020a). This organization includes within the SDM guidelines, the National Health Service (NHS) constitution for England, which holds: “You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and careers. This includes being given the chance to manage your own care and treatment, if appropriate” (Department of Health and Social Care 2015).

However, Childress (2017) states that SDM is discordant with patient autonomy: “The model of shared medical decision making is conceptually and normatively incoherent and thus threatens rather than sustains respect for and promotion of patient autonomy in terms of patient participation and control” (p. 53), as if the doctor’s intervention in decision-making disrupts the patient’s command of the decision. Ubel et al. respond to this comment, clarifying that the term “shared” does not refer to *who makes the decision* but to the *process* by which the patient and the doctor make those decisions. They point out that the key points of SDM would be to help patients understand the pros and cons of their alternatives and also help them achieve their goals/values in their choices (Ubel, Scherr, and Fagerlin 2018). It seems that Childress perhaps conflates “sharing the decision process” with “sharing the decision.”

Those who staunchly defend autonomy look with suspicion to the SDM method. They believe that the provider should not participate in decision-making. They see it as a threat to the patient’s maintaining control of the final decision. They argue that it is controversial to what extent the professional intervention is present: limited to reasonable advice or goes beyond that limit, influencing the patient

too much? (Huddle 2016, 459). In *Principles of Bioethics*, Beauchamp and Childress (2001) pointed out three aspects of autonomous acting: intentionality, understanding, and the absence of other control by others (p. 59). The latter would be the one that, according to this position, would be affected in SDM.

Without pretending to exhaust the concept of autonomy, some recent analyses can help us understand whether SDM respects and promotes the autonomy of the patient. For example, Dive and Newson criticize Beauchamp and Childress, stating that they take into account only the steps of the process, without considering the content or substance of the autonomous decision. They give as an example the varying degrees of intentionality that can affect a sick person and how internal factors can affect them. In practice, informed consent alone is not enough, because more information is not always equivalent to greater autonomy. The patient needs them to understand what’s happening to him or her; the patient must be able to reflect on his or her own desires and values. These authors claim that an autonomous decision should include the following conditions: appropriate mental skills, a set of appropriate options, and independence. The patient should know the “normative” content of the options (to be able to relate each option to his or her own values) to evaluate which of them are better or worse (Dive and Newson 2018, 193). The content of the communication should not only be limited to a mere enumeration of medical data but also a requirement on the part of the professional to connect that data with the reality of the patient.

Dunn et al. studied what level of detail the information provided to the patient should have. They analyze this regarding risks and conclude that it should include all that would be meaningful to a reasonable person, taking into account their values (Marzorati and Pravettoni 2017, 104). Both parties must consider the reasons of the other (Dunn et al. 2019, 124–25). This is what matters in SDM.

Brudney analyzes a series of concepts of patient autonomy in relation to refusal of treatment in the context of a shared decision model. He considers that it would be permissible for the physician to discuss the patient’s values as long as they are connected to the patient’s illness. In no case would it be right for the provider to discuss or challenge the fundamental beliefs that guide his or her life (Brudney 2019, 267–69). White adopts a similar position, which proposes *autonomy based on authenticity*. Authenticity would consist of action being consistent with enduring desires, values, and beliefs (White

2018, 207–08). The author suggests adding *authenticity* to the three conditions already stated by Beauchamp and Childress.

Huddle (2016) proposes a model *guided by the professional norm*: that is, the doctor should always seek health, heal the patient, and provide relief from sufferings. By doing so, the physician will not go against the patient's values. According to this author, "negative autonomy" (i.e., "not being dominated by others") would be absolute in patients. But autonomy in terms of choosing, in practice would be quite limited, because many times patients do not know what to decide (p. 468).

W. N. Epstein (2017) proposes to respect the autonomy of the patient's choice, but always having the one that best favors him or her according to medical criteria, as a *default* alternative: the one that would be chosen as long as the patient is not opposed. She affirms that this practice would save many mistakes that patients make, while both respecting their autonomy and seeking their well-being (pp. 1300–1304).

Osuji (2018) uses the term *relational autonomy*. He claims that all people are related to each other and interdependent and they practice their autonomy in relation to others. Relational autonomy refers to the ability to reshape and nurture new relationships. The relationships that emerge through health care should take into account all those who are significant to the patient. In this way, this author is opposed to the individualistic attitude, typical of the Kantian, utilitarian, and liberal currents (p. 109).

All these authors consider *greater communication* with the doctor to be compatible with the autonomy of the patient. It could even increase, as it helps the doctor to take into account other aspects of the patient and of care (Kirkscey 2018, 171). We believe that this is the contribution of SDM that can make the patient's decision more autonomous (Ubel, Scherr, and Fagerlin 2017, 34).

The crucial point is this: through a proper doctor–patient relationship, the patient can be sure of having the information he or she really needs to make the decision that suits his or her interests (Berger 2017, 46).

There is no doubt that the autonomy of the patient must be respected. He or she must decide whether to attempt a cure: this would be the first decision. Therefore, the decision to want to heal, if reasonably possible, is the first manifestation of autonomy. The second manifestation is choosing how to be cured. But, in turn, the patient should bear in mind that seeking a cure always means conditioning autonomy. Conditioning it doesn't mean losing autonomy. It does mean recognizing that if one wants to achieve a specific purpose, one must put in an appropriate means. In a way,

it means recognizing the weight of the reality in which we find ourselves, and accepting that we do not totally control it (Arnold and Kerridge 2018, 27).

The autonomy of the patient is conditioned by the possibilities medical science offers. In turn, who can explain these possibilities is the doctor. The fact that the doctor offers possibilities and even advises about choosing one of them, taking into account the patient's values and the risks that exist (PCM), would not mean taking away patient's autonomy: it means showing what medicine can do for the patient (EBM). In this way, the collaboration of the doctor serves to bring the patient's wishes closer to reality, concretized in the patient's disease (diagnosis) and the available therapies.

If the doctor seeks to offer treatments commensurate with the patient's condition and prognosis, it is possible to reach an agreement (SDM) that respects the patient's preferences (PCM) and the possibilities of science (EBM). The patient always chooses and retains the right to refuse treatment. To achieve the most appropriate result, good communication between the patient and their doctor (SDM) is essential (Stagno, Crapanzano, and Schwartz 2016, 3–4; Halpern 2018, S169).

Therefore, the SDM method, linked with PCM and EBM, respects and promotes the autonomy of the patient provided that:

- The patient is the ultimate decision maker (the decision is not shared) and the doctor informs and helps to reflect (the decision process is shared).
- Communication is oriented by mutual trust and respect, seeking to reach an *agreement*.
- There are two conditions of possibility: the patient would want to be cured, if reasonably possible, and the doctor would offer treatments proportionate to his or her situation and possible prognosis (Ferrand and Racine 2018, 81). If either condition does not occur, it is almost impossible to reach a shared decision that respects the patient's autonomy. Both need to seek a reasonable solution, if possible.

We believe that perhaps this is the more important relationship between SDM, PCM, and EBM, all three linked can promote a more effective autonomy of the patient.

Conclusions

SDM is a useful bridge between PCM and EBM and, in so being, means that the important value of patient

autonomy is still upheld by improving the doctor–patient relationship.

Autonomy can still be optimized using SDM. A partial conception of autonomy (lack of control) has led, in practice, to the use of informed consent. Although informed consent is necessary to ensure the patient’s autonomy, it is not sufficient. If the patient receives a quantity of information that overwhelms him or her, the decision ends up not being truly autonomous.

A good doctor–patient relationship, like the one proposed by SDM, supported by trust and mutual respect, seems to be the way to achieve a more complete autonomy in that it is more effective (information adjusted to its reality). This would be the best way at present to make a decision appropriate to the patient’s situation. SDM tries to combine PCM and EBM, for the benefit of the patient. In this way, informed consent is more effective.

Leaving the patient alone with his or her decision, therefore, is not synonymous with respecting his or her autonomy. Anything that would help the patient to reflect on and choose, which is his or her best option at any given moment, would be useful for him or her to making more autonomous decisions.


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