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A Compilation Study on the Concept of "Shared Decision Making" in Healthcare

Sağlık Hizmetlerinde "Paylaşılmış Karar Verme" Kavramı Üzerine Derleme Çalışması

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ABSTRACT

The health system has experienced change and transformation over time, as in every structure, in the light of sociological transformations and technological developments. Within these changes and transformations, the impact of the social structure on the health system and the relationships between the beneficiary and the provider of health services have also changed in terms of form and content. In this context, the healthcare transformation schema in both developed and developing countries has undergone a significant evolution. Initially, healthcare was organized around an approach that focused solely on implementing the most appropriate treatment for the recipient. In this model, the value judgments and opinions of the patient were largely disregarded, and the patient was treated as an object. The healthcare provider assumed full responsibility in the decision-making process, with the concept of "for the patient" playing a dominant role. Over time, this model has shifted toward a structure that is shaped by the relationship between the healthcare provider and the patient. This new framework emphasizes shared responsibility on both sides and promotes a "with the patient" perspective. It prioritizes patient and community participation in healthcare processes and highlights the importance of shared decision-making. In this context, the concept of shared decision-making, its development process, its requirements, its use in the health system in our country, the obstacles to its use, and research findings including the place and usage practices of the concept of shared decision-making in the health systems of developed and developing countries are discussed.

Keywords: Community and patient participation, Health services, Health system, Patient-centered care, Patient and community collaboration.

ÖZ

Sağlık sistemi zaman içerisindeki sosyolojik dönüşümler ve teknolojik gelişmeler ışığında her yapıda olduğu gibi bir değişim ve dönüşüm yaşamıştır. Bu değişim ve dönüşümler içerisinde toplumsal yapının sağlık sistemi üzerindeki etkisi ve sağlık hizmetinden faydalanan ile sağlık hizmetini veren arasındaki ilişkiler de şekil ve içerik yönüyle değişime uğramıştır. Bu bağlamda, hem gelişmiş hem de gelişmekte olan ülkelerde sağlık hizmetleri dönüşüm şeması önemli bir evrim geçirmiştir. Başlangıçta sağlık hizmetleri, yalnızca alıcı için en uygun tedaviyi uygulamaya odaklanan bir yaklaşım etrafında örgütlenmiştir. Bu modelde, hastanın değer yargıları ve görüşleri büyük ölçüde göz ardı edilmiş ve hasta bir nesne olarak ele alınmıştır. Sağlık hizmeti sağlayıcısı, karar alma sürecinde tüm sorumluluğu üstlenmiş ve "hasta için" kavramı baskın bir rol oynamıştır. Zamanla, bu model sağlık hizmeti sağlayıcısı ve hasta arasındaki ilişki tarafından şekillendirilen bir yapıya doğru kaymıştır. Bu yeni çerçeve, her iki tarafta da paylaşılan sorumluluğu vurgulamakta ve "hastayla birlikte" bir bakış açısını teşvik etmektedir. Sağlık hizmetleri süreçlerinde hasta ve toplum katılımını önceliklendirmekte ve paylaşılan karar almanın önemini vurgulamaktadır. Bu kapsamda çalışmada paylaşılmış karar verme kavramı, gelişme süreci, gereklilikleri, ülkemizdeki sağlık sisteminde kullanımı ve kullanımın önündeki engeller ile gelişmiş ve gelişmekte olan ülkelerin sağlık sistemlerinde paylaşılmış karar verme kavramının yeri ve kullanım pratiklerini içeren araştırma bulguları tartışılmıştır.

Anahtar Kelimeler: Hasta merkezli bakım, Hasta ve toplum işbirliği, Sağlık hizmetleri, Sağlık sistemi, Toplum ve hasta katılımı.

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INTRODUCTION

The health system and health services have experienced change and transformation over time, as in every structure, in the light of sociological transformations and technological developments. The changes experienced are closely related to the development and advancement of medical science, as well as the provision of health services and the change in focus in these services.[1] Naturally, within these changes and transformations, the impact of the social structure on the health system and the relationships between the beneficiary and the provider of health services have also changed in terms of form and content. The health system is inherently human-centered. The idea of emphasizing the subject here is based on the oldest historical records of medical science. In the 5th century BC, Hippocrates emphasized the importance of this issue by saying, "First of all, listen to the patient."[2]

Although early medical records emphasized the patient as the primary subject of the physician–patient relationship, this emphasis gradually changed over time. The sequential paradigms that shaped approaches to the patient in the healthcare system transformed not only the nature of this relationship but also the position of the healthcare recipient. Indeed, from the time when the World Health Organization defined health merely as the absence of disease or infirmity to the time when it conceptualized it as a state of complete physical, mental and social well-being, the biomedical model continued to dominate the field of health.[3] This transformation in the World Health Organization's definition of health paved the way for the theoretical and practical development of the biopsychosocial model. Thus, the biomedical approach, which tends to reduce health to the absence of disease and excludes the patient from decision-making processes, has been replaced by the biopsychosocial model, which addresses the physical, spiritual and social dimensions of the individual together.[4] The biomedical model's approach, which places patient participation in medical decision-making processes at a secondary level, has led patients to perceive themselves as passive objects of medical interventions, far from the center of care, and to experience alienation in their subjectivization experiences regarding their own bodies.[5]

While the biomedical model offers a framework that stipulates that the most appropriate treatment is determined by the physician and places the patient as a largely passive object in decision-making processes, the biopsychosocial model views health as a collaborative process arising from the clinician-patient interaction, placing shared responsibility and the participation of the patient and the community in the care process—especially shared decision-making—at its core.[6] Historically, healthcare has embraced different approaches, evolving from a focus on disease, patient, and individual in healthcare delivery. These successive frameworks have, of course, led to changes in the patient-physician relationship.[7] Szasz and Hollender (1956) categorized the historical evolution of patient-physician relationships as relationship based on activity-passivity, relationship based on guidance-cooperation, and relationship based on mutual participation.[8] In a different study, the patient-physician relationship was discussed more comprehensively, starting from the problem of patient autonomy in medical matters; paternalistic model, informative model, explanatory model and deliberative model.[9]

In the paternalistic model, the physician directs the patient to the treatment method she/he deems best and appropriate, with limited information and no options specified. In other words, the physician positions her/himself in a position where she/he knows what is best for the patient better than the patient does. The patient's request is not given sufficient consideration, the intervention exceeds the patient's request, or this request is not taken into account.[10] In the informational model, the physician provides the patient with medical information regarding their illness, treatment process, treatment options, and health status. The patient is free to choose the

treatment they desire based on their own judgments. The informative model represents the opposite of the paternalistic model and accepts the patient as the authority.[11] In the explanatory model, the physician informs the patient about the treatment process and options, as in the informative model. However, in addition to the informative model, the physician has the mission of helping the patient make decisions in accordance with the patient's value judgments during the decision-making process, rather than the patient making the decision alone.[12]

In the interpretive model, the physician informs the patient about the appropriate treatment model and options, taking into account the patient's value judgments. The aim is to help the patient choose the treatment that is appropriate for his/her values and to ensure that the patient understands and comprehends the medical science's treatment methods related to the disease and the possible complications of the treatment.[6] In this model, the doctor and patient discuss treatment options. However, this discussion is not intended to criticize the patient's values or impose them on the basis of a moral mission. The deliberative model involves both parties assuming joint responsibility and engaging collaboratively in the decision-making process. The interpretiveer model can be described as a kind of client-counselor relationship.[13] The fundamental basis for considering physician-patient relationships is the patient's participation in the treatment process, including the patient in decision-making processes, sharing responsibility, and taking into account that the patient is the subject in the treatment process. From this point of view, it can be said that the essence of determining the doctor-patient relationship is the concept of shared decision making.[6] The concept of shared decision-making has been explained in the literature with different concepts such as "patient-centered care", "patient and community collaboration", "community and patient participation" and "patient and community empowerment".[14-15] The aim of this study is to address the advantages and disadvantages of the concept of shared decision-making on the health system, to compile previously published studies on this subject in the literature, to identify possible obstacles to the implementation of the concept of shared decision-making and to emphasize the importance of the concept of shared decision-making in the provision of health services. To facilitate a clearer understanding of the historical and theoretical development of physician–patient relationships, the main models discussed in the literature are summarized in the following table.

Tablo 1. Physician–Patient Models in the Medical Decision-Making Process

Model	Physician's Role	Patient's Role	Key Features
Paternalistic	Directs the patient to what the physician deems best; provides limited or no options.	Limited input; requests often disregarded.	Physician assumes superior knowledge; "doctor knows best" approach.
Informational	Provides full medical information (diagnosis, treatment, options).	Free to choose based on personal values and judgments.	Opposite of paternalistic; patient as main decision-maker.
Explanatory	Provides information and also guides patient in aligning decisions with their values.	Participates in decision-making with physician's support.	Shared interpretation of medical info and patient values.
Deliberative	Discusses options while considering patient's values; shares responsibility.	Engages in dialogue; co-decides on treatment.	Client–counselor style; emphasizes joint responsibility.
Activity–Passivity	Acts upon patient without expecting cooperation.	Passive recipient of care.	Similar to parent–infant relationship (acute care, emergencies).
Guidance–Cooperation	Guides treatment, expects compliance.	Cooperates by following physician's guidance.	Comparable to parent–child relationship.
Mutual Participation	Collaborates as partner in decision-making.	Collaborates actively in care.	Comparable to adult–adult relationship; aligns with shared decision-making today.

As the table illustrates, these models represent a gradual shift from a physician-centered approach to one that prioritizes patient autonomy and shared responsibility. The evolution reflects broader sociological and ethical transformations in healthcare, ultimately converging on the principle of shared decision-making as the foundation of contemporary physician patient relationships.

The methodology of this review is a traditional narrative approach. Unlike systematic reviews, this study does not rely on predefined databases, search strategies, or explicit inclusion and exclusion criteria. Instead, it synthesizes and interprets national and international literature to construct a conceptual framework for understanding the historical development, theoretical underpinnings, and practical implications of shared decision-making in healthcare systems.

The Concept of Shared Decision Making

It is the clinical term for a patient-doctor relationship in which there is a two-way flow of information between the doctor and the patient, where the patient expresses his or her thoughts in line with his or her value judgments, where the doctor informs the patient about his or her options, and where the patient is guided in the decision-making process. In the concept of shared decision-making, the patient's participation in the decision-making process is of primary importance.[16] In this regard, a partnership is established between the patient and the healthcare provider.[17] The concept of shared decision-making involves developing patients' self-control over their own health. It adopts a relationship in which the concepts of responsibility and cooperation are shared, instead of the outdated relationship system that includes a superior-subordinate relationship between the healthcare recipient and the healthcare provider. [18] In the shared decision-making process, it is recommended that the patient choose the test and treatment that suits his/her preferences, but evidence-based information should be provided together with the physician during this selection phase.[19]

The concept of shared decision-making suggests that the physician should guide the decision-making process, but that during this guidance process, emotional persuasion that could cause the patient to change his or her decision should be avoided and the patient's autonomy should be respected. This model assigns the physician the role of guiding the patient during phases that are emotionally challenging and when the patient's psychological resilience is diminished. [20] It is very important for patients to be involved in shared decision-making processes, as patients have the right to self-determination. It is not compatible with the authority and skills of the medical profession for a physician to evaluate the patient's fate on behalf of the patient, the effects that the medical intervention will have on the patient and the patient's ability to cope with this situation.[21] However, it has been reported in the literature that patients need time to participate in the decision and to discuss their medical condition with other clinicians, and that the patient's needs should be considered and respected during this process.[22]

The concept of shared decision-making in clinical practice has three main components: notification of choice, presentation of options, and support for decision-making. In the notification of the right to choose, it means clarifying that the patient has the option to choose the treatment method he/she wants regarding medical practice. The component of presenting options is the step in which all appropriate treatment methods for the disease are outlined and the patient is fully informed. Supporting decision-making is the step in which the patient is made a stakeholder in the decision and the responsibility is shared with the patient. Although it is important to address the main components in the concept of shared decision-making, there is no strict order of the steps.[23]

Advantages of Shared Decision Making in Healthcare and Good Practice Examples

The concept of shared decision-making is increasingly being used in the provision of health services in developed and developing countries.[24] The 2015 decision of the United

Kingdom Supreme Court regarding the implementation of shared decision-making schema in all practices related to bodily integrity, the 2016 report of the United Kingdom National Health Services Institute mentioning the value of the concept of shared decision-making from medical, practical and ethical perspectives and the launch of a project to standardize shared decision-making in clinical practice can be cited as examples of how the concept of shared decision-making is increasingly being used in healthcare delivery.[25-26] In many European countries, the concept of shared decision-making is supported in patient rights legislation and patient charters. [27-28] A study examining the place and implementation of the concept of shared decision-making in Germany, France, Spain, the Netherlands, and the United Kingdom reported that interest in the concept of shared decision-making is increasing in each of the five countries, that there are strong research groups and a significant number of published articles, that many clinicians, health insurance companies, and policy makers are emphasizing participation in decision-making, and that some guideline groups and professional organizations are encouraging shared decision-making.[29]

Additionally, foundations operating in the US and Europe are working to promote the concept of shared decision-making. The Informed Medical Decisions Foundation, operating in the US, and The Health Foundation, operating in Europe, provide grants, scholarships, and support for research and research aimed at promoting shared decision-making.[24-30] Despite the widespread use of the concept of shared decision-making in the delivery of health services, some clinicians believe that adopting the concept of shared decision-making leaves the initiative to the patient and thus does not provide the expected benefit from treatment.[31] However, it has been found that when the clinician takes an authoritarian attitude in making decisions about medical interventions and does not evaluate the decision with the patient and does not discuss its benefits and possible complications, the clinician falls short of meeting the patient's expectations and value judgments regarding the disease and recovery.[19-32] Shared decision-making, which is also used in studies aiming to increase patient participation, has been reported to increase patient compliance with treatment and make the patient more physically functional.[33-34]

Evidence from 86 randomized studies indicates that patients with shared decision-making make better progress in acquiring medical information, have more confidence in medical intervention decisions, and play a more active role in decision-making processes.[35] It has also been stated that the use of shared decision-making systems reduces the anxiety levels experienced by patients regarding medical intervention and its aftermath.[36] The goal of medical practice is to achieve healing. Treatment success is closely linked to the patient's acceptance of this practice. Therefore, it would not be wrong to say that the use of shared decision-making in medical practice will increase treatment success rates.[37] Studies conducted at different levels of healthcare indicate that patients tend to participate in treatment decisions. Shared decision-making increases the patient's confidence in the final decision and increases their sense of satisfaction with the healthcare they receive.[23] Additionally, it positively impacts patient compliance with treatment. It reduces costs by preventing the use of unnecessary medical procedures and diagnostic tests, while also utilizing limited resources in the provision of healthcare.[38]

Possible Obstacles to Implementing the Concept of Shared Decision Making

Despite the advantages of shared decision-making in medical practice and healthcare delivery, it is stated that primary care patient interpretives account for 11% of shared decision-making. [39-40] In the literature studies conducted on this subject, it has been stated that shared decision-making is not used due to time constraints, problems arising from the personal characteristics of the patients, the physical conditions of the clinics where the patient-physician relationship takes place, physicians' lack of knowledge about shared decision-making, physicians' finding shared

decision-making unprofessional, and lack of belief and motivation regarding shared decision-making.[41-42-43] Some healthcare professionals have expressed concern that shared decisions about medical interventions will lead to negative outcomes due to patients not having sufficient information, and they have argued that shared decision-making is hampered by the limited time they allocate to patients during clinical interpretives. Some have stated that they already use shared decision-making, but their studies have not shown this to be the case.[44]

Empirical studies suggest that patients' reluctance to engage in the decision-making process often stems from inadequate access to information or a limited understanding of the potential benefits of participation.[45] It was also stated that patients were hesitant to meet with a doctor, did not believe they would receive sufficient information, and were afraid of being stigmatized by the doctor.[46] In a study conducted in the USA, where cultural factors play a role in the concept of shared decision-making and where people exhibit different approaches to the concept of shared decision-making depending on their social identities, it was stated that people of other races were more hesitant about shared decision-making compared to whites.[47] Some patients perceive physicians as authorities and, concerned that shared decision-making imposes a burden on them, prefer to have the physician make the decision themselves. The concept of shared decision-making can be unsettling for these patients. Some studies in the US have also reported that individuals belonging to ethnic minorities prefer the physician to be the authority and to make the decisions themselves.[48-49-50] Some cancer studies have indicated that patients diagnosed with cancer do not want the information needed for participation in decision-making, which would be useful in shared decision-making.[51-52]

CONCLUSION AND RECOMMENDATIONS

This review demonstrates that the implementation of shared decision-making processes in healthcare provides strong benefits in terms of decision-preference congruence, information transfer, and the process's compatibility with patient values; however, the practice is not used adequately and as desired in healthcare.[6-19] Implementing shared decision-making systems in healthcare improves patient understanding of options and the balance of risks and benefits, reduces decisional conflict, and increases confidence in the final decision in many contexts. At the psychosocial level, reductions in anxiety and perceived uncertainty, and improved treatment adherence have been reported.[36] However, the adoption and continuity of the shared decision-making system in the health system are closely related to communication skills and self-efficacy at the clinical level. They are also influenced by factors such as workflow, the physical environment, and institutional culture.[43] Studies conducted in the primary care of the health system show that the use of the concept of shared decision-making in health practices remains low.[39] While this situation explains the widespread perception that shared decision making is "a good principle but difficult in practice," these challenges are not considered obstacles that cannot be overcome with targeted design and training.[38]

Although time concerns are among the most frequently cited implementation challenges by practitioners, recent systematic reviews and meta-analyses have reported no significant difference in interview length between encounters involving shared decision-making and those that do not. When increases are observed, they are generally related to the intervention itself.[53] Therefore, integrating shared decision making into institutional policy, training, and process design will strengthen the time constraint barrier.[22] In particular, considering the health system as a team and implementing role sharing is considered an important step in improving the quality and applicability of shared decision-making processes.[16] Another important outcome of implementing shared decision-making processes is the potential to

reduce workload in testing and intervention systems. Current findings suggest that discussing options together supports cost-effective policies in the long term by encouraging patients to forego some tests and interventions.[54] Shared decision-making is therefore not only an ethical imperative but also a quality strategy that promotes rational resource use.[22-24] Strengthening clinicians' communication skills in physician-patient communication; integrating informative materials about shared decision-making into patient waiting areas and appointment management systems; assigning supportive healthcare professionals to regions with low health literacy; and establishing multidisciplinary research teams to evaluate the short- and long-term outcomes of these interventions are recommended for the evolution of the healthcare system to processes focused on shared decision-making in line with contemporary practices.

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