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Generalized shared decision making approaches and patient problems. Adapting AHRQ's SHARE approach for Purposeful SDM

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Abstract

Objective—Generalized shared decision-making (SDM) describes the involvement of patients in choosing options. However, there are many situations in which patients and clinicians make decisions together that don't focus on choosing between options, e.g. problem-solving dialysis and insulin use while traveling. Poor uptake associated with clinicians' perception that SDM doesn't apply to clinical situations **they face** may reflect the lack of adaptation of generalized SDM approaches to patients' problems. The Purposeful SDM schema published in 2019 identifies problems for which different kinds of SDM are appropriate.

Methods—The U.S. Agency for Healthcare Research and Quality developed SHARE as a generalized SDM approach. We sought to adapt SHARE to the different problems that patients face using a matrix to relate SHARE steps and Purposeful SDM modes and describe changes in generalized concepts and practices of SDM across these modes.

Results—Many SHARE communicative behaviors applied across modes, although the meaning of SDM terms and practices, e.g. patients involved as problem solvers versus experts, **varied substantially**.

Conclusion—Aspects of SHARE require adaptation to different patient problems.

Practice Implications—SDM in education, practice, and tools may be supported by adapting generalized SDM approaches to patients' problems.

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Authorship

I.G.H and A.K.F led the writing of this manuscript. All authors contributed to the discussions in which the four modes of Purposeful SDM were related to the five SHARE steps. All authors contributed revisions and approved the final version of this paper.

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Keywords

Shared Decision Making; Purposes; Problems; Purposeful SDM; AHRQ; SHARE; SHARE Approach

1. Introduction

Shared decision making (SDM) is a patient-centered approach to making health care decisions that are individualized to the patient and incorporate their values and preferences. **Investments in implementation toolkits, cultural interventions, clinician training, decision aids, guidelines, and policy enforcement have not resulted in widespread adoption of SDM [1], and its success in clinical practice has been mixed [2, 3]. Well-documented barriers persist to the uptake of interventions to promote SDM and patient involvement [4–6].**

A primary barrier to the adoption and implementation of SDM in practice is clinician perception that SDM is not pertinent to the decisions they are making with patients [5]. The issue of the pertinence of SDM to clinical problems was raised in the 2019 Purposeful SDM schema [7]. This work proposes that what patients and clinicians are trying to achieve together and how they interact and make decisions is significantly determined by the problem that makes decision making necessary (Text box). It suggests that there are several kinds of SDM each pertinent to the need to resolve different kinds of patient problems (Table 1).

Text box.

Generalized models of SDM [9–11] have helpfully identified essential communicative elements of SDM, e.g. describing the pros and cons of options, that are useful in training clinicians in how to do SDM. However, less guidance is given to how these behaviors should change when clinicians apply them to the different problems and situations that they encounter with their patients. Our intention is to begin to conceptually and practically relate generally accepted elements of SDM, to different kinds of problems for which shared decisions are made. We use the established United States Agency for Healthcare Research and Quality's (AHRQ) SHARE Approach as an instance of a generalized SDM model.

In 2015 AHRQ, released the SHARE Approach [12], a generalized SDM model that streamlined the nine essential steps of SDM identified by Makoul and Clayman [13] into five steps, each represented by a letter of the SHARE mnemonic (Seek, Help, Assess, Reach, Evaluate). The SHARE Approach model is supported by a training workshop curriculum for clinicians emphasizing how to carry out each step of SDM [14] (Appendix 1), basic communication skills, and the use of comparative clinical effectiveness evidence and tools to inform decisions. Payers, health systems, and clinicians have adopted the SHARE Approach to improve communication and patient engagement and implement value-based care initiatives and evidence-based guidelines [15].

The SHARE Approach model, and others like it [9–11], describe best or effective general communication and inter-personal practices **to help patients with their clinicians choose** between evidence-based options, which often are in equipoise. However, there are many occasions where patients and clinicians need to make decisions together that do not principally focus on choosing among **known options, e.g. the ALS case in the** Text box [7, 16–19]. **The SHARE Approach and similar models that focus on general communicative and interpersonal behaviors, do not currently account for variation in the patient problems that guide decision making. We theoretically and practically related the generalized SHARE Approach model to each kind of problem identified through Purposeful SDM.**

2. Method

We developed a matrix (Table 2) that sets the five steps of SHARE against the four modes of Purposeful SDM. Within the cells of the matrix we explored differences in the terms, concepts, methods, and warrants for SDM arising at each intersection. The matrix was first populated by I.G.H., reflected upon from a clinical perspective by V.M.M., and from an AHRQ SHARE perspective by A.K.F. and A.S.B. Discussion and modification of the matrix continued until it was deemed by the authors to be conceptually consistent, clinically pertinent, and productive in expanding and further elucidating the SHARE approach.

Because we focused on expanding SHARE as a *method* for SDM that varies with kinds of problems, we selected the columns “*Mode of working with*” (Alternatives, Conflict and Ambiguity, Problematic Situation, Humanity) from the Purposeful SDM schema, further informed by the “*Approach*” column. For clarity, we have changed the name of the second mode from “Desires of people choosing and agreeing” in the original Purposeful SDM schema [7] to “Conflict and Ambiguity”. Each of the columns in Table 2, provided a perspective for analyzing and expanding what each of the five steps of the SHARE Approach might mean.

The four column heads of the matrix—Alternatives, Conflict and Ambiguity, Problematic Situation, and Humanity – represent four different beginning points for SDM. Broadly, these beginnings indicate what decision making is about and what motivates decision making. For example, in mode 1, decision making is about *alternatives* and the need for SDM begins from a need to select between alternatives, the preference sensitive nature of the alternatives, or evidential uncertainty or equipoise relating to the alternatives. Whereas, mode 3 decision making is about *problematic situations* and the need for SDM begins from the need to act **within an ill-defined problem and unclear potential responses.**

We found variation in the definition and interpretation of pertinent SDM terms, methods, and concepts across the modes of Purposeful SDM, e.g. there is a difference between a preference being a material *attribute* of a person and a preference being an arbitrary *statement* of will. In drawing out these differences, our goal was not to settle on a single definition of “preference”, for example, nor was it to synthesize the variation in an overarching account. Rather, our goal was to discern a range of meanings for terms such as

“preference” based on their pertinence to the kinds of situations identified by the Purposeful SDM modes.

The matrix is pluralistic as it recognizes that different perspectives and methods are required to account for, and support, different phenomena and actions, or that different perspectives allow us to do different things with the “same” phenomenon. Respecting this pluralism requires allowing each perspective to have its own internal coherence, and recognition that coherence is compromised when we assimilate or reduce one perspective into another, e.g. equating the mode of working with internal conflict with weighing the pros and cons of alternatives. The approach that we follow in the matrix is based on and supported by the work of the philosopher of pluralism, Richard McKeon[20–22].

3. Results

All accounts of SDM, implicitly or explicitly, deal in some way with a problem that leads to decision making (problem), different ways of addressing that problem (options), the involvement of people in decision making (roles and communication), the interactions between them in addressing the problem (deliberation), the desires (desires) at play, and the final action taken (decision) [23]. All of these elements are present in some way in the SHARE Approach and each mode of Purposeful SDM. The analysis presented here suggests that each of these elements vary conceptually and practically across the modes of Purposeful SDM. We found that many patient-centered communication skills are helpful across all modes of SDM, although their use and significance may change with the patient’s situation. In order to demonstrate the variation of SHARE terms and concepts across the different modes of Purposeful SDM we discuss the modal variation within the theme of each SHARE step.

3.1 Seek your patient's participation

The theme of this step is bringing the participants into the roles, activities, and substance of decision making. Table 3 shows the common roles and activities assumed by patients, **caregivers**, and clinicians that are associated with the various modes.

3.1.1 Seek and the alternatives mode—When the decision is about alternatives, SDM involves weighing pros, cons, and preferences relating to the alternatives. In this process, clinicians often focus on involving patients in the exchange of information, expertise and weighing activities. Typically, the alternatives (e.g. diabetes medicine A or B) are evidence-based and identified prior to SDM commencing. The process is frequently treated as cognitively additive and subtractive, with different attributes of the alternatives, context, and the patient building up or decreasing an alternatives appeal [24]. **AHRQ’s SHARE Approach tips suggest** (Appendix 1) the clinician guiding the decision making process should summarize the problem and the alternatives and ask the patient to participate, including family or caregivers as warranted [14].

3.1.2 Seek and the mode of conflict or ambiguity—In mode 2, where decision making and the situations leading to it arise from conflicts and ambiguities within or between decision makers, decision making proceeds through negotiation or argumentation,

e.g. negotiating an inner conflict as to how to give birth. Arguments, positions, issues, interpretations, and evaluations are stated, created, discovered or changed until agreement within a patient or between patient, caregivers, and clinicians is reached. Freedom of expression is core to this approach, and large a part of seeking participation involves verbalizing a need for and creating a relationship that allows for openness, multiple voices, listening, and wrestling with ambiguity and conflict. While options may be given, the meaning that parties bring to them is somewhat arbitrary [25]. This can lead to surprising arguments for and against options that do not necessarily rest heavily on their medical attributes e.g. a generally healthy young person selecting a “Do Not Resuscitate” **status** prior to an elective surgery because their elderly grandfather spent three weeks on life support prior to passing away.

3.1.3 Seek and the problematic situation mode—In the third mode, patients and clinicians participate in problem resolution. Patients and clinicians are caught up in a problematic situation [26] and their shared purpose is to work towards its resolution, e.g. a need to travel on dialysis. Because it is often uncertain what the human situation is and what an appropriate response might be, options may be less clear upfront. Recognition and articulation that joint participation in investigating, working through, and resolving the problematic situation is required.

3.1.4 Seek and the humanity mode—In situations of existential fracture, disintegration or transition, multiple parties, including clinician teams, family members, and caregivers, may be involved in decision-making conversations. Focused on the deep humanity of the situation, the purpose of SDM is to discover and strengthen bonds in an overarching deeper understanding, relationship, meaning, insight, truth, or love so that what to do becomes clear. The effort to seek participation is to draw patient, family, and oneself into the relationships and dialogue [27–29] that allow for insight into identity, life story, community, meaning or spirit to develop. Participants should be invited to talk together to reveal what truly matters, what should be done, and what the people involved can be for themselves and each other.

3.2 Help your patient explore and compare treatment options

The theme of this step is working together with options in decision making. As with other terms, what “option” means varies with the Purposeful SDM modes (Table 4).

Although the definition of options may vary in each mode, the tips AHRQ offers in its tool kit (Appendix 1) can be used across all modes as they relate primarily to clearly communicating information [14]. These include discussing the available options, risks and benefits of each and limitations in what is known or unknown about them, in plain language and communicating any numeric information clearly. The tool kit also suggests assessing what participants know or understand about the problem or options, using teach-back methods to check for understanding, and looking for signs of decisional conflict.

3.2.1 Help and the alternatives mode—This is done by presenting the positive and negative attributes of the alternatives, eliciting or determining preferences and values, and assisting the patient in weighing them against one another.

3.2.2 Help and the conflict or ambiguity mode—This involves establishing an environment that is safe for the patient and clinician to freely express their desires, conflicts, or confusions so that they can be worked through in discussion, sense making, debate or negotiation. **While this is important in all modes, the creation of an open environment is central to negotiating conflict.**

3.2.3 Help and the problematic situation mode—This mode focuses on helping patients and clinicians attend to a problematic situation. The “situation” is not limited to medical diagnoses, prognoses, and potential treatments. Also, a particular “situation” does not encompass all of the overarching structural factors that may be detrimental to the patient. “Situation” refers to the particular problem at hand and the distinctive factors that contribute to it and limit or enable the ability to resolve it.

Practically, the resolution of problematic situations requires relating two interrelated questions of care: “What is the situation that demands care/action?”, and “What is the care/action that the situation demands?” [30]. This involves working together to develop and test hypotheses about the nature of the situation and potential responses to it. Conversation should also uncover reasons for or against the hypotheses and the situationally appropriate method of judging them.

3.2.4 Help and the humanity mode—The mode of humanity involves people talking together to share opinions, stories, memories, meaning, community, or love in order to develop insight into what truly matters and what should be done. Clinicians can help this process by facilitating, witnessing, and participating in the conversations in which talking together reveals greater existential insight.

3.3 Assess your patient's values and preferences

The theme of this SHARE step is ensuring that matters of human desire are incorporated in decision making. The term “preferences” is most at home in the alternatives mode where it refers to the patient's preferences with respect to an alternative. The term is also commonly used in the second mode as a catch all for any expression of what the patient wants. In both cases, preference is typically associated with the interior states of individuals. In other modes, the concept of preference changes significantly as attention moves to problematic situations and dignity/love/meaning as the focus of care. To account for this, we use the more neutral term desire, of which ‘preference’ is only sometimes the pertinent concept (Table 5).

The tips for this step can also be applied across all four modes because they relate to and include basic patient-centered communication skills [31] that draw the participants into the conversation and signal that their input is important. These include encouraging patients to talk about what matters most to them by asking open-ended questions, listening actively, showing empathy and acknowledging their values, preferences, and desires.

3.4 Reach a decision with your patient

The theme of this step is bringing the decision-making process to a close in the initiation of action (including no action), medical or otherwise. The SHARE Approach suggests guiding the patient toward a decision by asking if they are ready to **decide** and to provide additional information or tools necessary to help in reaching a decision. This may also include discussing additional options if necessary.

Reaching a decision varies across modes by the nature of the process' closure, what the participants are doing in closing the discussion and initiating action, and what a decision is. In the first mode for instance, a process of weighing ends in a determination that pros, cons, and preferences are adequately balanced. In contrast, reaching a decision in the second mode involves bringing activities of negotiation and argumentation to a close in an agreement within or between parties of what they want and are willing to do. The ethics of contemporary medicine requires agreement before medical intervention—informed consent at a minimum. However, in some modes this agreement is a formal codification and confirmation of a decision, while in the second mode agreement, or the acceptance and mitigation of disagreement, is a central part of the method (Table 6).

3.4.1 Reach and the alternatives mode—In this mode a decision is a determination that one alternative is the most satisfactory in terms of the balance of its pros, cons, and the preferences and values of the patient. It represents the end of a process of examining and weighing the attributes of alternatives, the patient, and context.

3.4.2 Reach and the conflict or ambiguity mode—Here, a decision is an agreement between or within parties that occurs at the end of a process of negotiation or argumentation. It involves reaching a point where conflicting points of view, priorities, or inner voices have reached a point of accommodation and in which people can speak clearly to what it is that they want to do.

3.4.3 Reach and the problematic situation mode—In this mode, a decision is the conclusion of a problem resolution inquiry[26]. Here “**conclusion**” does not only mean the end of the process, rather the investigative conclusion that patient and clinician have reached. It represents the formation of a well-composed synthesis of the factors contributing to the humanly experienced problem, the potential means of bettering it, and the values developed in conversation that guide a plan for action[30]. The conclusion need not lead to the ultimate resolution of an illness, more often it represents a plan for moving forward in the face of limitations. When well-formed, this plan has an emotional, practical, and intellectual coherence—it is emotionally responsive to the situation, feasible and desirable to implement, and has an intellectually sound logic or argument. The decision represents the conclusion that this is the situation that we’re currently responding to, this is what we will do, this is how we will do it, and this is why we are doing it.

3.4.4 Reach and the humanity mode—In this mode a decision is insight into the human significance of what is happening, what truly matters, and what should be done.

Ideally, this insight develops within the group as well as its members. It may be experienced as a deep understanding, a sense of meaning, an emotional rightness, or love.

In the SHARE Approach guidance, the focus is primarily on reaching a decision together with the patient, but recognizes that the patient may want to consult with or make decisions together with caregivers or family members. However, in some complex problem-solving or humanity situations, the caregivers and/or family members may be the primary decision makers on behalf of the patient.

3.5 Evaluate your patient's decision

The theme of this step is ensuring that the decision is well grounded, appropriately arrived at, and actionable. The SHARE Approach guides clinicians to monitor implementation of the decision and assist the patient in overcoming any barriers to implementing the decision. The basis for evaluation changes across the differing Purposeful SDM modes. In end of life decision making, for example, the grounds for judging the appropriateness of a decision may be different than those for the decision to undergo **colon** cancer screening.

3.5.1 Evaluate and the alternatives mode—When decision making is focused on alternatives, evaluation of the decision is evaluation of the likelihood that the selected alternative is the one that best balances pros, cons, and preferences to achieve the desired outcome.

3.5.2 Evaluate and the conflict or ambiguity mode—In this mode, the basis for evaluation is the extent to which the agreed-upon option reconciles conflict or ambiguity. An important indicator of this is the extent to which the patient is able to express and initiate what they want.

3.5.3 Evaluate and the problematic situation mode—The basis for evaluation of the decision in this mode is the plan's appropriateness as a response to the human problem being attended to. An important question in this evaluation is "Is the plan actually responding to the human problem at hand?" Additionally, the coherence of the plan should be considered in terms of its emotional, practical, and intellectual **qualities**.

3.5.4 Evaluate and the humanity mode—Evaluation in this mode rests on the quality of the insight gained through dialogue and the existential reintegration achieved through it. This may be indicated by the strength of feeling that a particular action is the right thing to do, the ability to place the decision within the context of larger narratives, spiritual or other meaning systems, and the community affected by the decision. Strengthening, creation, or revelation of the bonds or love between people may also indicate that insight has been achieved.

4. Discussion and Conclusion

4.1. Discussion

Patients and a broad range of clinicians make decisions together in response to many kinds of problems. General models of SDM such as SHARE were developed in response to

limited kinds of decisional situations. The matrix provides a structure for adapting SHARE to the broader reality of clinical practice in order to help patients and clinicians with more individualized and caring conversations that are responsive to the problems that patients are experiencing. Through this, clinical perception of the pertinence of SDM may increase and supports developed to help in the underrecognized places in which SDM is already an everyday part of care, e.g. problem solving in social work.

4.2. Conclusion

The matrix traces the themes of each SHARE step across the modes of Purposeful SDM. In so doing, many general best communicative and interactional practices described in the SHARE model remain helpful, e.g. “Speak slowly and avoid using medical jargon.” At the same time, the matrix demonstrates significant variation in the beginnings, concepts, methods, terms, and purposes of SDM. Each variation appears consistent within its own column, e.g. an “option” being a hypothesis in the problematic situation mode is consistent with patients participating as problem solvers/investigators. Additionally, each variant is significantly different from those found in other columns, e.g. in the alternatives mode, “preference” is central to weighing alternatives, while in the humanity mode, the term fades in significance as the issue is not predominantly preferences of individuals but what truly matters at an existential level. Generalized SDM models such as SHARE can be built upon and extended to provide support for different decisional situations.

4.3. Practice Implications

In the results, we focused on the rows of the matrix to demonstrate modal variation. Reading down each of the columns provides practitioners and learners with an indication of how to perform each kind of Purposeful SDM. **This invites future elaboration in new training materials, SDM interventions such as decision aids, and implementation strategies targeting new clinical settings and audiences. It also has implications for which behaviors are evaluated and valued in SDM measures. At this early stage, we enthusiastically anticipate the empirical work needed to address these matters.**

Because understanding of the situation, objectives, and the needs of the patient develops over time in conversation, switching modes of purposeful SDM is often appropriate. For instance, when a decision conversation about alternative depression medications is underway during which spousal abuse is discovered, any decisions that follow may turn away from weighing the *alternative* drugs to matters of the woman’s inner *conflict* about leaving her spouse, the *problems* of her domestic situation, or *existential* matters of identity and self-worth. In the change of conversation, the beginnings, concepts, terms, methods, and purposes of SDM could usefully change. When they do not, harm may be caused to the patient-clinician relationship and the ability of that relationship to help the situation that the patient finds themselves in, e.g. treating the turmoil of deciding to leave an abusive relationship as a preference-sensitive decision is likely to induce mistrust, isolation, and possibly deeper depression.

For this reason, it is important to enable learners of SDM to recognize how general steps of involving and supporting patients and families in decision making vary with different kinds

of situations. It is also important that any supporting interventions such as decision aids and training materials are developed conceptually, methodologically, and linguistically to assist in attending to the kinds of problems that the patient is experiencing rather than follow assumed general steps, terms, and behaviors of SDM. It is our hope that the distinctions made in the matrix are useful in aiding these efforts. This line of education, practice, and research is at an early stage, there remains much to learn and expand on.

The pluralism of SDM methods, concepts, and purposes presented here cautions against the pursuit of singular all-encompassing definitions, behaviors, norms, and measures of SDM. This does not mean that hard-won existing definitions and concepts should be abandoned, rather, that their scope of practice be considered and that the discovery, creation, and acceptance of new language, practice, and science follow the need to address newly recognized problems in caring for the living experience of patients.

Clinical care must respond to individual patient's situations and in so doing develop the concepts, norms, methods, and relationships that are fit for this purpose.

This responsibility is at the heart of the caring and learning health system [32]. To fulfill this responsibility, we must continue to discover and implement patient-centered methods, such as SDM, that first and foremost address problems as they are experienced by patients [33, 34].

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Appendix 1

Seek participation	Help explore options	Assess values and preferences	Reach a decision together	Evaluate your patient's decision
Communicate that a choice exists and invite your patient to be involved in decisions. <ul style="list-style-type: none"> Summarize the health problem. Let your patient know about their options. Ask your patient to participate with the health care team in making decisions. 	Discuss the benefits and harms of each option. <ul style="list-style-type: none"> Assess what your patient already knows about options. Describe them in plain language. Clearly communicate the risks and benefits of each option. Explain 	Take into account what matters most to your patient. <ul style="list-style-type: none"> Encourage your patient to talk about what matter most to him or her. Ask open-ended questions. Listen actively, show empathy and interest. Acknowledge the values and 	Decide together on the best option and arrange for follow-up. <ul style="list-style-type: none"> Guide your patient to express what matters the most in the decision. Help your patient move to a decision. Provide additional information tools to help make a decision. 	Support your patient so the treatment decision has a positive impact on health outcomes. <ul style="list-style-type: none"> Monitor how the decision is implemented. Assist your patient with implementing his or her decision. Revisit the decision with your

Seek participation	Help explore options	Assess values and preferences	Reach a decision together	Evaluate your patient's decision
<ul style="list-style-type: none"> • Include family or caregivers in discussions. • Remind your patient that his or her participation is important. 	uncertainties in the evidence <ul style="list-style-type: none"> • Offer evidence-based decision aids whenever possible. • Check for understanding. 	preferences that matter to your patient. <ul style="list-style-type: none"> • Agree on what is important to your patient. 	<ul style="list-style-type: none"> • Check to see if your patient needs more time to consider the options or discuss them with others. • Confirm the decision with your patient. 	patient and determine if other decisions need to be made.

* Adapted from The SHARE Approach—Essential Steps of Shared Decisionmaking: Quick Reference Guide. Agency for Healthcare Research and Quality, Rockville, MD.

<https://www.ahrq.gov/health-literacy/curriculum-tools/shareddecisionmaking/tools/tool-1/index.html>

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Text box. The case for purposeful shared decision making

Purposeful Shared Decision Making (SDM) organizes modes of SDM according to the types of problems being addressed. Its premise is that the need to act, the process for and roles in determining action (decision making), and the act that responds to the need are functions of the situation that the patient and clinician are experiencing and caught up in (problem), and that the concept and practice of SDM can usefully be defined by a problem rather than an ethical imperative for patient involvement [8].

Example 1: A generally healthy 44-year old male and his clinician are deciding on primary prevention of cardiovascular risk. The clinician presents the risk of heart attack (problem) and the option (options) of taking statins. The two weigh the pros and cons (deliberation). The patient decides that he would like to begin taking statins (decision).

Example 2: The same man 9 months into a diagnosis of ALS. He, his partner, and clinical team need to make decisions about when and how to withdraw from work and how to re-organize the home and home life. As they talk they develop a sense of the loss involved in leaving work, the practical challenges to be navigated, and new demands being placed on the domestic relationship (problem). Previously unapparent possibilities for reconfiguring the home, maintaining connection with work projects, and for spousal support emerge (options) and are entertained and amended (deliberation) until a plan (decision) emerges.

Different kinds of decision making are used in each example. The difference is not only in the seriousness of the situation but also in how the participants work together and what they're doing together—choosing for or against statin therapy (which alternative?) by weighing pros and cons, versus figuring out how to reconfigure a life and what's important in doing so. These differences suggest a variety of ways and purposes of making decisions together (SDM)

We have found that the strongest support for Purposeful SDM comes from clinicians. They are intimately familiar with how decision making with patients varies by the problem the patient and clinician face and by the joint deliberative methods appropriate to addressing it.

Highlights

- General SDM approaches e.g. AHRQ's SHARE don't account for patient problems
- We related the 5 SHARE steps and Purposeful SDM's problem specific modes of SDM
- SDM terms, concepts and practices vary significantly with kinds of patient problems
- SDM practice may be supported by adapting general SDM approaches to problems

Table 1.

Beginning points of decision making in Purposeful SDM

Mode	1	2	3	4
The decision is about	Alternatives	Conflict and ambiguity within or between the parties to decision making	A problematic situation and what to do about it	The humanity of those caught in a situation of existential suffering or transition
Decision making begins or arises from	Uncertainty in the course of illness and in what the harmful and beneficial outcomes of alternative interventions will be for a patient and their preferences	Patients, caregivers, or clinicians torn by inter or intra-personal conflict about what they want to do	Living within a multifaceted problematic human situation, and its thwarted need for resolution	The fracturing or transition of self and community associated with illness or existential transition
	Example			
Problem	How to treat this patient's depression?			
Example: Question SDM must help answer	Which antidepressant to take to treat the patient's depression?	Does the patient want to be a person who takes pills for depression when he sees taking medications as a sign of weakness?	How to manage depression and other ongoing conditions and life demands while caring for a spouse with cancer?	How can the patient's sense of self be restored so that he can be who he wants to be for his children?
Example: The joint deliberation process to answer the question and address the problem.	Identify the antidepressant that is most consistent with patient preferences for efficacy, cost, and risk and type of adverse effects.	Help the patient articulate why he patient prefers to avoid psychotropic medications and reconcile these reasons with the medications' availability and safety vs. psychotherapy.	Develop together a clear understanding of how depression treatment can facilitate or hinder the control of the other conditions and the caregiver role to justify a particular treatment rationale and approach.	Talk together to develop insight into what the patient's suffering has meant for him and his family and find reasons within that for pursuing a therapeutic approach.

Table 2.

Matrix relating SHARE steps and modes of Purposeful SDM

SHARE / Purposeful modes of SDM	Mode 1 Working with... Alternatives	Mode 2 Working with... Conflict and Ambiguity	Mode 3 Working with... A Problematic Situation	Mode 4 Working with... The Humanity of an Existential Transition
Seek your patient's participation	In weighing pros & cons, preferences, and values In information exchange In their own and medical expertise	In negotiation, sense making, or argumentation In developing a shared language In developing a shared problem definition In voicing perspectives, desires, agendas, conflicts	In problem resolution and management In the work of responding and managing a problematic situation	In meaning and insight In a shared humanity In love
Help your patient explore and compare treatment options	By presenting and interpreting the characteristics of the alternative treatments and their interaction with the preferences of the patient	By establishing a relationship and way of talking in which intra or interpersonal conflict, or confusion can be freely expressed and negotiation or sense making can occur	By developing in conversational inquiry hypotheses regarding the nature of the full human problem that patient and clinician are caught in along with hypotheses regarding what might be done. Testing in conversation the hypotheses of what might be done with respect to the problematic situation	By joining the life and story of the patient and their loved ones out of which the significance of any intervention arises By developing in dialogue insight into what ultimately matters so that what to do becomes clear
Assess your patient's values and preferences (<i>desires</i>)	In terms of the alignment of treatment attributes and patient preferences	In terms of the stated or repressed will of the patient and clinician	In terms of the plan as a potential response to the situation—i.e. does the plan make intellectual, practical, and emotional sense	In terms of the development and support of meaning and dignity
Reach a decision with your patient	That is a determination that the selected alternative is the most compatible with the patient's preferences	That is an agreement that the will of the parties to the decision is to proceed with the chosen option	That is a conclusion reached in inquiry that: • This is the situation • This is what we'll do • This is how we will do it • This is why we will do it	That is insight into what ultimately matters and how caring action integrates in the life and story of those affected by it
Evaluate your patient's decision	On the basis of the likelihood that the selected alternative is the most acceptable and likely to succeed	On the basis of the reconciliation of intra or interpersonal conflict or ambiguity	On the basis of the care plan's appropriateness as a response to the intellectually, practically, and emotionally troubled situation	On the basis of the meaning , insight, reintegration, love or regeneration achieved through dialogue

Table 3.

Participation across Purposeful SDM modes

	1 Alternatives	2 Conflict and Ambiguity	3 Problematic Situation	4 Humanity
Roles: Patients and clinicians commonly act and may be supported as...	Experts Evaluators	Agenda holders Sense makers Negotiators Debaters	Problem solvers Investigators Planners Co-designers Experimenters	Fellow dignified, storied, and sacred human beings
Examples of conversation starters	“There is good information about how these treatments differ that I’d like to discuss with you before we decide on an approach that is best for you. Your input is important.”	“I want to hear about the different things that are weighing on you as you make this decision. Talking them through might help and allow us to agree on a path forward that make sense for you.”	“It’s not yet clear what is going on or what the next steps should be. Let’s work together to figure out how to proceed.”	“This is an incredibly challenging time for all of you. We have some time, let’s take it to talk together and see if we can discover what really matters for you as a family and for your mother as her life story comes to a close.”

Table 4.

Variation in what is meant by the term “option” and examples

1 Alternatives	2 Conflict and Ambiguity	3 Problematic Situation	4 Humanity
An option is an alternative—one thing or another, a fork in the road	An option is a firm, ambiguous, or conflicted notion, speculation, proposal, or position expressed as belief, opinion, experience, or will	An option is a hypothesis—a tentative potential contributor to the resolution of a problem. Hypotheses arise and are accepted or dispensed with while working through a problematic situation.	An option is a partial image or glimpse of what should be done.
“You can decide if you want to have your lungs screened for cancer or not.”	“I think that maybe I could stop taking my anti-seizure meds?” “I feel awesome, I don’t want to take these damn bipolar meds!”	“Perhaps we could lower your blood pressure medication while we start you on insulin.” “Is there a cheaper way to get my insulin?”	“Mom, I know it’s hard. I can leave the kids for a bit and be with you while you transition to the elder community.” “I need to go home to Ireland before the ALS gets too bad.”

Table 5.

Variation in what is meant by the term “preferences” and examples

1 Alternatives	2 Conflict and Ambiguity	3 Problematic Situation	4 Humanity
Desires are preferences, and preferences are taken to be attributes of person with respect to an alternative	Desires are arbitrary assertions of will voiced and unvoiced, tentative or firm	Desire is inherent to the situation. It is the desire for resolution of the problematic situation	Desire is the longing of an individual or community to be whole or part of something greater, truer, or more meaningful³
“Mr. Smith’s preference is not to risk radiation exposure from testing.” “Ms. Jones, you seem to be the sort of person who prefers conservative approaches, is that right?”	“I want antibiotics for my kid.” “I really don’t know if I want to get this nodule checked out or let it be for now.”	“I can’t not work and keep on paying for all these meds.” ¹ “Maybe it’s preferable to hold off surgery for now until I can get my knee pain under control.” ²	“Who am I if can’t be at home, my whole life is here?” “I can’t make sense of it, I can’t let her go.”

¹. Desire, in this example, is the desire to be in a situation where a patient’s ability to work is in alignment with her ability to pay for medicines.

². When “preference” is used in this mode, it is often merged with the activity of generating and judging hypotheses.

³. The use of “preference” in this mode commonly happens early in dialogue where participants are stating their positions or speculating on what another person would want. As attention moves from the preferences of individuals towards developing insight into what truly matters, the term becomes less adequate.

Table 6.

Variation in what is meant by the term “decision” and examples

1 Alternatives	2 Conflict and Ambiguity	3 Problematic Situation	4 Humanity
A decision is a determination	A decision is an agreement	A decision is a conclusion	A decision is insight
“After weighing the pros and cons of each option, and how they fit with your lifestyle, we are choosing treatment X. We will follow up to see how it is going at your next visit.”	“So, we agreed to hold off on surgery for now. Are you feeling ok about that? If it doesn't feel right at any time, give me a call, and we can talk more. You can always change your mind.”	“OK, so I think we have a better sense of what we're dealing with. While we're waiting for more test results, you're going to contact your insurance company, and I'll reach out to our social worker and see what resources might be available.”	“We talked long into the night and remembered all sorts of things about mom and the stories she used to tell. I think we all woke up this morning and knew what we needed to do.”