The Moral Psychology of Person Centred Adolescent Diabetes Care

two potentially conflicting ethical dimensions of shared decision making for sustainable self-care

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Introduction

+ Person centredness and shared decision making are established ideals for pediatric diabetes care.

+ These ideals assume robust decision capacity and capacity for taking responsibility for self-care, seldom applicable. Challenges for adolescent patients lie outside of the clinic and may easily undercut prerequisites for god care.

+ Self-care needs to be managed without special support and patients need to be able to take responsibility for this, in spite of known weaknesses linked to teenage years.

+ In this study, we explore how models of person centred adolescent diabetes care and attached shared decision making may be developed and modified to account for such special needs.

Materials and methods

+ Video-recordings of 12 regular consultation meetings between adolescents with diabetes and health care professionals.

+ Analysis of empirical material using theories from ethics, philosophy and psychology

+ Comparison to standard models of person centred care and shared decision making from the literature

+ Development of suggested additions and revisions on the basis of further psychological and ethical analysis

Diabetes care, habitual and deliberative decision making

Two types of decision making at work in diabetes care: habitual and deliberative decision making; Kahneman's "fast" and "slow" thinking.

Deliberative decision making involves afterthought and consideration, while habitual decisions are taken without much preceding cognitive activity and are sensitive to momentary and unconscious influence. Habitual decision making is what we all use in our daily lives, following instinct and impulse, rather than attetive deliberation.

DELIBERATIVE DECISION MAKING

57 / 3 – 3.17 (4 + 45 / 98.234) = ?

Slow thinking in a controlled and adapted environment with support present and disturbances and temptations at a distance

How should I manage checking levels, eat, drink, sleep and adjust insuline dosage in various situations, given recorded past levels, levels, variations and mishaps?

HABITUAL DECISION MAKING

Here's a person stretching out a hand, what do I do?

Fast thinking in regular environment with no support and disturbances and temptations ever present

How about a drink?
Let's skip lunch and check out X!
Can't you up some extra, so you can stay?
Don't be a bore!

Person centred focus on deliberative decision making: rational problem solving removed from the actual context of execution.

Little attention to patients' resources for habitual decision making, where adherence and quality of self-care is determined.

Three Pillars of Habitual Care Decisions
+ Internalisation of care goals
+ Ability to identify significant choice situations
+ Emotional feedback mechanisms inspiring self-care according to plan

Relation in PCC/SDM meetings

Person centred approaches need focus also on the fostering and cultivation of *patient virtues*, not only autonomy and rationality

Traditional person centred approaches may even undercut prerequisites for patients to manage habitual decision making well

Conclusions

Opportunities to help patients to develop appropriate virtues are often neglected by caregivers when they apply standard person centred formulas, e.g. regarding teenage type 1 diabetes.

Three aspects are essential for improved habitual decision making and long-term adherence to diabetes treatment: internalisation of care goals, improved perception generation, and appropriate emotional feedback mechanisms.

Caregivers can affect all of these, but it requires…

+ Case-sensitivity and attention to opportunities.

+ Individuals are different, have different interests, perceive of the world in different ways and have different emotional feedback mechanisms.

+ All patients may reveal opportunities for caregivers to intervene and attempt to improve habitual decision making, but caregivers may lack the training to recognize and/or exploit these.

+ Person centred care for areas dominated by self-care and patients with weak or vulnerable capacity for responsibility needs to trade off traditional aims of autonomy and rationality against long-term concern for virtue development, responsibility capacity and adherence.

+ Lack of attention to this virtue ethical dimension of adolescent diabetes care is a potential threat to patients' health and future autonomy.

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