



# Shared Decision-making, moral psychology and "family-centeredness": the case of parents and adolescents

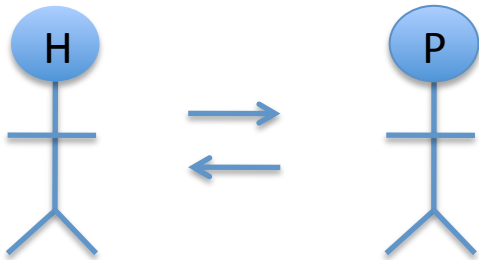
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## Standard SDM Approach: deliberative decision making under assumption of robustness

### CONTEXT OF CLINICAL DECISION MAKING

Shared Decision Making (SDM)



Rational, autonomous and  
health-promoting decisions  
in care meetings

### CONTEXT OF CARE EXECUTION

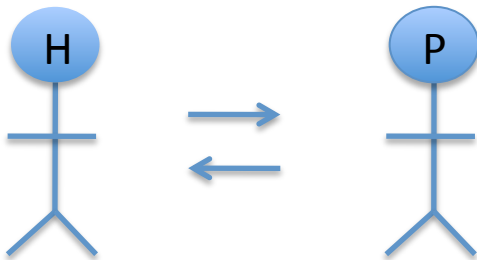
Assumption 1:  
Care is executed by experts

Assumption 2:  
P is a robust decision maker

ERGO: Good decision results  
in adequate care

## Self-care, adherence: habitual decision making not necessarily robust

### Shared Decision Making (SDM)



Rational, autonomous and health-promoting decisions in care meetings



Capabilities  
Health  
Autonomous  
life  
Virtues

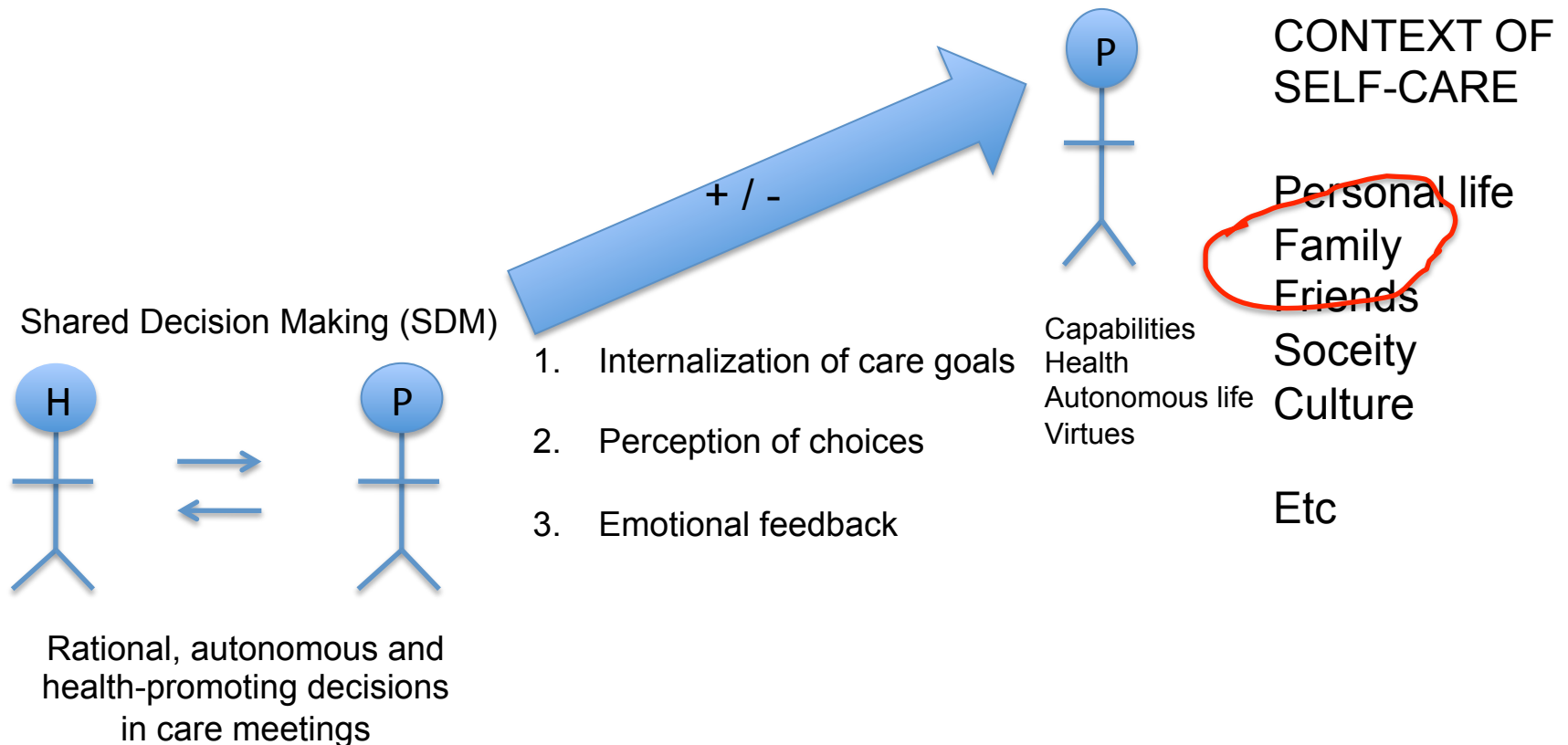
### CONTEXT OF SELF-CARE

Personal life  
Family  
Friends  
Society  
Culture

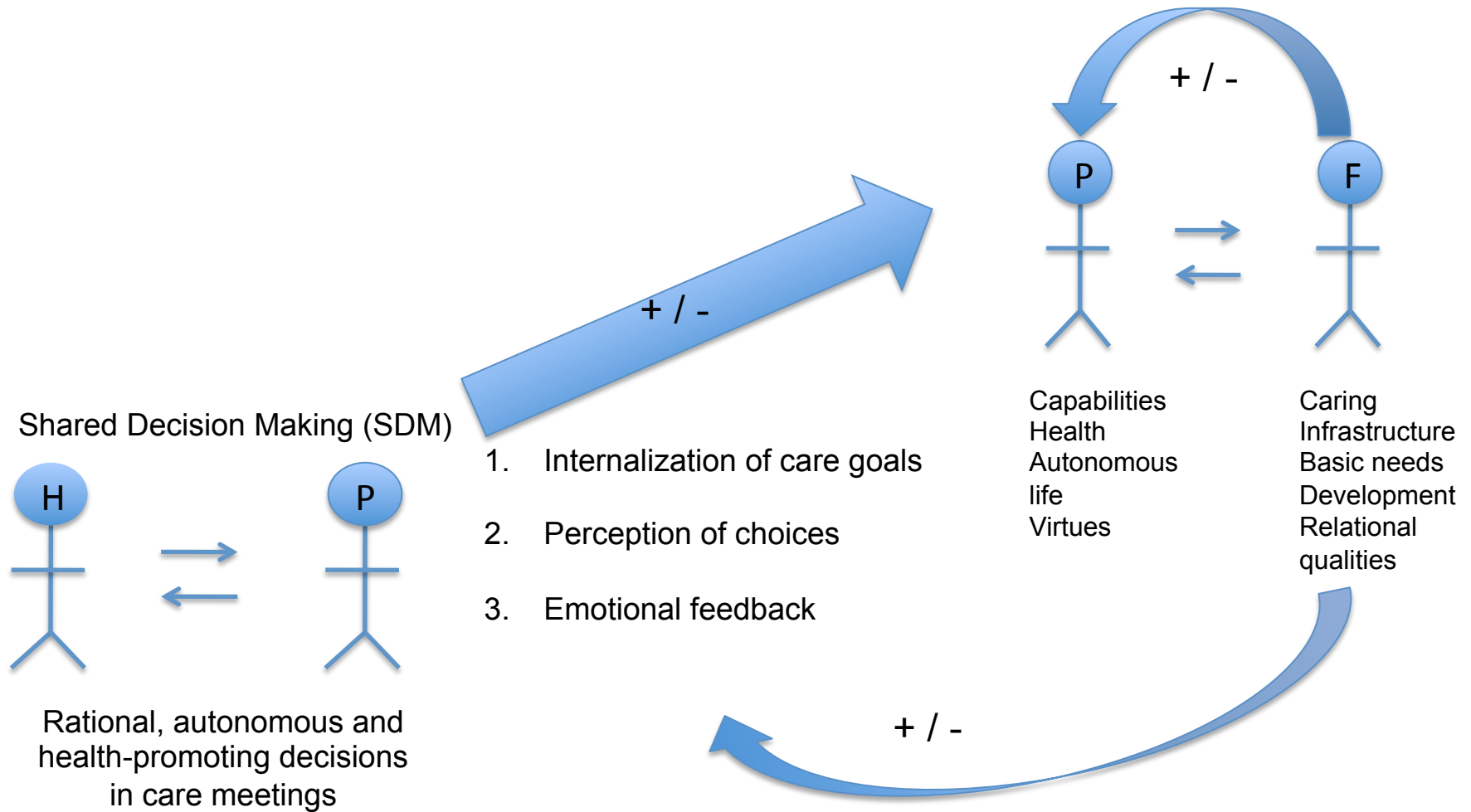
Etc

Robustness can often not be assumed:  
Young ppl, elderly, mental ill-health...

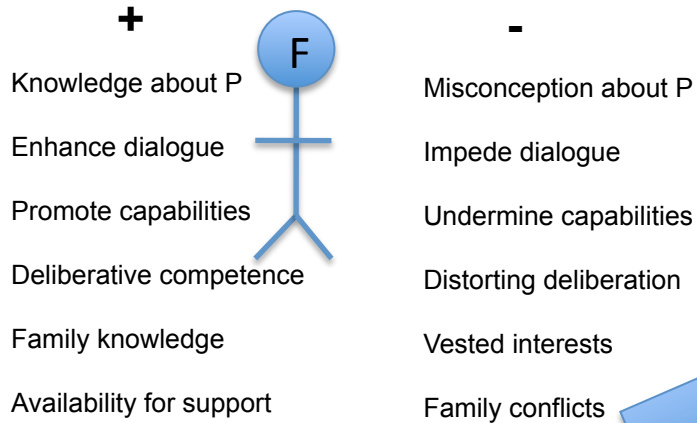
# Self-care, adherence: habitual decision making not necessarily robust: **weak capacity to take responsibility**



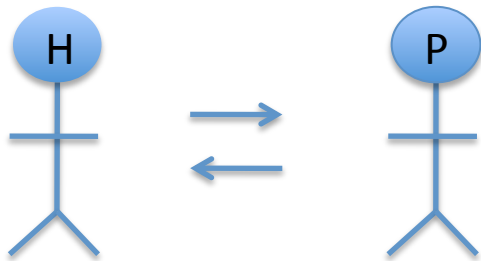
## Self-care, adherence: habitual decision making not necessarily robust **and sensitive to family dynamics**



## Bringing family into deliberative SDM? How and when?

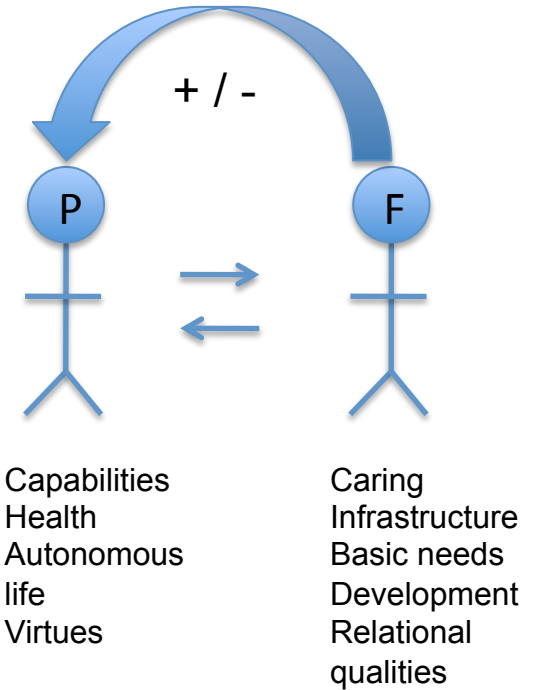


### Shared Decision Making (SDM)



Rational, autonomous and health-promoting decisions in care meetings

1. Internalization of care goals
2. Perception of choices
3. Emotional feedback





## Questions we're pondering ...

- Family as consultant or participant or object of care-action in SDM?
- Structural action towards family: education within H-C, etc?
- Structural action beyond H-C → where does H-C responsibility end?
- Generalisation to other cases than young child – parent: spouse, adult child – elderly relative, dysfunctional family member ...
- Risk of undermining relational values (actual concern of h-c staff)
- Risk of having patients instrumentalized for the "good of the family"