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)

H

P

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

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**

Shared Decision Making (SDM)

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

Rational, autonomous and health-promoting decisions in care meetings

**CONTEXT OF SELF-CARE**
- Personal life
- Family
- Friends
- Society
- Culture
- Etc
Self-care, adherence: habitual decision making not necessarily robust and sensitive to family dynamics

Shared Decision Making (SDM)

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

Rational, autonomous and health-promoting decisions in care meetings

Capabilities
Health
Autonomous life
Virtues

Caring
Infrastructure
Basic needs
Development
Relational qualities

+ / -

+ / -
Bringing family into deliberative SDM? How and when?

Shared Decision Making (SDM)

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

Rational, autonomous and health-promoting decisions in care meetings

+ Knowledge about P
  - Misconception about P
  - Impede dialogue
  - Undermine capabilities
  - Distorting deliberation
  - Vested interests
  - Family conflicts

+ / -

Capabilities
  Health
  Autonomous life
  Virtues

Caring Infrastructure
  Basic needs
  Development
  Relational qualities
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”