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Journal of Medical Ethics (ISSN: 0306-6800)

Citation for the published paper:
Sandman, L. ; Gustavsson, E. ; Munthe, C. (2016) "Individual responsibility as ground for priority setting in shared decision-making". Journal of Medical Ethics, vol. Online first.

http://dx.doi.org/10.1136/medethics-2015-103285

INDIVIDUAL RESPONSIBILITY AS GROUND FOR PRIORITY-SETTING IN SHARED DECISION-MAKING

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Funding

This research was supported by the Swedish Research Council for Health, Working Life and Welfare (FORTE) and the Swedish Research Council (VR) contract no. 2014-4024, for the project *Addressing Ethical Obstacles to Person Centred Care*; and VR, contract no. 2014-40, for the project *Gothenburg Responsibility Project.*

Abstract

Given health care resource constraints, voices are raised to hold patients responsible for their health-choices. In parallel, there is a growing trend towards shared decision-making, aiming to empower patients and give them more control over health care decisions. More power and control over decisions is usually taken to mean more responsibility for these. The trend of shared decision-making would therefore seem to strengthen the case for invoking individual responsibility in health care priority setting.

Objective and Design

The objective was to analyze whether the implementation of shared decision-making would strengthen the argumentative support for invoking individual responsibility in health-care priority setting, using normative analysis.

Results and Conclusions

Shared decision-making does not constitute an independent argument *in favor* of employing individual responsibility since these notions rest on different underlying values. However, these theoretical tensions do not constitute a problem for combining these phenomena in practice. If a health system employs shared decision-making, individual responsibility may be used to limit resource implications of accommodating patient preferences outside of professional standards

and goals. If a health care system employs individual responsibility, high level dynamic shared decision-making may disarm common objections to the applicability of individual responsibility, in virtue of making them more likely to exercise adequate control of their own actions. However, if communication strategies applied in the shared decision-making are misaligned to the patient's initial capacities, the result may be the opposite. Non high-level dynamic types of shared decision-making would not seem to affect the applicability of individual responsibility at all.

(1) Background and problem

Adam and Eve suffer from type-2 diabetes, and they are both recommended to observe a rather strict diet, engage in regular physical exercise and follow dosage guidelines regarding insulin. Eve fails to observe the diet, abstains from exercising and is highly variable in the meeting of insulin administration recommendations. As a result of this, she suffers from increased symptoms and ends up with renal failure. Adam instead adheres to the recommendations, but still (due to unknown factors) suffers similar symptoms and renal failure. Do Adam and Eva have equally strong claims to public health care resources? According to one notion in medical ethics they do, because they have similar health care needs. According to other ethical notions, they do not, as Eve voluntarily caused her health care need and therefore is in some sense responsible for it in a way that Adam is not. If both of them cannot have their needs optimally satisfied, this suggests that Eve should be assigned a lower priority in spite of their equal needs, a view that we will refer to as *individual responsibility* (IR) [1-3]. Theories affording IR may, of course, be debated as such, quite independently of health care issues. In this paper, however, we will assume that some such theory is acceptable in order to address arguments criticizing the practical applicability of IR within health-care under non-ideal circumstances. These arguments focus on the difficulty of establishing whether an individual is in fact responsible for a health care need; on feared consequences of introducing an IR-theme into clinical dialogue and practice; and on structural risks or unwanted consequences if IR is implemented as policy. In particular, we explore whether these arguments can be ameliorated by the introduction of shared decision-making (SDM).

SDM has emerged in the last couple of decades as part of a trend towards a more patient or person centred care [4 5] and means that the patient is given room to voice her subjective perspective as a basis for a collaborative approach in health care decision-making. Main reasons for SDM are that the room for patient autonomy may then be expanded, while retaining opportunities to influence the patient's health [6 7], and that SDM may result in better adherence to care decisions when these are adapted to the patient’s situation [8].

SDM presupposes that the patient either *is* competent and able to partake in a dialogue, make decisions about care in his or her daily life, or that SDM serves to *empower* patients to attain such abilities within a trustful relationship. This seems to ring well with advocacy of IR which usually refers to similar sort of competences in the patients [9]. Given this characterization, SDM seems to have the potential of weakening objections to the applicability of IR to health care priority-setting. Can this intuition be supported when analyzing the relationship between SDM and IR more in detail? Can SDM thereby support the introduction of IR in health-care? These questions depend on the closer understanding of both IR and SDM, but also on analyzing closer in what various ways they may relate ethically to one another: as facilitators or undermining factors for practical application, and as exponents of underlying ethical ideals in potential conflict or support. This relationship between IR and SDM is of interest to proponents of IR, but also to those who generally oppose IR, as it may then provide them with reasons to resist SDM.

However, if SDM would in fact support the introduction of IR in health care it is also of interest to the proponents of SDM, as they might find this aspect more or less welcome.

The paper has the following structure. In sections 2 and 3, we elaborate SDM and IR respectively. Based on this, we then argue, in section 4, that at least *some* version of SDM and IR indeed seem to strengthen the case for holding *some* non-adherent patients responsible through some degree of de-prioritization in the delivery of health care services. Other versions may instead have no or the opposite tendency. In section 5 we argue that it is not the case that SDM provides independent support for IR, rather, IR and SDM rest on potentially conflicting underlying normative ideas. At the same time, IR may be used to limit some unwelcome side effects of SDM.

(2) Shared Decision-Making

We will not repeat the independent arguments for introducing SDM or analyze them in detail, since this has been explored elsewhere[4 8 10 11]. Still, we need a clearer picture of what SDM may amount to. Sandman and Munthe[10] have presented a taxonomy of nine generic models of SDM. Several of these do not suggest the shift of responsibility discussed in the present setting. Here, we will therefore focus on the versions that do. These models all assume that the patient has shared a narrative of his or her situation with the professional, disclosing not only immediately medically relevant aspects, but also more general aspects regarding his general conditions, experiences, values and goals in life, which may affect how a chosen treatment proceeds[10]. The patient and professional then collaborates in a decision-making process that may have three outcomes: joint decision; a decision made by the patient without professional support; or a compromise where the professional strategically accepts something less than ideal (from the perspective of the professional) to achieve consensus.

These versions of SDM all facilitate that professional standards and goals are open to criticism from the patient, that the patient’s preferences and views may be discussed and questioned by the professional, arguments can be proposed and accepted or rejected, and both parties may revise their initial standpoints. This "high level dynamics"[10] implies that the patient is given substantially more involvement and power in the decision-making, thereby possibly acquiring the control underlying the thesis that SDM may promote IR. Of course, *actual attempts* at high level dynamics SDM may come closer or farther from this generic ideal type. However, even in imperfect cases, there will be considerably increased room for patients to influence the decision on treatment, either by arguments accepted by the professional, or by declaring unwillingness to adhere to what the professional suggests, pressing the latter to a compromise. If the patient insists on too risky or unmotivated treatments, however, the professional might withdraw her support and declare to the patient that she cannot condone such an action.

For concrete illustration of this, let us introduce a third patient, Lily. Lily suffers the same symptoms and renal failure as Adam and Eve. Unlike these two, however, her care has involved high level dynamics SDM. Her GP has taken the opportunity of more advanced dialogue to empower Lily to better understand and appreciate the treatment and the risks she is exposing herself to and first attempted to reach a consensus on what she perceives as the ideal treatment, but failed. Lily has made it clear that she cannot imagine a life without alcohol and sweets, without a social life implying late night activities and sometimes irregular eating hours, that she has difficulty motivating herself to training and that she is a bit sloppy with here insulin intake. Lily's GP then explained that the risks could be better, though not ideally, managed with a reduced alcohol intake, somewhat less irregular eating hours and late nights, a bit more exercise, somewhat more adequate insulin handling, and so on, and as a compromise declared herself is willing to accept and support Lily in an attempt to accommodate to Lily's personal priorities and accomplish such an (imperfect) improvement. However, at the end of the day, Lily decided not to adhere to what was agreed, likely causing her current renal failure.

(3) IR: Entangling Responsibility and Priority-setting in Health Care

IR rests on two general claims that entangles responsibility and resource allocation:

(i) If a person is in adequate control of her own actions and their consequences, she is also responsible for these (*The control-claim)*.

(ii) If a person is responsible for an action and its consequences, she has a weaker claim on others to assist her in the continued performance of these actions or the management of these consequences than if she had not been so responsible (*The reduced assistance-claim)*.

If these conditions are met in a health care context, such as in our examples with Eve and Lily, this may be taken as a strong argument for IR itself:

> **IR**: Assuming that needs for health care are equally large and resources scarce, society should allocate less of health care resources to people who are responsible for their own ill-health than to people who are not.

Indicated above, we will simply accept IR as a claim of distributive justice at an ideal level for the sake of the argument. As IR is formulated we have taken the stand that the reduced assistance claim should be based on the notion of "option luck" [2 16] rather than a morality of desert. According to this so-called luck egalitarian reasoning, the unfairness is not that Eve and Lily receive undeserved benefits, but that this implies that others with equal (or greater) needs, e.g.

Adam, might have to be unfairly prevented from receiving the same benefits (regardless of whether this concerns the whole or parts of the benefit).[1]

Assuming IR, we still find a number of arguments concerning its practical applicability, however, and our focus in the following analysis is on these. [1 9] These arguments can be grouped under four different headings:

(a) Questioning the applicability of the control claim.

> People are not able to control their unhealthy behavior in the way assumed by the control claim and therefore the reduced assistance claim is not applicable.

and/or

> There is no plausible way for health care professionals to ascertain that patients have fulfilled the control claim and thus they lack practical means to assess when the reduced assistance claim applies.

(b) Questioning the therapeutic consequences of IR

> IR threatens the trust between patients and professionals.

(c) Questioning the overall benefit of IR

> Behavior that poses risks to health often confers other benefits to patients,

and/or

> IR makes people generally less ready to tend to their health,

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[1] Luck egalitarianism has generated a wide body of research and interested readers are referred to 17. Knight C, Stemplowska Z. *Responsibility and Distributive Justice*. Oxford: Oxford University Press, 2011. and 18. Lippert-Rasmussen K. Justice and Bad Luck. In: Zalta E, ed. Stanford Encyklopedia of Philosophy, 2014. for further explorations.

and/or

IR means that people will be left to suffer and die from curable or manageable conditions

(d) Structural arguments against the social efficiency of IR

It is too costly to ascertain the required control of patients, as well as to monitor to what extent it is in place in single cases,

and/or

IR will in practice express social biases and prejudices regarding which risky behaviors are normal or acceptable and which are not, thereby producing skewed, unfairly discriminatory distributive results.

(4) Combining SDM and IR: What Difference Does It Make?

In this section, we will be using the contrasting cases of Eve and Lily, to test the force of the arguments against IR one by one to assess if the addition of the high level dynamics SDM in the case of Lily makes any difference. Existing ethical discussion of IR typically assume cases like Eve as point of departure: a patient arriving as a pristine wreck with dire needs of care, but no previous treatment history or any sort of SDM, albeit a long life of health mismanagement assumed to be readily knowable . In contrast, what we address is cases like Lily, where there *is* a treatment history including high level dynamics SDM and where the health problems have come gradually during this process, due to the fact that the patient does not keep to agreed treatment plans. At this point, when Lily has developed renal failure, her GP might not be willing to deny her dialysis but still may find it motivated to decrease the time for future consultations or increase the time between these, becoming less active in reoffering services of a sort that Lily has proved unlikely to use, and so on[2]. This might also be an openly addressed topic in the continuing SDM between Lily and her GP.

(a) The applicability of the control claim

This questioning of IR applies when either people are not able to control their unhealthy behavior in the relevant sense although they have an idea of how to do this, or when they lack such relevant knowledge. It can be debated what sort of control is implied by the control claim and to what extent people generally do have the appropriate control over their health-related behavior and its consequences[12] (cf. criminal behaviour[19]). In the present context we will simply assume, that the appropriate control is not so demanding that it is unattainable for an adult human being in standard circumstances. We may then grant that, probably, many people will not initially be in much control when being struck by ill-health or a health-threat [9]. However, the control can then be increased through support offered by health professionals. Lily has been given extensive help to understand her health problem and the opportunity to present her narrative about the kind of life she wants to live, discussed this together with her GP and appreciated the risks she is facing. Based on this, Lily and her GP have deliberated about what

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[2] This opens up for more difficult decisions concerning how far we can accept a patient's condition to deteriorate? In the luck-egalitarian literature this is described as the abandonment objection and different authors related differently to this. For example, 3. Segall S. *Health. Luck and Justice*. Princeton: Princeton University Press, 2010, suggests an add-on to the luck-egalitarian theory according to which we guarantee the patient sufficient health-care (regardless of IR) to avoid this. This is done for other moral reasons than out of fairness or justice. However, it is important to note that this problem is also present in relation to non-adherent patients in general, i.e. how far should the health-care professional go to have the patient accept treatment and will s/he have to accept even more dire consequences for the patient?

adjustments to her life-style and treatment recommendations that could be acceptable and Lily has come to terms with some adjustments as necessary to continue with a valued life. In the continued process, she has tested these adjustments, realized that she could follow some whilst others where more difficult, which led to further adjustments of her treatment plan. Although this plan will result in somewhat worse than the best possible outcome with regard to her health, this is due exactly to her own ability to control the treatment decisions on the basis of a developed understanding of her disease in relation to her own life. If she then chooses not to adhere further to what has been decided, plausibly, this non-adherence is also within her control. While the poor health from the joint compromise (compared to an unlikely perfect treatment) is the responsibility of both Lily and her GP, the responsibility for the non-adherence to the compromise rests on Lily (assuming nothing else has occurred that undermines her control[3]). This observation leads over to the second way of questioning the applicability of the control claim, whether it is possible to successfully assess the extent to which the outcome of care is a result of the patient's voluntary actions, taken under appropriate control. Since it may be difficult to distinguish how patient choices and other independent factors have been influencing the health care needs, using IR in practice requires the acceptance of a certain degree of imprecision and margin of error. This margin may have to be increased further due to ethical restrictions against otherwise effective means for monitoring patient capacities due to respect for patient privacy. At

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[3] If so, since Lily and her GP have an ongoing treatment relationship, this could be exposed and explored in the continuing high level dynamics SDM and motivate further empowering measures to increase Lily's control in these respects.

the same time, since this can be explored in an ongoing treatment relationship based on SDM, this argument is somewhat ameliorated compared to the traditional situation.

(b) The therapeutic consequences of IR

The way in which health professionals and patients communicate and interact may in itself have considerable therapeutic effects. In order to actually apply IR, health professionals will need to actively *hold* patients responsible for what they do. This is often understood as a call for *blaming* patients, something that might threat the "therapeutic alliance", wherein it is often thought that professionals should retain the main responsibility themselves, in order not to endanger the trust necessary for a working alliance [9].

Accepting this possible downside of applying IR, we note that openly holding patients responsible for their health-related behavior is an age-old and common ingredient in the traditional therapeutic relationship – the health professional telling the patient about the expected outcome of various health-destructive behaviors, mismanagement of treatments, and so on - suggesting that the trust in a working alliance is assumed to cut both ways [9]. Adding high level dynamics SDM with its extended consultation, where the patient's perspective, preferences and decision are acknowledged, taken seriously and adapted to, possibly applying various support and empowerment measures, is likely to provide *better* ground for trust-building between patient and professional.

In the case of Lily, the GP clearly shows that she is willing to adapt to Lily's perspective or compromise with her own preferred line of treatment to allow Lily some leeway. This signals that the GP trusts Lily to be able to handle her own life as she sees fit (within the constraint that Lily participates in the SDM). In other words, adding SDM introduces a number of ways to strengthen and preserve a mutual trustful care relationship, which may compensate for and perhaps even counteract the assumed threat to trust by openly applying IR. In addition, assuming that IR is applied by the GP, SDM opens for Lily to challenge the GP's responsibility and priority-setting judgements, thus introducing an element of control on Lily's part also in this respect.

(c) Questioning the overall benefit of IR

The first argument under this heading is the observation that what explains a patient's unhealthy behavior may be the fact that this person has other values and aspirations in life than just good health. As we have seen, SDM may serve to strengthen such aspects of patients either not adhering to a treatment, or (as in the case of Lily before non-adherence) adapting the treatment to secure adherence but with a worse health output. However, this does not seem to undermine the applicability of either the control or the reduced assistance claim or present a forward-looking reason against IR. To the extent that the control claim applies, this argument underlines the fact that a patient may find good reasons to voluntarily care less about his or her health than other things, and this is a reason to give the health care needs of this person lower priority. For the professional to insist on another priority would amount to disqualifying this person's view of how to value different aspects of his or her own life. Adding SDM to this picture would seem to strengthen the case for the applicability of the control claim, and therefore also the just made point.

The second argument is that the use of IR may make people more reluctant to tend to their health, since open resentment such as blame may result in a feeling of hope- and pointlessness: "If you think I'm such a failure, why should I care or think I can improve?". A recent group of studies of adolescent diabetes (type 1) care provides reason to acknowledge this risk, and that SDM may make it *worse* if performed according to a standard conception that puts the achievement of rational and autonomous decisions at the focus of attention [20-22]. The reason for this outcome is that if the patient is assumed to possess robust decision-making and responsibility-taking capacities not necessarily in place, the focus on how the patient fails to take care of him- or herself stimulates a self-image that undermines the applicability of the control claim, and thus also IR. If so, the SDM process has undermined the patient's already vulnerable capacities to adhere to treatments they may very well prefer. Herlitz and colleagues [20] have sketched a markedly different "counselling, self-care, adherence approach" to SDM, focusing on long-term empowerment to develop every day capabilities of taking responsibility for care-related behavior. Such strategies focus on gradually helping the patient to develop more robust capacities to manage self-care according to plan, and during this development the control claim may not apply and therefore neither IR. However, at the end of the day, when the patient's self-image and capacities are more robust, this person might after all prefer to prioritize other things in life than health (cf. Lily). Then the reason against IR does not apply, as it is not IR that has made the patient care less about his or her health, but rather a systematic *avoidance* of applying IR while empowering, supporting and capacitating the patient.

The last argument under this heading is the proposition that IR may mean that people with serious health needs may be left to die or suffer in spite of the presence of effective treatments. This is true, but it should be observed that it is also true of any priority-setting decision in a situation of scarcity, even if made on strictly needs-based grounds. This since untreated mild conditions might suddenly develop into serious and even fatal conditions, where it is too late to intervene. In other words, the effect held out here seems primarily to depend on scarce resources. IR may stand out as adding insult to injury in this respect if it is applied to more dire needs, e.g. if Lily is not only denied more counselling and support etc. but also dialysis or a kidney transplant. Hence, from this perspective it will be important to consider the severity of the health care needs to which IR is applied.

A similar reasoning applies to the use of IR based on the luck egalitarian reasoning indicated in section 3: If scarcity is decreased, the reasons for setting the priority of attending to the health care needs of a non-adherent patient lower than an adherent patient are weakened. Our conclusion is, therefore, that this argument concerns not IR as such, but what level of resource scarcity should be accepted in the health care sector. Whether or not SDM is used does not seem to affect this analysis at all.

However, imagine a health system where the application of SDM is systematic: half of patients end up in outcomes like Lily, the other half end up like Adam. As a result, there is more scarcity of health care resources due to the behavior in the first group and, because of this, some in the second group will run higher risks of not receiving optimal treatment when struck by the most serious complications, even if they have not been part in causing this situation. In this situation, IR may therefore apply to the extent that the control claim applies (and we assume the reduced assistance claim to hold) and support the contention that less attention should be given to the non-adherent group (at least when it comes to less serious needs), and the freed resources rather be spent to meet the more dire health care needs that these and the other group of patients may all end up in. In effect, applying IR may in this respect produce a more efficient output of a health system on the whole.

(d) Structural arguments against the social efficiency of IR

One claim under this heading is that it is too costly to ascertain the required control of patients, as well as to monitor to what extent it is in place in single cases. This suggestion partly takes us back to the second version of the argument against the control claim. The validity of this claim seems largely dependent on how much of certainty and precision is required for the assessment and monitoring, and compromises regarding this may lead to less of a basis for applying IR unless margins of error are accepted. At the same time, we have also noted that the use of high level dynamics SDM seems to involve both a constant empowerment and capacity promotion of patients, and a more extensive monitoring of the output of this through interaction and dialogue. This will result in increased costs. Such increased costs may be seen to boost the reason to apply IR, as that would help to balance the costs and the use of resources where they have better effect. However, it may also be the case SDM on the whole has effects that balance the costs.[4] The situation may, of course, also be the opposite, but this is basically an empirical question, depending on many factors besides the mentioned cost.[5]

Another claim under this heading is that implementation of IR as an institutional policy is very likely to express social biases and prejudices regarding which risky behaviors are normal or acceptable and which are not, thereby producing skewed and unfairly discriminatory distributive patterns. Health risks resulting from broadly undertaken activities, or activities viewed as part of a "normal" social life, will be less influencing of the priority-setting than others, albeit the

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[4] This will depend on how the effects of SDM are evaluated not only in cases where the outcome is suboptimal from a health standpoint, but across the entire health system.

[5] One such factor is to what extent SDM will lead to a "fragmentation" of treatment strategies due to an increased plurality resulting from individual adaptions. As has been held out 8. Sandman L, Granger BB, Ekman I, et al. Adherence, shared decision-making and patient autonomy. Medicine Health Care and Philosophy 2012;**15**(2):115-27, 23. Gustavsson E, Sandman L. Health-care needs and shared decision-making in priority setting. Ibid.2014., such a plurality may undermine the very basis for assessing the cost-effectiveness of treatments, based on controlled studies of larger series of standardized treatment protocols.

resulting health needs may be the same. We acknowledge this risk as quite real and it remains even if we assume the patient to achieve a better control and capacity through the addition of high level dynamics SDM. However, compared to an implementation of IR with a traditional approach to clinical decision-making, it may seem that such SDM may weaken the force of this claim. This since SDM facilitates openly addressing and questioning implicit attitudes about which health risks are normal or more socially acceptable and which are not [24].

(5) Juxtaposing IR and SDM: Deeper Tensions

Provided that IR is used, combining it with high level dynamics SDM fitted to a patient's capacities may significantly decrease the applicability of a wide collection of objections, mainly practical or pragmatic ones at the clinical as well as overarching policy levels. The more exact variant of SDM may make some difference to what extent the increased responsibility for the outcome of care ascribed to patients amounts to a *transfer* of responsibility from professionals to patients (as noted in the case of Lily when moving from adhering to the compromise to becoming non-adherent). High level dynamics SDM that misalign communicative approaches to patients' capacities may instead undermine patients' ability to control care decisions and health outcomes (thus strengthening the case against the applicability of IR). SDM variants other than the high level dynamics ones do not seem to make any difference to whether or not IR is applicable.

None of this, however, means that (well fitted) high level dynamics SDM provides a direct argument *for* using IR. On the contrary, we will now argue that, despite the fact that SDM may increase the applicability of IR, ethical ideas underlying SDM are in conflict with IR.

We noted that SDM and IR may seem to share a similar ideal that people should be enabled, capacitated and empowered to decide and take responsibility for their own life and the choices in it. On closer inspection, however, the ethical undercurrents of these respective ideas are less in agreement than what may appear through the mist of political rhetoric. First, IR does not rest on the contention often advanced politically, that a better society is a society populated by citizens to which the control claim applies. IR (as interpreted here) is silent on the issue of what makes for a better life or a better person or a better citizen or society, it only makes an ethical claim about what follows if the control claim happens to apply. Neither does IR imply a necessary focus on reducing public spending; IR says nothing about this, but only states one principle for distributing resources whatever level of spending there is. High level dynamics SDM, in contrast, does seem to embrace as a central idea the notion of the capacitated and empowered patient as a positive ideal to strive for, but this ideal does not harbor the notion of specific ways for patients to take responsibility based on that. This includes the notion of spending the resources necessary to achieve the desired emancipating result, no matter what this implies for health (although there often seems to be a hope that emancipated patients will also choose the healthier courses of action).

At the same time, different SDM variants express slightly different variations on this basic theme, suggesting different attitudes to the exact scope of the emancipation, from the patient deciding on her own to a compromise within professional standards.

If IR is introduced, this picture is changed by the added conversational theme of the patient receiving less of attention from health care if choosing courses where options accepted by professionals are ignored. This is no necessity from the point of view of SDM and its capacitation and emancipation ideal for patients. The only way to find a reason for IR from this standpoint, is to combine SDM with a concern for the overall dynamics of health care spending, and the effects on all (potential) patients in a health care system in view of the scarcity of resources.

Hence, the exact version of SDM will influence to what extent SDM and IR could be combined without limiting SDM. When the patient is in full control over the decision and basically defines her health care need, the health professional becomes a deliverer of services to a customer on the behest of the latter[6]. If so, use of IR undercuts the very idea of SDM, both as it introduces an ingredient of open threat seemingly at odds with the capacitating and empowering aim[7] , and as its output seems contrary to SDM regarding the issue of what to spend resources on (as IR speaks in favour of withdrawing resources from some activities which SDM strives to promote). When, on the other hand, SDM implies a compromise between patient and professional, one of the reasons for wanting to limit the patient's influence is distributive effects due to scarce resources. Introducing IR could here serve to constrain how far a professional strategic compromise to adapt to a patient's special situation and preferences can go before a resulting greater need implies a de-prioritization of the patient. Such limits for risk-taking will facilitate patient deliberation about his own risk-taking, sometimes possibly providing an incentive for the patient to stay within the accepted risk-taking levels.

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[6] This risk of moving from a needs-based to a demands-based health care with SDM is analysed in 23. Gustavsson E, Sandman L. Health-care needs and shared decision-making in priority setting. Ibid.2014.

[7] Although sometimes a forceful behavioural "incentive", fear mostly incapacitate and disempower people.

(7) Conclusions

In this paper we have explored the thesis that the practice of SDM may diminish the force of commonly cited arguments against IR. The crucial findings of this analysis are the following.

It is not the case that SDM (and arguments in favor of SDM) constitute an independent argument *in favor* of employing IR but rather these notions rest on quite different underlying values. However, these theoretical tensions do not seem to constitute a problem for combining SDM and IR in practice. If a health system employs SDM, IR may be used to limit how far resources are spent on accommodating patient preferences outside of professional standards and undermining health. If a health care system employs IR, what we have called high level dynamics SDM may disarm common objections to the applicability of IR to health care priority setting, but only on certain conditions. High level dynamics SDM may pave the way for IR in virtue of empowering patients and making them more likely to exercise adequate control of their own actions. But if communication strategies applied in the SDM are misaligned to the patient's initial capacities, the result may be the very opposite. Other types of SDM would not seem to affect the applicability of IR at all.

Acknowledgements

Competing interests:

None.

Funding statement:

References

1. Sharkey K, Gillam L. Should patients with self-inflicted illness receive lower priority in access to healthcare resources? Mapping out the debate. Journal of Medical Ethics 2010;**36**(11):661-65.
2. Arneson RJ. Luck Egalitarianism: An Interpretation and Defense. Philosophical Topics 2006;**32**:1-20.
3. Segall S. *Health. Luck and Justice*. Princeton: Princeton University Press, 2010.
4. Munthe C, Sandman L, Cutas D. Person Centred Care and Shared Decision Making: Implications for Ethics, Public Health and Research. Health Care Analysis 2012;**20**(3):231-49.
5. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Social Science & Medicine 2000;**51**(7):1087-110.
6. Emanuel EJ, Emanuel LL. 4 MODELS OF THE PHYSICIAN-PATIENT RELATIONSHIP. Jama-Journal of the American Medical Association 1992;**267**(16):2221-26.
7. Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: What does it mean? (Or it takes at least two to tango). Social Science & Medicine 1997;**44**(5):681-92.
8. Sandman L, Granger BB, Ekman I, et al. Adherence, shared decision-making and patient autonomy. Medicine Health Care and Philosophy 2012;**15**(2):115-27.
9. Persson K. The right perspective on responsibility for ill health. Medicine Health Care and Philosophy 2013;**16**(3):429-41.

10. Sandman L, Munthe C. Shared Decision Making, Paternalism and Patient Choice. Health Care Analysis 2010;**18**(1):60-84.

11. Sandman L, Munthe C. Shared decision-making and patient autonomy. Theoretical Medicine and Bioethics 2009;**30**(4):289-310.

12. Persson De Fine Licht K. *Responsibility and health: explanation-based perspectives*. Gothenburg: Department of Philosophy, Linguistics, and Theory of Science, University of Gothenburg, 2014.

13. Walker T. Who Do We Treat First When Resources Are Scarce? Journal of Applied Philosophy 2010;**27**(2):200-11.

14. Smart B. FAULT AND THE ALLOCATION OF SPARE ORGANS. Journal of Medical Ethics 1994;**20**(1):26-30.

15. Wilkinson S. Smokers' rights to health care: why the 'restoration argument' is a moralising wolf in a liberal sheep's clothing. Journal of applied philosophy 1999;**16**(3):255-69.

16. Dworkin R. *Sovereign Virtue*. Cambridge MA: Harvard University Press, 2000.

17. Knight C, Stemplowska Z. *Responsibility and Distributive Justice*. Oxford: Oxford University Press, 2011.

18. Lippert-Rasmussen K. Justice and Bad Luck. In: Zalta E, ed. Stanford Encyklopedia of Philosophy, 2014.

19. Eshleman A. Moral Responsibility. In: Zalta E, ed. The Stanford Encyclopedia of Philosophy, 2014.

20. Herlitz A, Munthe C, Törner M, et al. The Counselling, Self-care, Adherence Approach to Person-centred Care and Shared Decision-making: moral psychology, executive autonomy and ethics in multi-dimensional care decisions. Health Communication 2016; **31**(8): 964-973

.

21. Boman A, Bohlin M, Eklof M, et al. Conceptions of Diabetes and Diabetes Care in Young People With Minority Backgrounds. Qualitative Health Research 2015;**25**(1):5-15.

22. Wigert H, Wikstrom E. Organizing person-centred care in paediatric diabetes: multidisciplinary teams, long-term relationships and adequate documentation. BMC research notes 2014;**7**:72.

23. Gustavsson E, Sandman L. Health-care needs and shared decision-making in priority setting. Medicine Health Care and Philosophy 2014.

24. Bjork J, Lynoe N, Juth N. 'Are smokers less deserving of expensive treatment? A randomised controlled trial that goes beyond official values'. Bmc Medical Ethics 2015;**16**.