Shared decisionmaking has been proposed as a method to promote active engagement of patients in emergency care decisions. Despite the recent attention shared decisionmaking has received in the emergency medicine community, including being the topic of the 2016 Academic Emergency Medicine Consensus Conference, misconceptions remain in regard to the precise meaning of the term, the process, and the conditions under which it is most likely to be valuable. With the help of a patient representative and an interaction designer, we developed a simple framework to illustrate how shared decisionmaking should be approached in clinical practice. We believe it should be the preferred or default approach to decisionmaking, except in clinical situations in which 3 factors interfere. These 3 factors are lack of clinical uncertainty or equipoise, patient decisionmaking ability, and time, all of which can render shared decisionmaking infeasible. Clinical equipoise refers to scenarios in which there are 2 or more medically reasonable management options. Patient decisionmaking ability refers to a patient’s capacity and willingness to participate in his or her emergency care decisions. Time refers to the acuity of the clinical situation (which may require immediate action) and the time that the clinician has to devote to the shared decisionmaking conversation. In scenarios in which there is only one medically reasonable management option, informed consent is indicated, with compassionate persuasion used as appropriate. If time or patient capacity is lacking, physician-directed decisionmaking will occur. With this framework as the foundation, we discuss the process of shared decisionmaking and how it can be used in practice. Finally, we highlight 5 common misconceptions in regard to shared decisionmaking in the ED. With an improved understanding of shared decisionmaking, this approach should be used to facilitate the provision of high-quality, patient-centered emergency care. [Ann Emerg Med. 2017;70:688-695.]

**CLINICAL VIGNETTE**

A 59-year-old man with a history of hypertension and hyperlipidemia presents to the emergency department (ED) after experiencing an unwitnessed syncopal episode at his home while walking to the bathroom. His prodromal symptoms include brief dizziness, described as light-headedness, but no chest pain, palpitations, or dyspnea. He presents to the ED because he is worried that he has had a heart attack or a stroke. On examination, there are no signs of head trauma and no neurologic deficits. Furthermore, there is no evidence of an aortic murmur, heart failure, or other abnormal cardiac findings. Serial vital signs are within normal limits. His laboratory testing results, including a urinalysis, CBC count, chemistry panel, and serial cardiac enzymes, are unremarkable. His chest radiograph result is normal. His ECG shows a normal sinus rhythm with nonspecific T-wave changes in the precordial leads. He is now asymptomatic and feeling well. The physician and the patient discuss possible causes of this fainting episode. The patient is relieved to hear that the evaluation has uncovered no evidence of a heart attack or stroke. However, was this patient’s syncope caused by a dangerous arrhythmia?

Should he be admitted for observation and further testing? This decision should be guided not only by the medical evidence and the clinician’s experience but also by the patient’s values and preferences.

**INTRODUCTION**

Emergency care is becoming increasingly complex.1 As the number of tests, treatments, and clinical pathways continues to increase, patients and clinicians are faced with an increasing number of decision points. This trend, coupled with an increased commitment to patient-centered care,2 has expanded the potential for patient engagement to influence the course of emergency care. Shared decisionmaking has been proposed as a method to actively engage patients in their health care decisions. Shared decisionmaking is defined as “a collaborative process in which patients and providers make health care decisions together, taking into account the best evidence available, as well as the patient’s values and preferences.”3 Although the general principles of shared decisionmaking have almost certainly been used, at least in part, by emergency
physicians ad hoc for decades, the systematic use and evaluation of shared decisionmaking in the ED remains in its infancy. Despite the increased recent attention shared decisionmaking has received in the emergency medicine community, including being the topic of the 2016 Academic Emergency Medicine Consensus Conference, misconceptions remain in regard to the precise meaning of the term, the process, and when it should be used.

In this article, we present a simple framework to demonstrate how shared decisionmaking fits into broader decisionmaking in the ED. We believe that shared decisionmaking should be the default strategy for all significant emergency care decisions and should be replaced by other approaches only when 1 or more of the 3 essential factors are absent. This new framework could lead to a greater understanding of which clinical scenarios are amenable to shared decisionmaking, minimize the misconceptions surrounding this approach, and help emergency physicians use shared decisionmaking in their clinical practice.

PART 1: IS THIS CLINICAL SCENARIO APPROPRIATE FOR SHARED DECISIONMAKING?

Three Factors Necessary for Shared Decisionmaking

At least 3 factors, all of which exist on a spectrum, play a role in determining whether a decision in the ED is appropriate for shared decisionmaking. The factors are clinical uncertainty or equipoise, patient (or surrogate) ability to engage in decisionmaking, and time. Shared decisionmaking in the ED is appropriate when all 3 factors are present (Figure). Because these factors are somewhat subjective, in practice there will likely be variation between clinicians in regard to when they are deemed to be present. We explore each factor individually. Assessment of these factors can occur in any order, not necessarily in the one presented in the Figure, and often occur in a dynamic, nonlinear fashion. Shared decisionmaking need not be solely performed with the patient but can be performed with a surrogate as well: a parent in the case of a young child or a health care proxy in the case of a cognitively impaired or incapacitated patient. Henceforth, when we refer to “patients” we do so with the understanding that we are also including surrogates.

Factor 1: Clinical Uncertainty or Equipoise

For many conditions in the ED, there is certainty in regard to the single best evidence-based course of action (eg, antibiotics for sepsis); for many others, however, there is more than one reasonable option. Equipoise in the clinical context has been defined as a situation in which available options are roughly in balance in regard to the potential for harm and benefit. Equipoise exists when there are 2 or more medically reasonable management options, either of which could be favored according to the patient’s values and preferences. We include uncertainty with equipoise to highlight the many situations in which we are uncertain about the best course of action for a particular patient, even when risks and benefits are not

![Figure. Shared decisionmaking model.](image)
perfectly balanced. In these situations, shared decisionmaking should be the default approach to decisionmaking. However, if there is clearly only one medically reasonable option, then shared decisionmaking is no longer appropriate.

Consider, for example, the decision to admit or discharge a patient with possible acute coronary syndrome and an unremarkable ED cardiac diagnostic evaluation result. Both disposition decisions could be deemed medically reasonable and yet could have vastly different repercussions for the patient. If the patient is admitted, he or she will incur costs and experience the inconvenience of hospitalization and the possibility of iatrogenic injury or false-positive findings. On the other hand, if the patient is discharged, he or she risks recurrence of pain and the low likelihood of a missed acute coronary syndrome. The patient may prefer to avoid the disruption associated with hospitalization and undergo provocative cardiac testing as an outpatient, even if this is associated with a small medical risk. Conversely, the patient may feel unsafe going home and prefer to expedite the evaluation by being admitted.

Other examples include immediate antibiotics or a wait-and-see approach for acute otitis media, choice of anticoagulation for atrial fibrillation, initial imaging for acute flank pain, and thrombolysis for acute ischemic stroke.

Such conditions have been described as “preference sensitive,” defined as conditions in which treatment options exist that come with trade-offs between potential harms and benefits for the patient. In the context of emergency care, there are many decisions in which equipoise could be considered to exist, including those that involve testing, therapy, or disposition. Clinical decisions in the ED lie on a spectrum from complete perceived certainty to equipoise or uncertainty. Clinical equipoise is a dynamic element that can change over time as new evidence emerges or the patient’s condition changes.

**Compassionate persuasion.** For scenarios with uncertainty or equipoise, shared decisionmaking is the preferred strategy for decisionmaking, assuming time and patient ability permit. For clinical decisions in which medical benefit clearly outweighs the risks and the treatment is in line with the patient’s goals of care, shared decisionmaking is not appropriate; rather, the paradigm of informed consent (or informed refusal) will guide decisionmaking. If the patient is hesitant to receive care that is clearly in the best interest of his or her health and in line with his or her values, the clinician should attempt compassionate persuasion, which is a benevolent attempt to persuade a patient to receive care that he or she does not initially want, if it is, in fact, consistent with his or her values. This persuasion may appeal to a patient’s rational or emotional faculties and is justified if guided by the ethical principle of beneficence. It should start with an exploration of why the patient is declining care. Although guided by the principle of beneficence, compassionate persuasion must always be balanced with respect for patient autonomy. For example, if a patient with an acute myocardial infarction resists admission to the hospital, the clinician should first try to understand the basis of the resistance and, if appropriate, try to persuade him or her to stay and receive care. If the patient is refusing care because he or she needs to be at work the next day, it is reasonable to remind him or her that a telephone call or letter from the physician to the employer can be made and is often enough to appease the employer. If, on the other hand, the patient’s religious beliefs preclude him or her from receiving a treatment, such as a blood transfusion, the clinician should seek to understand these preferences and respect them by not attempting to impose his or her own belief system on the patient.

**Factor 2: Patients’ Decisionmaking Ability**

For a clinician to successfully engage a patient in shared decisionmaking, the latter must be willing and able to participate in medical decisions. First, the patient must have the capacity to make informed decisions. Patients can lose decisionmaking capacity for a variety of reasons, including cognitive impairment, delirium caused by acute medical illness, severe mental illness, and intoxication. Without basic capacity, shared decisionmaking is clearly inappropriate and other decisionmaking strategies must be used, unless a proxy is present. Although capacity is often thought of as a binary variable—either a patient has the mental status to make decisions or does not—in reality, this factor lies on a continuum and may be dynamic over time. Second, a patient must have the cognitive skills and self-efficacy to make potentially complex decisions about his or her medical care. Patients who are in the ED with acute complaints may have reduced self-efficacy in regard to decisionmaking because of pain, stress, or anxiety, potentially making them less receptive to shared decisionmaking. Cultural factors may also play a role in determining the patients’ willingness to engage in shared decisionmaking. In the case of a patient who is unable or unwilling to participate in decisionmaking, and there is no access to surrogates, shared decisionmaking is not appropriate and care should proceed based on physician-directed decisionmaking. Low health literacy and numeracy should not preclude attempts at shared decisionmaking. It is both the responsibility and the challenge of the clinician to explain options clearly and to
make decisions accessible to patients, even to those with lower education. Additionally, the patient's willingness and ability to participate should be actively assessed, often simply by beginning the shared decisionmaking conversation. The clinician can and should cultivate self-efficacy and promote patient autonomy by empowering patients with information, options, and positive language. Clinicians should not make assumptions about patients' preferences or their ability to be involved because they are often wrong about a patient's desired level of involvement.\textsuperscript{16}

**Factor 3: Time**

Emergency medicine often involves the evaluation and treatment of acute, time-sensitive medical conditions. Emergency physicians must also be cognizant of the overall flow of the ED, the safety of the entire population of patients for whom they are responsible, and the opportunity cost of spending additional time with an individual patient. For these reasons, shared decisionmaking should be used only when time allows. If a delay in decisionmaking could put the patient, or other contemporaneous patients, at risk of a bad outcome, then shared decisionmaking may not be appropriate or should be deferred until time allows. If too little time exists and a decision must be made quickly, then shared decisionmaking is not appropriate and, again, physician-directed decisionmaking should proceed. ED interventions, both diagnostic and therapeutic, vary widely in their time sensitivity. This time-sensitivity lies on a spectrum from emergency, requiring action within seconds to minutes, to nonurgent, requiring action within several hours. Most clinical decisions in the ED are not subject to such acute time sensitivity and can be discussed with the patient before clinical action. With proper training and practice, shared decisionmaking can be accomplished efficiently by the skilled clinician in the majority of cases, thus enabling delivery of personalized, high-quality care for the entire population of patients for whom the physician is responsible.

Although a highly time-sensitive condition may make shared decisionmaking more difficult, these encounters could still warrant it.\textsuperscript{17} Consider, for example, the case of a patient with terminal cancer who presents to the ED with severe respiratory distress. Although the decision to intubate should be made quickly, discussion with surrogates in regard to goals of care and code status should be attempted in an effort to align interventions with the patient's values and wishes. Lifesaving interventions should not be withheld for the sake of shared decisionmaking, but if the intervention being considered might not align with the patient's overall goals of care, surrogates should be engaged as quickly as possible.

**PART 2: HAVING THE SHARED DECISIONMAKING CONVERSATION**

The clinician should be the one to initiate the shared decisionmaking conversation, assuming the 3 factors set forth in the Figure are met: there is more than one reasonable option, the patient is willing and able to participate, and there is sufficient time. There are 4 general steps to engaging in shared decisionmaking.

**Step 1: Acknowledge That a Clinical Decision Needs to Be Made**

First, the clinician should make it clear what he or she is going to discuss and why. This can be prefaced by stating what is currently known about the clinical situation. Then a clear statement should be made indicating that a decision with various options needs to be discussed. Potential phrases include “We have a decision to make…” or “We have a couple of options going forward…”

Take, for example, a patient with possible acute appendicitis. The following script could be used:

> "Anytime a patient comes to the ED with pain in their right lower abdomen, we consider the possibility of appendicitis. Your temperature and urine and blood test results were all normal. However, ultrasonography was not able to show your appendix. Going forward, we have a decision to make, so let’s talk about the options and consider the decision together."

**Step 2: Share Information in Regard to Management Options and the Potential Harms, Benefits, and Outcomes of Each**

This step will vary according to how much is known about an individual patient’s risk and can be challenging in low-evidence scenarios. This discussion could include both logistic details and estimates of risk. Information should be provided in a stepwise fashion at a pace the patient can understand, in an effort to avoid cognitive overload. The information should also be expressed in lay language, free of medical jargon.

> "In accordance with what we know, there is still a small chance you have appendicitis. One option would be to do a computed tomography (CT) scan of your abdomen now. This is like a very powerful radiograph and involves some radiation exposure. It would involve staying another few hours in the ED and waiting for the radiologist to provide a report. If you prefer, you could..."
also go home and come back in 6 to 8 hours if the pain returns, you develop a fever, or you feel worse in any way. I think both options are reasonable.”

More risk and logistic information can be provided according to the patient’s specific follow-up questions. Decision aids, if available, can facilitate the communication of options and accompanying probabilities.

Step 3: Explore Patient Values, Preferences, and Circumstances

This is best accomplished by asking questions to facilitate a conversation about what the patient is thinking, what matters to him or her, and what social factors may be at play. Examples include the following:

“How are you feeling now? What are you thinking about when you hear these 2 options? What practical concerns do you have? What are you worried about? Do you live alone? Can you come back easily to the ED? What is most important to you?”

Step 4: Decide Together on the Best Option for the Patient, Given His or Her Values, Preferences, and Circumstances

Shared decisionmaking should be viewed as a conversation. Ultimately, the conversation should result in a mutual decision. This can be based on suggestions from the clinician, but ideally the patient would be provided sufficient time and conversational space to engage in the decisionmaking process. The clinician should try to resist dictating the course of action, even in the event of the commonly asked question “Well, what would you do, doctor?” because the clinician’s personal preferences and values may or may not match the patient’s. The patient may be asking this question to access the physician’s intuition and overall clinical gestalt. Many patients have a tendency to trust physicians in regard to their knowledge and judgment. It is the clinician’s responsibility to understand the patient’s preferences and values and help him or her make a decision most consistent with these. The clinician should be careful not to unduly sway the patient. If pressed to make the decision, clinicians may offer suggestions about how the patient’s values could line up with the various options.

“I can share my opinion about which choice I would make for myself if I were facing the same circumstances. You may completely agree with my choice or you may question whether it is suitable for you. If you are nervous about going home or you feel like you are getting worse, it might make sense to have the CT now. If you are feeling better and you feel like you can come back if you feel worse, you may prefer to leave and get some rest in the comfort of your own home.”

Clinicians should be aware that many patients will not be accustomed to making collaborative decisions with their physicians, particularly one who is new to them, and may not volunteer their values and preferences without considerable prompting. Transmission of knowledge alone may not be sufficient; clinicians should be aware that no matter how well they convey the necessary information to a patient, he or she may not feel empowered to voice preferences, concerns, or questions. The clinician should strive to create an environment in which the patient feels at ease expressing preferences and asking questions.

Decision Aids

Patient decision aids, also known as decision support interventions, are evidence-based tools designed to increase patient understanding of medical options and possible outcomes, facilitate conversations between patients and clinicians, and improve patient engagement. ED decision aids have the potential to standardize the shared decisionmaking process and activate patients by offering them information and encouraging them to explore and express their preferences. Ideally, these decision aids would provide individualized probability estimates and would not be “one size fits all.” However, unstructured shared decisionmaking can be performed without a decision aid; lack of one should not preclude attempts at shared decisionmaking. There is currently limited research on ED-based decision aids but there will surely be further work in this area in the coming years. A full discussion on the effectiveness and use of decision aids is beyond the scope of this article.

PART 3: MISCONCEPTIONS ABOUT SHARED DECISIONMAKING

Misconception 1: Shared Decisionmaking Is the Same as Informed Consent or Refusal

Shared decisionmaking is sometimes conflated with the related but separate concept of informed consent or informed refusal. The key difference is that with informed consent or refusal, there is one clear medically superior option, whereas with shared decisionmaking there are 2 or more medically reasonable options, ie, there is clinical equipoise. Informed consent is a largely legal construct, whereas shared decisionmaking is a largely ethical construct. Informed consent relies heavily on the medical risks and benefits, whereas shared decisionmaking relies heavily on patients’ values and preferences.
Consider the example of an adult patient presenting to the ED with acute chest pain who is found to have evidence of a non-ST-segment elevation myocardial infarction. In accordance with high levels of evidence, this patient should receive inpatient medical therapy.23 The clinician should still seek to communicate with the patient in regard to the potential harms and benefits of the interventions, as well as educate the patient in regard to the diagnosis, prognosis, and therapy. Once this is accomplished, a professional recommendation should be made and informed consent should be sought. If a patient is reluctant to undergo such treatment, the clinician should explore the reasons for this resistance and use compassionate persuasion as described above, if the patient’s values are aligned with receiving medical care to decrease morbidity and mortality. Persuasion in this case is not coercion and is ethically justifiable.24 Because refusing care would not be considered medically reasonable, this is not an exercise in shared decisionmaking. However, patients may rationally choose to forgo medical care for valid, personal reasons. In this situation, respect for patient autonomy would take precedence.

Misconception 2: Shared Decisionmaking Is Simply Good Patient-Clinician Communication

Shared decisionmaking has also been misappropriated to signify good patient-clinician communication or patient education. Although effective patient-clinician communication and education are necessary conditions for a successful shared decisionmaking interaction, they are insufficient in and of themselves to constitute shared decisionmaking and represent distinct concepts. Shared decisionmaking, as stated above, requires some level of equipoise between 2 (or more) medically reasonable options. Discussing the rationale behind clinical actions, be they testing, treatment, or disposition, should be a part of every ED encounter, regardless of equipoise. These discussions can happen regardless of the degree to which the patient is engaged in the decisionmaking process. Effective communication is essential to all patient care but alone does not constitute shared decisionmaking.

Misconception 3: The Goal of Shared Decisionmaking Is to Decrease Resource Use

Although shared decisionmaking has been promoted as a mechanism to improve resource use,25 the imperative for it is not a reduction in resource use. Rather, it rests on principles of patient-centered care, including respect for patient autonomy, ie, that a patient’s informed preferences should be the basis for medical action.26 Shared decisionmaking may, as a secondary effect of incorporating evidence-based information in the decisionmaking conversation, reduce unnecessary care, but this should not be the primary goal of engaging patients in shared decisionmaking.27

Misconception 4: Shared Decisionmaking Is a Means of Shifting Responsibility for Decisions to the Patient, Leaving the Patient to Make the Medical Decision Alone, Once Informed

Shared decisionmaking is not a means for the clinician to abdicate responsibility for the medical decision. It does not constitute patient abandonment. Rather, shared decisionmaking implies that the final decision is made by the clinician and the patient together. Shared decisionmaking should not replace the clinician’s expertise in educating, counseling, and guiding the patient through the decisionmaking process,28 nor should it be used expressly to decrease the clinician’s medicolegal risk. However, because shared decisionmaking is a model of good communication, it is reasonable to believe that genuinely engaging in it may decrease a clinician’s malpractice risk.29 Shared decisionmaking is not abandoning patients to make decisions alone, but rather inviting them to collaborate in the decisionmaking conversation to the extent they feel comfortable.30,31

Misconception 5: Shared Decisionmaking Is Offering Patients Any Intervention They Would Like

As stated above, shared decisionmaking is appropriate only when 2 or more medically reasonable options exist. It is not a call for “fast-food medicine,” whereby patients are encouraged to “order from a menu.” For example, if a patient presents with mild, nontraumatic low back pain of short duration, without any neurologic signs or symptoms, advanced imaging should not be offered in the name of shared decisionmaking because it is not medically indicated.

CONCLUSION

As emergency physicians have adapted to the increasing complexities of emergency care, shared decisionmaking has emerged as the preferred approach to providing high-quality, patient-centered care in the ED. In this article, we discuss 3 factors necessary for shared decisionmaking to be performed—clinical equipoise or uncertainty, patient decisionmaking ability, and time—which exist on a spectrum and are often assessed in a dynamic, nonlinear fashion. If a clinical scenario lacks equipoise, a professional recommendation should be made by the clinician, using compassionate persuasion as needed, until informed consent or refusal is obtained. If the patient is not willing and able to participate in the decision, or too little time exists, then physician-directed decisionmaking should
proceed. Our guiding framework demonstrates the potential broad reach that shared decisionmaking can have in emergency medicine and also recognizes those clinical scenarios in which other approaches are necessary. Barring these 3 factors, we believe shared decisionmaking should be the default approach to decisionmaking. We outlined the 4 steps emergency physicians should take when engaging patients in shared decisionmaking and clarify common misconceptions in regard to shared decisionmaking in the ED. We hope that emergency physicians can use this framework to successfully implement shared decisionmaking into their practice.

CLINICAL VIGNETTE CONTINUED

The clinician approaches the patient and explains to him what is currently known: the patient has experienced syncope, suddenly passing out or fainting with a rapid recovery. He has no high-risk features such as dyspnea, hypotension, anemia, heart failure, or coronary artery disease.32,33 His blood test and radiograph results are all reassuring. The clinician explains that a decision must now be made: whether to admit him for further testing and monitoring or discharge him with expedited follow-up. The clinician then describes what these 2 options entail, describing the potential harms and benefits of each and stating that both are medically reasonable. The patient asks questions in regard to the nature of inpatient testing and length of the admission. After some dialogue, it becomes clear that the patient lives nearby with his wife, who is a nurse, and has a strong preference for going home. He also has ready access to a cardiologist whom he can consult within 2 or 3 days. The patient is discharged with return precautions and a specific follow-up plan.

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Author affiliations: From the Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York, NY (Probst); the Department of Emergency Medicine, University of California at San Francisco, San Francisco General Hospital, San Francisco, CA (Kanzaria); the Department of Emergency Medicine, Baystate Medical Center/Tufts School of Medicine, Springfield, MA (Schoenfeld); the Department of Emergency Medicine, University of Southern California/Keck School of Medicine, Los Angeles, CA (Menchene); the School of Visual Arts, New York, NY (Breslin); the Department of Emergency Medicine, Yale School of Medicine, New Haven, CT (Melnick); and the Department of Emergency Medicine, Mayo Clinic, Rochester, MN (Hess).

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