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PERSON CENTREDNESS AND SHARED DECISION-MAKING

IN FORENSIC CARE, SOCIAL SERVICES AND PUBLIC HEALTH

CHRISTIAN MUNTHE[a,c,d], LARS SANDMAN[e,f], PIA NYKÄNEN[a,b], LEILA EL-ALTI[a,c]. CONTACT: CHRISTIAN.MUNTHE@GU.SE

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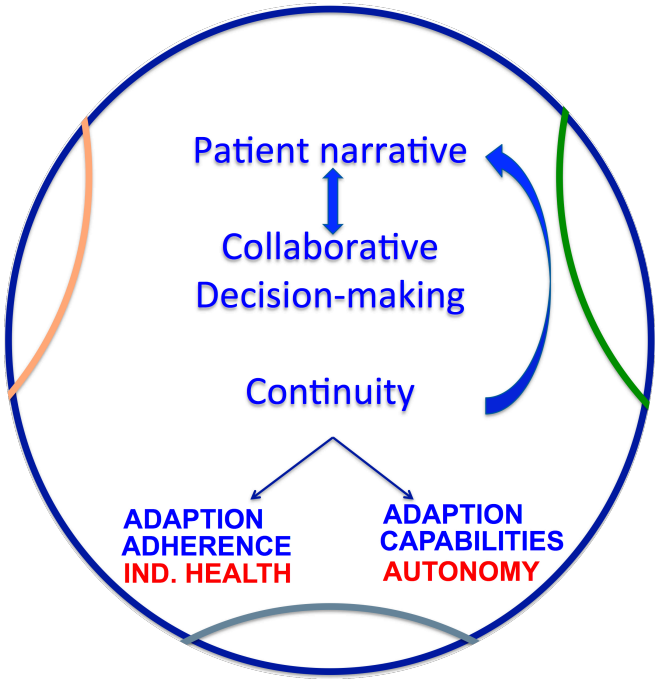
Person centred care and shared decision-making (PCC/SDM): The basic assumptions

- Increasingly embraced framework for how to organise health care professionals' interaction with patients
- Core ingredients
  - **Personal narrative** about general life-situation
  - **Collaborative decision-making** facilitating adaption to individual circumstances & views
  - **Mechanisms ensuring continuity** of the above, e.g. documentation, extended care relationship, etc.
- **Aims/values**: promote autonomy and individual health (wellbeing) through flexible adaption, better adherence, and empowered patient capabilities



Munthe et.al. (2012). Person centred care and shared decision-making: Implications for ethics, public health and research. *Health Care Analysis*, 20 (3): 231-249

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The Migration of PCC/SDM

- Patients in non-standard conditions implying particular vulnerability (e.g., dementia care and pediatrics): both peculiar problems to achieve core values and obvious risks to both autonomy and health

Entwistle & Watt (2013). Treating Patients as Persons: A Capabilities Approach to Support Delivery of Person-Centered Care. *AJOB*, 13(8): 29–39
Herlitz, et. al. (2016). The Counselling, Self-care, Adherence Approach to Person-centred Care and Shared Decision-making. *Health Communication*, 31 (8): 964-973

- More drastic (and recent): areas farther removed from patient focused somatic hospital care, **w. different core aims and values**
  - Social services
  - Public health (antibiotic resistance management)
  - Forensic psychiatric (court ordered) care

- Is it possible to preserve to notion of PCC/SDM in such areas?
- What are the ethical implications of such expansions?

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Social Care & Services

- **Aims/values**: promoting a set citizen ideal and fostering linked virtues through promoting social function and relevant capabilities

- Measures can be adapted in order to facilitate these aims and values

- Autonomy and power may sometimes be a part of the citizen ideal, but may also be more or less absent

Example:

Client with a drug addiction and unemployment problem pressed by threat of losing monetary support to join treatment and job-seeking programme to become a ”responsible citizen”, capable of financial self-provision.

Munthe, et. al. (2016). *Delat beslutsfattande och evidensbaserad praktik inom socialtjänsten mål, begrepp och etik för utformning och implementering.* Report to theSwedish National Board of Health and Welfare, University of Gothenburg.

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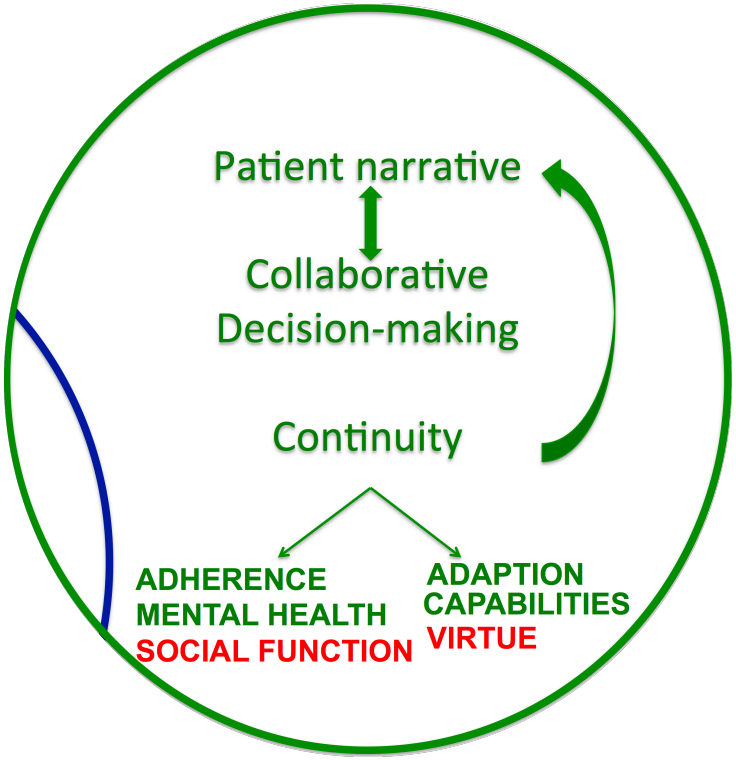
Forensic Psychiatric Care

- **Aims/values**: minimal social function (law abidingness) and fostering of linked virtues through promoting mental health and relevant capabilities (responsibility taking)
- Adherence relative to state prescribed aim, adaption can be done within that room only.
- Context coersive from the outset. Autonomy a reward for reaching the goal of care, rather than an ethical constraint on how it proceeds.
- Gradually introduced respect for autonomy and empowerment, in order to foster better capacities of taking responsibility, seem necessary.



Example:

Patient in court ordered care due to grave criminal offense pressed to maintain very uncomfortable drug regimen to enjoy laxed security and eventual discharge into outpatient programme to become law abiding & socially adapted

Appelbaum (2008). Ethics and Forensic Psychiatry: Translating Principles Into Practice. *J Am Acad Psychiatry Law* 36:2:195-200.
Munthe et.al. (2010). Ethical Issues in Forensic Psychiatric Research on Mentally Disordered Offenders, *Bioethics*, 24 (1): 35-44 .

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Public Health: AR Prevention

- **Aims/values**: Promote public health through making patients adapt to and accept role in set political action to optimise antibiotics use.
- Adherence relative political aim, adaption can be done within that room only.
- Autonomy and empowerment *may* be part of this, but only if patients embrace the objective of obedience in light of the political goals.
- Contextual threat of collective coordination problems makes adaption to individual need and preference difficult to aquare with public health aims.

Example:

Patient with persistent bacterial infection without serious somatic risk pressed to accept domestic and financial adjustment to accommodate for extra sick-leave time, as part of programme to reduce antibiotics prescription rates

Littman & Viens (eds.) (2015). Special issue: Antimicrobial resistance. *Public Health Ethics*, 8 (3): 209-265
Leibovici, et al. (2012). Ethical dilemmas in antibiotic treatment. *J. Antimicrob. Chemother,* 67 (1): 12-16

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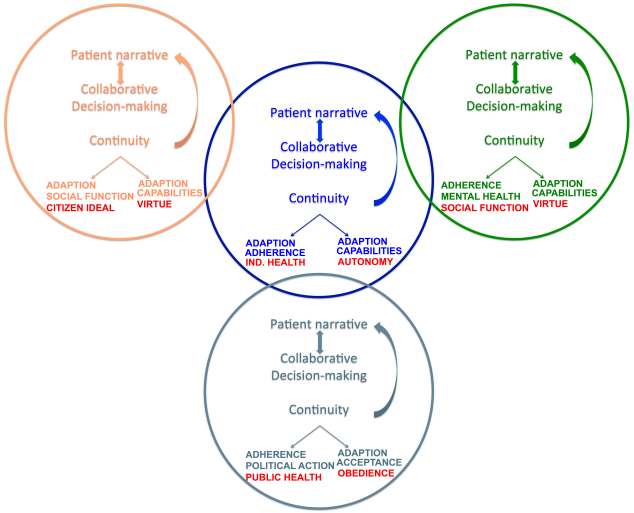
Conclusions:

- PCC/SDM is a ”thin” notion that can be adapted to serve very diverse aims/ values
- Migration into the considered areas will in different ways actualise quite different values than focus on individual health and autonomy
- Each of these areas need further ethical analysis, as the ethics of PCC/SDM has so far assumed a context of ’ordinary’ health care
- At the same time, all of these areas will in different ways interact with health care (staff), actualising intersectorial value tensions and conflicts
- ’Moving’ approaches to PCC/SDM between areas and sectors without careful ethical amnalysis not advisable.



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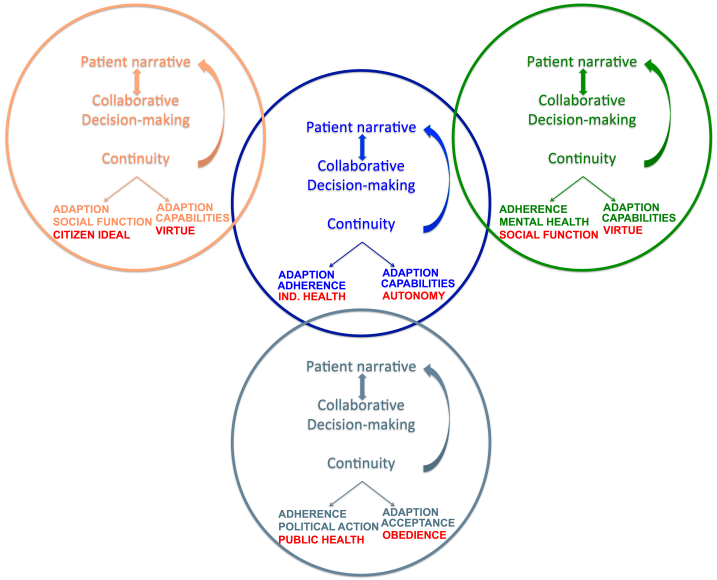
Thank You!



Christian Munthe[a,c,d], Lars Sandman[e,f], Pia Nykänen[a,b], Leila El-alti[a,c]. Contact: christian.munthe@gu.se

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