Approach Briefings: A Call for a Full Repertoire of Decision-Making Skills

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J Gen Intern Med 40(16):3900–3
DOI: 10.1007/s11606-025-09683-4

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The resident was doing very well explaining the chemotherapy reaction to the patient. And then the plan: "We are going to give you three days of steroids before the next dose, and an antihistamine". Did she notice that sudden glint of disagreement in the patient's eyes? And my raised eyebrows? Turns out she did: "Well, there is also the option of trying just an antihistamine, which may be less effective, but also avoids the side effects of steroids…so we can talk about which you would prefer".

The patient relaxed and smiled. Well done, I thought. Options, patient autonomy, shared mind,[1] and shared decision-making.[2]

Two weeks later, I found myself again observing the same trainee at the bedside of a rapidly deteriorating patient who was agitated in the throes of terminal delirium, discussing options with the patient's husband: "We could continue with intravenous immunoglobulin treatment, or we could stop infusions and focus more on comfort. Both are options with pros and cons. How would you like to proceed?" After a few minutes of deliberation all around, I stepped forward with some version of a clear decision message and recommendation, the gist of which was that based on prior conversations with them, I had understood that at the end of life, a focus on comfort was what they had wished for. In my assessment, the time had now come to focus on getting his wife feeling more comfortable and settled, considering further treatments would be futile,[3] and that I believed that she would pass away within the next several hours to days.

The husband, although visibly upset, stopped glancing furtively back and forth between us and his wife. He quietly nodded. The path — as sad as it was — was clear; there was no point imagining other options, and their repeated theoretical contemplation would only prolong his wife's suffering.

Received January 27, 2025
Accepted June 11, 2025
Published online July 2, 2025

I wonder what the resident thought of my two opposing interventions. Was I coming across as one of those grumpy inconsistent consultants who are just never happy with what the trainees do? Because here I was, after all my chronic pontificating about shared decision-making discussions, practising two rather different approaches. I realised that in the clinic, I may have been practising the old saying "If all you have is a hammer, everything looks like a nail" — the hammer being a shared decision-making approach, and "everything" being, well, everything. Proponents of this approach cite benefits of using this "hammer" broadly, including improved decision regret, better patient-physician communication, and more values-congruent care.[4–7] And yet, decision-making and the physician's role appeared more nuanced to me now as I contrasted these two scenarios — they exemplified a *spectrum* of approaches to making decisions, the undifferentiated term "shared decision-making" (SDM) being too broad a concept to be universally applied without causing confusion amongst our trainees.

And it is not only our trainees who might be confused — although the concept of SDM has been in use for over three decades, it still means different things to different people, and a universal definition remains elusive.[8,9] For instance, some readers might consider a strongly directive intervention, as in the end-of-life case just described, to be paternalism.[10] Figure 1 clarifies the spectrum of decision-making according to the role of the physician, as I see it. The informational model is the "plumber" approach of Veatch,[11] where the doctor just follows the patient's instructions, is willing to perform whatever the patient wants, and only has a role in explaining the options. Arguably, even plumbers offer more input to their clients than in this extreme "moral abdication on the part of the physician",[11] which some might even consider a dereliction of duty — although in the real world, this is certainly still practised at times. Paternalism represents the other extreme of physician involvement, and it can come in two variants: *patient-focussed* paternalism is taken here to mean the physician acting in what they perceive to be the patient's best interest, taking full responsibility but also without explicitly clarifying (or having ever clarified) with the patient what that "best interest" might be. This is Veatch's "Priest" approach.[11] *Doctor-centred* paternalism can still involve discussions with patients; however, the decision is primarily determined by the physician's motivation. This can be considered unethical, for example, due to ulterior motives

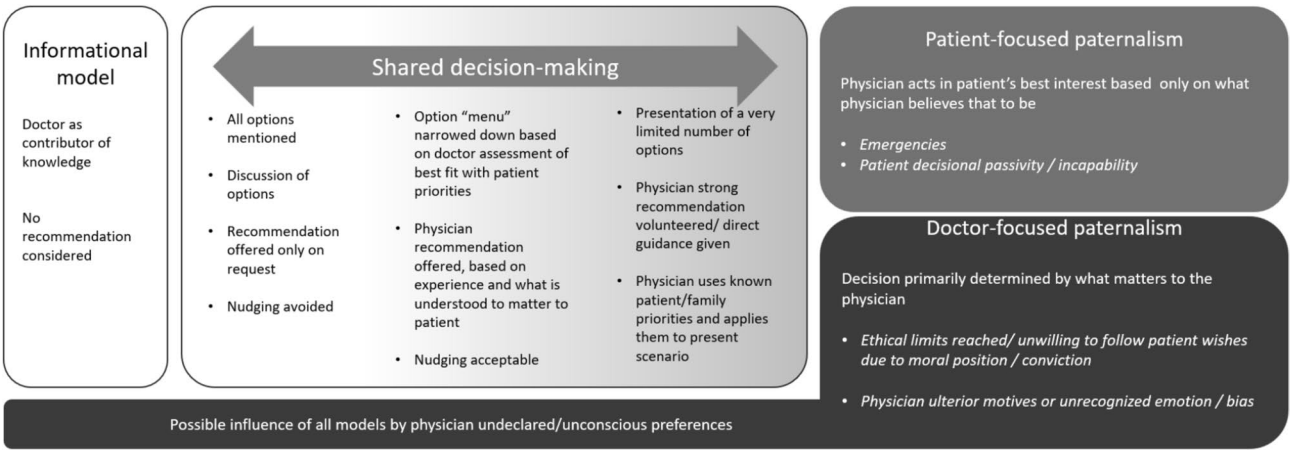

Figure 1 Approaches to decision-making.

outside the patient interest, such as remuneration, clinical trial quotas, or the doctors' own needs to see their actions as meaningful to themselves. Or, conversely, it can be very much tied to valid ethical scenarios, for example, if a physician is not willing to provide a treatment a patient requests on moral or ethical grounds. And between these extremes, shared decision-making is positioned (Veatch's "contractual approach"), varying from an approach where strong physician recommendations establish it closer to the paternalism side, to situations where recommendations are only given on request, almost approaching a completely detached informational model.[12] Nudging is the presentation of options in a way that guides a patient towards a certain option without declaring that the physician is favouring this option for the patient ("When we do CPR we usually break ribs"). I also situate this within the SDM spectrum, though some call it libertarian paternalism.[13,14]

Returning to the situation involving the dying patient and my hesitant trainee: here was a situation which clearly called for a strong directive role for the physician, at least if I listened to my clinical instinct. Removed from the deliberative space of an outpatient clinic, the acuity of the situation called for physician-driven (and yet still patient-focussed) decision-making, a different option in my repertoire than deliberating various outpatient treatments. Reading the room and the situation and having not just the medical knowledge to diagnose and prognosticate, but also the courage to bear the responsibility of action and its consequences, relieving the patients and families of a potentially confusing option-contemplation burden they are not expecting or trained for: this seemed to be what was needed. Such an approach could apply broadly within medicine — I presume intensivists would not enter into a deliberation with the patient regarding which drug to use to control a dangerous arrhythmia, that would be absurd. And any patient would expect their surgeon to use whatever means are required to quickly and effectively manage their perforated bowel — assuming surgery is within their goals of care.

Aye, there's the rub. Surgical method might be a clinician decision, but whether to use it at all might be a shared decision — and patients and physicians generally seem to assume everybody knows which decisions to delegate to the physician (the technical ones), and which require patient input to various degrees. It is not my intention to tediously argue which of the decision-making approaches in Fig. 1 is "best", or to devise a list of situations where one approach may be more suited than another, longer than I already did at the outset. However, I do wish to point out that in my experience a deliberate and explicitly discussed establishment of the approach to decision-making is not yet part of routine clinical practice or medical education in most specialties. "Team talk" is the first phase of a widely practised decision-making model and is aimed exactly at such role clarification between physician and patient.[15] Just as an airplane crew needs to perform an approach briefing before landing — discussing how they will come in to land and who will perform which roles — perhaps we would do well to do our own approach briefings around medical decisions.

A decisional approach briefing would be akin to surgical "time outs": a brief step away from action and a review of where along the spectrum of decision-making we will position ourselves as we prepare to engage with our patient's situation. In acute situations, we may take no more than a few seconds to remind just ourselves in our own minds of our appropriately directive decision-making approach, of the fact we are taking more control, *for now*. Perhaps, this brief reminder of the fact that other approaches even exist (although we do not consider using them at the time) may pave the way for us noticing when the clinical situation changes, and it is time to transition to a more balanced role between physician and patient down the road. In less acute situations, it would take the form of a brief discussion with trainees or with other health care professionals involved, and

with the patients. In a recent study, our trainees described how they witnessed oncologists' decision-making approaches varying during a cancer patient journey from very directive (at the initial consultation) to very passive/informational (towards the end of life), without this ever being a topic for discussion.[16] Trainees felt this should ideally be reversed, with more openness at the outset, and more courageous guidance in the face of impending treatment futility. Based on this feedback, I now routinely clarify before the patient encounter much more precisely, what I am willing to offer, whether I will present all options or just a few, and how we will justify this explicitly with our patients. To the best of my knowledge, decisional approach briefings have not been formally studied — however, I have found them to be tremendously helpful in bringing out biases and uncovering instances of doctor-centred paternalism. For instance, trainees will often say "I will dose-reduce the treatment due to the neuropathy" — and when we clarify that we can operate more in the middle of the SDM spectrum, it provides an opportunity to understand how the patient might be willing to sacrifice function for the sake of trying everything to prevent their cancer from relapsing — while the trainee had been just implicitly avoiding causing harm in the moment because they, the trainee, would not feel good about doing so, resulting in them being more directive without considering why.

But I feel we owe it to patients to deliberately move back and forth along the decision-making spectrum, commensurate with the dynamics of their medical situation. With the introduction of the "decisional approach briefing" into our clinical reasoning minds, we may even try to gently introduce a more shared approach with the patients, in situations where historically it was implicitly assumed that "doctor knows best" and paternalism is expected. Minor ailments, family medicine routine care, and internal medicine inpatient management may be good starting points to question this. If time permits and it would not be absurd (for example during a resuscitation), I think a brief conversation could be had even in complex situations with the patient or family explicitly establishing, for example, that they will delegate and entrust the minutiae of the medical management to the physician if the overall goal of care is agreed upon. And if such a brief clarification dialogue around the decision-making model in use becomes part of routine medical culture, perhaps over time we will all (patients, trainees, and physicians) get more familiar with using more than one or two approaches to making decisions. There may be less documentation of patients "refusing" treatment or of being "non-compliant". Dr. Google may cause less irritation, if it is established a priori what role they are going to play.

The challenge, of course, is how to reach this goal. We need a conceptual framework, a way to integrate decision approach briefings into clinical practice and education, and skills training not just in shared decision-making "not otherwise specified" — but specifically in various approaches along the SDM spectrum. I would argue that a conceptual framework already exists around the nuances of decision-making. [17] I think it just is not taught sufficiently broadly yet, to both physicians and patients, to enable routine dialogue in the clinical space. In fact, trainees who wish to bring up discomfiture they had around the way decisions were reached may suffer from hermeneutical epistemic injustice — the lack of input into a situation by somebody positioned lower within a power gradient and culture, due to the absence of a shared framework or language to express themselves.[18,19] A curriculum dedicated to an understanding of the variety of ways in which physicians, patients, their families, and the disease can interact around a decision is important. And once we have all internalized our *conceptual* toolkit of decision-making approaches, and have established a personal habit of a "decisional approach briefing" — either in our own minds or as a brief time-out during which we clarify approaches with trainees, coworkers, and patients — then the more difficult work starts, which is developing a *skills* acquisition toolkit for the actual "landing", i.e. engaging in nuanced and differentiated SDM. I envision physicians and trainees moving smoothly between a more shared and a more explicitly guiding, directive approach to the moment, open to what the moment or the patient are calling for, and knowing what approach they are using, ready always to either change or maintain course. Skilled in playing and articulating various roles along the spectrum, and in teaching various roles as well. Taking most of the responsibility for tough decisions, or sharing it. Such a curriculum will take much educational effort to develop. No wonder Hippocrates lamented: "Life is short, and art is long".

But every journey of 1000 miles begins with a single step, and my first step will be to sit down with the trainee in question tomorrow morning and offer a debriefing to retroactively discuss the actions of her contrarian consultant in light of this reflection. We don't know which decision we will face together next or if we will agree on how to approach it, but we should at least know what is in our respective decision-making toolkits — *before* we use them.

Acknowledgements *The author would like to thank Dr. Megan Smith-Uffen for her valuable feedback on this manuscript.*

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Author Contributions *This work is the sole work of the author (concept, writing, editing)*

Declarations

Ethics Approval and Consent to Participate *Not applicable.*

Conflict of Interest *The author declares that he/she does not have a conflict of interest.*

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