INTRODUCTION

Shared decision making (SDM) is a pivotal component of nursing that enhances autonomy, personal involvement in care, and positive care experiences, thereby reinforcing person-centered care. SDM is described as a method in which healthcare professionals and patients collaborate, sharing the best available evidence to make informed decisions and supporting patients in evaluating their options to reach well-informed preferences. This concept is deeply ingrained in global healthcare quality standards, policies, guidelines, and best practices [1]. Among older adults, SDM offers numerous advantages, such as a deeper comprehension of risks and benefits, enhanced awareness of potential dangers, and reduced decisional conflict [2]. Nurses are ideally positioned to lead SDM across various healthcare environments, thus playing a crucial role in shaping positive outcomes in the care for older adults [3]. This role is particularly critical when caring for older individuals who often face complex health, well-being, and quality-of-life decisions that require navigation through evolving contexts and transitions in care [4]. Engaging older adults in SDM ensures their autonomy and upholds their basic right to self-determination. However, global evidence indicates that SDM has not been consistently implemented in gerontological

Invited review: Enabling shared decision making in gerontological nursing: Barriers and facilitators

Myonghwa Park
Professor, College of Nursing, Chungnam National University, Daejeon, Korea

Shared decision making is globally recognized as an important concept in healthcare research, policy, education, and practice that enhances person-centered care. However, it is becoming increasingly evident that shared decision making has not been successfully translated into healthcare practices, especially in gerontological nursing. Central to person-centered and shared decision making is the need to recognize the importance of life experiences to inform decision-making processes. With the world’s aging population and older adults facing more complex decisions and transitions in care, it is important to integrate shared decision making into person-centered care for older adults. This invited paper reviews the key issues in shared decision making in the context of older persons and the role of nurses. The review was divided into three parts. The first describes and comments on the main theoretical frameworks, while the second and third deal with barriers and facilitators to shared decision-making of older persons and issues related to their practice. There is a critical demand for focused research on older individuals with intricate needs and family-centered approaches to shared decision making. The tools and resources that support shared decision-making such as adequate time, consultation services, culturally appropriate decision aids, and systems that track patient progress, are essential for effective decision-making. As shared decision making involves various community resources, nurses must not only educate patients about these resources, but also provide patients with advice and support to ensure that the patients can effectively access and utilize these resources.

Keywords: Shared decision making; Aged; Nurses; Geriatric nursing; Patient-centered care
nursing practice [5]. The SDM process is more intricate in older adults than in younger adults. Challenges associated with cognitive impairment and communication further complicate the attainment of optimal healthcare outcomes and experiences for older adults. This underscores the urgent need to deepen our understanding of how SDM occurs between older adults and nurses [6].

This invited review paper aims to understand shared decision-making in the field of gerontological nursing, explore related theoretical frameworks, identify barriers and facilitators in its practical application, and provide directions for future practices in the field.

**THEORETICAL FRAMEWORK**

1. Ottawa Shared Decision-Making Model

The Ottawa Shared Decision-Making Model provides a theoretical framework for applying shared decision-making to older patients [7]. This model emphasizes the collaborative nature of the decision-making process between healthcare providers and patients. It is particularly relevant for older adults, as it respects their unique needs, preferences, and values. The model outlines several key components. First, it involves identifying the decision points and understanding that a decision needs to be made. Next, both healthcare professionals and patients must be aware of the necessity of decision-making and each other’s roles in this process. A crucial step in this model is mutual sharing of information. Healthcare providers share medical information, treatment options, and potential outcomes, whereas patients share values, preferences, and personal experiences that may influence their decisions. The model encourages the assessment of both parties’ readiness to participate in the decision-making process, and helps patients evaluate their options based on their values and preferences. This is crucial to ensure that decisions align with what is most important to patients. Finally, the model advocates the implementation of the decision, which includes planning and taking steps to apply the chosen option and the subsequent evaluation of the decision-making process. This evaluation helps to understand the effectiveness of the decisions made and adjust future decisions accordingly. This model is particularly effective for older adults as it leverages their life experiences and values, which are integral to making meaningful healthcare decisions. It also promotes autonomy and respect for their capacity to make informed choices, thereby enhancing their quality of care and satisfaction.

2. Share Decision Making With Multiple Chronic Conditions

Multiple chronic conditions present a challenge for traditional SDM models, which are typically geared toward achieving disease-specific outcomes for single diseases [8]. However, for many older adults with multiple chronic conditions, personal health outcomes such as maintaining functional independence, minimizing symptoms, enhancing emotional well-being, and ensuring treatment safety often take precedence over specific disease outcomes. To address these personal health outcomes, recent action steps for decision making for older adults based on the American Geriatrics Society’s Guiding Principles for the Care of Older Adults with Multimorbidity advocate integrating patient priorities into medical decisions. This model emphasizes establishing personal goals, values, and preferences as well as discussing preferred roles and decision-making capacities [9]. Validated by healthcare professionals and older adults, this model promotes informed decisions based on patient-prioritized health-outcome goals. This model includes a comprehensive assessment of patient issues, determination of significant health outcomes, and consideration of the decision-making capabilities and preferences of both the patient and informal caregivers.

3. Person-Centered SDM

The concept of shared decision-making in health care, as discussed by McCormack et al. [10] and Daly Lynn et al. [6], is highlighted as a process integral to enhancing person-centered practices. This approach involves the facilitation of active participation in decision-making by patients and their significant others, considering their values, experiences, concerns, and future aspirations. The objective was to transform patients’ experiences and empower them to consider the diverse perspectives that shape their perceptions and understanding. This empowerment enables patients to choose their paths in the most trustworthy manner. Essential to the effectiveness of SDM is the development of a trusting, honest, and mutual relationship between healthcare professionals and older adults that acknowledges and values the unique perceptions each brings to the healthcare experience. This relationship should focus on
being and working with the patient, rather than simply doing so for them.

4. Relational and Emotional Dimensions of SDM

Effective decision-making must be based on interdependent and interconnected relationships, where beliefs, values, and perspectives are exchanged and the entirety of the person is considered. The effectiveness of SDM hinges on the healthcare professional's application of effective communication skills; the older person's knowledge, experience, and personality; and the time allocated for making the decision [11]. SDM can restore the independent decision-making ability of individuals experiencing uncertainty in a state of vulnerability and diminished authority, thereby acknowledging and respecting personhood. Achieving SDM requires building relationships grounded in a fundamental respect for an individual's autonomy and the need to focus more on the emotional and relational dimensions of SDM [12]. Decision-making in older adults often differs from that in other age groups because of increased reliance on emotions, experience, and values in guiding their choices. Emotions are critical to how individuals form value judgments and derive meaning from the world as having reflective and retrospective quality [11]. These emotions allow individuals to reflect on their past life experiences and share who they are, their actions, and their lifelong commitment. Retrospective introspection adds new meaning to a person's life and influences future decisions. Emotional processes become increasingly central in decision making as one ages, as emotions help one logically understand and evaluate choices, thereby enhancing the capability to make decisions that are consistent with one's values and are thus rational in nature [13].

BARRIERS OF SDM FOR OLDER PERSONS

However, SDM has not been widely adopted. Healthcare professionals and older patients face obstacles in collaborative decision-making [14]. Older patients with multiple chronic conditions are often less involved in SDM and are concerned about the burden associated with treatment regimens. Patients, informal caregivers, and healthcare professionals consider both cognitive and physical impairments as obstacles to SDM. Cognitive impairments hinder the understanding of information and expressing preferences, which lead to not desiring or not being capable of participating in decision-making. Physical impairment may affect treatment adherence, whereas severe illnesses prevent older patients from engaging in decision-making [15].

Both patients and healthcare professionals identified inadequate communication methods, poor language selection, and lack of empathy as obstacles to effective SDM. Older patients often doubted their ability to be meaningfully involved in the SDM process or felt that their insufficient medical knowledge hindered their participation. Conversely, some patients felt that healthcare professionals underestimated the value of their expertise. Informal caregivers reported feeling dependent at the discretion of healthcare staff and ultimately observed that final decisions were typically made by health professionals. Health professionals concede that patients and informal caregivers are frequently not regarded as integral members of healthcare teams [16].

Not all patients desire or require the involvement of SDM. Some older patients prefer to play a more passive role in the SDM process. However, health professionals often perceive this lack of involvement as an obstacle to effective SDM as it makes it difficult to infer the patient's preferences. This discrepancy in perspectives can further complicate SDM. For instance, patients may prioritize reducing the treatment burden, whereas clinicians are more concerned about managing the risks of morbidity and mortality [17].

When healthcare professionals fail to tailor information to the individual needs and capabilities of patients or use complex medical jargon, this acts as an impediment to SDM. Furthermore, decision-making support from informal caregivers can complicate SDM. First, informal caregivers may feel imposed responsibility for decision-making. Second, discrepancies may arise between informal caregivers and healthcare professionals, such as when caregivers are overly protective, or disagree with professional recommendations. Third, there may be conflicting opinions between informal caregivers and patients regarding treatment or care, as well as the patient's ability to effectively communicate with healthcare providers, especially in instances of cognitive decline. Finally, the presence of multiple informal caregivers, each holding a different view, can further complicate SDM [18].

Care for older adults often involves various healthcare professionals operating in different settings. Poor or ineffective communication among these professionals, resulting in difficulties in prioritization and a lack of comprehensive patient oversight, is perceived as a barrier to SDM and the delivery of
integrated care in general. Divergent perspectives, such as differing priorities between medical focus and focus on overall well-being or conflicting ideas regarding patient involvement, further impede SDM [19].

In addition, high staff turnover poses challenges in developing meaningful relationships with older patients, leading to deficiencies in the continuity of care and ambiguity regarding patient responsibility. Inadequate electronic patient records contribute to patients who frequently receive repeated explanations. Patients may feel pressured to make room for new arrivals, with decisions regarding discharge predominantly made by professionals rather than collaboratively. Establishing a relationship between older patients and clinicians is essential for discussing personal preferences and requires time. Patients may feel less motivated to participate in decision-making when the clinicians seem to be stressed [20].

A key component in facilitating informed choices truly reflects the patient’s values and preferences. In a study on the health priorities of older adults managing both hypertension and the risk of falls, approximately half of the participants prioritized reducing cardiovascular risks by minimizing the risks of falls and side effects of medication, with the remainder having the opposite preference [21]. For instance, older adults may be more averse to the side effects of medications used for the primary prevention of cardiovascular disease than to their potential benefits. The complexity increases for older patients with multiple chronic conditions owing to the diversity in their health status, physical and cognitive functions, side-effect tolerances, life expectancies, and treatment outcomes, which may prioritize either length or quality of life. In such cases, the clinician’s role extends to include expertise in the potential adverse interactions between medications and diseases and between different drugs, enhancing the decision-making process.

Existing guidelines often pose challenges in the management of multimorbidity because they typically lack adequate support for SDM, especially for older adults and those with multiple health conditions [22]. For instance, standard guidelines for managing heart failure and preventing cardiovascular disease primarily emphasize risk reduction, frequently overlooking individual patient concerns or preferences, such as those related to the quality of their remaining life. Furthermore, these guidelines usually concentrate on initiating medication while providing insufficient advice on deprescribing or reducing or stopping medication [23]. Although guidelines often mention the importance of employing clinical judgment in these complex scenarios and assert that decisions made with the patient reflect the patient’s preferences, needs, and values, they rarely provide concrete guidance, methods, or tools to facilitate this. Consequently, they are not ideally structured to promote patient involvement and effective SDM [24].

Patient decision aids are designed to enhance the decision-making process by providing comprehensive information about treatment options along with their respective benefits and risks, often including prompts to help patients reflect on their values and preferences [25]. Although some decision aids address cardiovascular conditions, they are generally not tailored for individuals with multimorbidity. Systematic reviews suggest that decision aids can boost patient knowledge, enhance risk perception, and foster participation in decision-making, thereby reducing decisional conflict. These benefits are similar to those observed in the general population. However, few aids are specifically crafted for older adults, and most do not consider the complexities associated with aging, such as multimorbidity, caregiver involvement, or age-related cognitive and emotional changes, nor are they tested in the oldest age group (over 80 years). The current methodologies used to develop and structure decision aids often fall short of integrating the diverse evidence required for managing multiple chronic conditions simultaneously [26].

FACILITATORS OF SDM FOR OLDER PERSONS

Reviewing the factors that promote SDM from both systemic and individual perspectives will assist in developing future strategies. In the context of the healthcare system, nurses who evaluate a patient’s comprehension of information and ability to articulate their symptoms, thoughts, and feelings, especially in cases of cognitive decline, can enhance decision-making processes. Health professionals also emphasize that understanding a patient’s quality of life, functional status, and the priorities, goals, and preferences of both patients and informal caregivers enhances the SDM process [16]. Effective collaboration, communication, and use of consistent terminology among members of the interdisciplinary team were key facilitators of SDM. When the workflow is truly centered on the patient, it promotes SDM. Conversely, a value-based payment system supports SDM because it ties payments to patient-relevant outcomes, which can vary from comprehensive medical interventions to watchful waiting [20].
In the context of older people and their family caregivers, older patients expressed feeling more engaged in SDM when healthcare professionals encouraged them to discuss their symptoms, pose questions, and share their primary concerns. Furthermore, when older patients believe that they possess the most comprehensive knowledge about their bodies and specific health conditions, they are encouraged to actively participate in the decision-making process. Patients believe it is their responsibility to ask questions, educate themselves about their condition and medications, and ask about diagnostic tests and medical evaluations. Additionally, older patients indicated that being motivated, having self-confidence, preparing themselves, and receiving support from family members facilitated their involvement in SDM. When patients experienced cognitive decline or were significantly ill, informal caregivers played a crucial role in the decision-making process by providing information, posing questions, and aiding the comprehension of information. Moreover, these caregivers ensured that older patients’ preferences were acknowledged. Personal experiences of family and friends also play a critical role in weighing different options. Access to tailored information about conditions, treatment options, and potential outcomes is a significant facilitator of SDM [18].

**CONCLUSION**

Research and evidence from stakeholders indicate that older adults with complex health conditions, often compounded by depression as a common comorbidity, may require substantial support to participate in SDM. This need is further intensified by socioeconomic deprivation, low health literacy, or cognitive decline. There is a critical demand for focused research on older individuals with intricate needs, including investigations into the dynamics of SDM conversations in this group, the application and effectiveness of patient decision aids, and the outcomes of these tools. Additionally, there is a call for more studies on family-centered approaches to SDM, such as exploring the effects of routinely involving family members in care discussions with the consent of older individuals. Moreover, while healthcare delivery is increasingly adopting an interprofessional team-based model, most existing research on SDM is limited to the interactions between a single healthcare professional and a patient. Thus, there is a significant gap in studies exploring interprofessional approaches to SDM in which the development and engagement of all healthcare staff are essential.

For older adults with multimorbidity, SDM should follow a structured and personalized process. Initially, the conversation should focus on identifying older patients’ most pressing concerns and goals, ensuring that any proposed care is aligned with these priorities. Once these goals are established, discussions can progress toward choosing the best methods to achieve them. Although traditional decision aids may assist these discussions, they should be approached with caution. These aids often do not account for the increased risk of adverse effects in older patients or the potential for drug-drug or drug-condition interactions; thus, personalizing this information becomes crucial. In managing the various priorities, conditions, and multiple healthcare providers involved, our goal is to assist patients in meeting their objectives with minimal disruption to their daily lives.

The tools and resources that support SDM, such as adequate time, consultation services, culturally appropriate decision aids, and systems that track patient progress, are essential for effective SDM. These elements suggest a need for policy changes at the organizational level. At the healthcare level, although evidence-based practices are beneficial, they may also restrict patients’ choices. Educational initiatives that boost nurses’ ability to implement SDM in their practice are crucial. Competencies in reflective practice, relationship building, communication, assessment, ethics, and understanding of the role of social support are vital. Moreover, nurses must examine their comfort levels with SDM, as some may hold positive views in theory, yet feel ambivalent about partnering with patients because of trust issues. Patients also require competency to actively participate in SDM, which requires nurses to offer support, guidance, mentorship, coordination, and education throughout the SDM process. As SDM can involve various community resources, nurses not only educate patients about these resources, but also provide advice, support, and advocacy to ensure that patients can effectively access and utilize them.

**ORCID**

Myonghwa Park, https://orcid.org/0000-0002-0329-0010

**Authors’ contribution**

Concept development, drafting, and critical revision of the manuscript - MP

https://doi.org/10.17079/jkgn.2024.00451
Conflict of interest

No existing or potential conflict of interest relevant to this article was reported.

Funding

This study was supported by the National Research Foundation of Korea (NRF) grant funded by the Korean Government (MSIT) (No. 2022R1A 2C1003904).

Data availability

Please contact the corresponding author for data availability.

Acknowledgements

None.

REFERENCES

16. Cranley LA, Slaughter SE, Caspar S, Heisey M, Huang M,


