Nordic Journal of Psychiatry

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ipsc20

# Clinicians’ experiences on patients’ demands and shared decision making in Finnish specialized mental health care

Hanna-Mari Hilden, Lotta Hautamäki & Jyrki Korkeila

**To cite this article:** Hanna-Mari Hilden, Lotta Hautamäki & Jyrki Korkeila (2021) Clinicians’ experiences on patients’ demands and shared decision making in Finnish specialized mental health care, Nordic Journal of Psychiatry, 75:3, 194-200, DOI: 10.1080/08039488.2020.1833983

**To link to this article:** https://doi.org/10.1080/08039488.2020.1833983

© 2020 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group

Published online: 24 Oct 2020.

Submit your article to this journal

Article views: 485

View related articles

View Crossmark data

Citing articles: 1 View citing articles

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=ipsc20

NORDIC JOURNAL OF PSYCHIATRY
2021, VOL. 75, NO. 3, 194–200
https://doi.org/10.1080/08039488.2020.1833983

Taylor & Francis
Taylor & Francis Group

ARTICLE

OPEN ACCESS Check for updates

# Clinicians' experiences on patients' demands and shared decision making in Finnish specialized mental health care

Hanna-Mari Hilden[a], Lotta Hautamäki[b] and Jyrki Korkeila[c]

[a]Department of Psychiatry, University of Helsinki, Helsinki, Finland; [b]Faculty of Social Sciences, Tampere University, Tampere, Finland; [c]Department of Psychiatry, University of Turku and Harjavalta Hospital, Hospital District of Satakunta, Turku, Finland

**ABSTRACT**

**Purpose:** Psychiatric patients' awareness of treatments options and their possibilities to influence their care has increased. For the clinicians, the management of evidence-based care, as well as organizational and resource aspects, set different goals for the clinical encounter. In this article we are focusing on the clinicians' experiences and ask: How do the clinicians view situations in which there is a conflict between patients' individual needs and goals and other aspects in decision-making?
**Materials and methods:** We implemented a qualitative study of 13 thematic semi-structured interviews with clinicians working in psychiatry. We used discourse analysis to investigate how the clinician view the doctor–patient interaction.
**Results:** We identified three discources which were termed the medical standpoint, the psychodynamic standpoint and the standpoint of the patient's experience.
**Conclusions:** In their talk, the clinicians use the three discources to make sense of the diverse expectations from both the patient and the mental health care system. The three discources also reflect different aspects in psychiatric treatment cultures, such as evidence-based medicine, the ideal of patient-centeredness, therapeutic interaction and organizational requirements.

**ARTICLE HISTORY**
Received 19 November 2019
Revised 11 August 2020
Accepted 4 October 2020

**KEYWORDS**
Shared decision making; patient consumerism; patient empowerment; doctor–patient relationship; qualitative study

## Introduction

In the last decades the treatment culture in psychiatry has changed towards the ideals of evidence-based and patient-centered clinical practice, as well as shared decision-making between the clinician and the patient [1–7].

Coincide with this development, psychiatric knowledge is increasingly spread, used and shaped by media, patient associations, education and in the Internet [8–11]. Patients' knowledge on diagnoses and treatments has increased [12,13] and they have more expectations on the decision making concerning their care [4,7,10].

In this article we report an interdisciplinary qualitative analysis about clinicians' experiences on shared decision making (SDM) in specialized mental health care in Finland. Using discourse analysis on interview data, the article investigates how the clinicians view conflicts in the doctor–patient interaction and how they experience the balancing between medical, organisational or therapeutic demands and the patients' individual needs and goals.

### *Shared decision making in psychiatry*

In psychiatry, medical decision-making is significantly dependent on the communication between the clinician and the patient. The interaction in the clinical encounter is the key to correct diagnosis and right treatment decisions. How do the observations of the clinician and the patient's personal account of his or her symptoms together pave the way to diagnosis? What kind of available therapeutic options are suitable and acceptable for the particular patient? What are the risks and benefits of psychotropic medication or the decision of not having any? In psychiatric practice, the communication can be complicated also with the symptoms of mental disorders or patient's emotional stability affecting the interaction [14].

SDM is ideally a form of communication where the clinician and the patient exchange unbiased information, work in collaboration and have mutual respect for their differing expertise. The psychiatrist's expertise stems from knowledge on the evidence-based treatment standards, diagnostic classifications, therapeutic interaction and the mental health care system, whereas the patient's expertise stems from the experience of living with the symptoms of a mental disorder and knowing their own life history possibly affecting the diagnosis and treatment decisions [2,9,15,16].

SDM is often viewed between the two extremes of paternalistic and autonomous model of making treatment decisions. In the traditional paternalistic or authoritarian model, the decision is made solely by the clinician based on

CONTACT Hanna-Mari Hilden hanna-mari.hilden@fimnet.fi Department of Psychiatry, Helsinki University Central Hospital, Helsinki, 00029, Finland

© 2020 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

scientific evidence and clinical judgment, whereas in the fully autonomous model, the patient collects and weighs the information and makes the choice him/herself [2,17]. Patients' active role in SDM empowers patients to participate in their own care. SDM has raised fears that it might challenge the medical decision-making and add to health-care costs and medicalization [12,18] and clinicians have feared that internet peer experiences may complicate the shared decision making [8,19,20].

Studies on patient-controlled admission to psychiatric inpatient care however report that health-care costs have remained the same or decreased [21,22] and patients are more satisfied and become more active in their care [23–25]. Clinicians' experiences on patient activation in these studies were as well positive but they understood patients' decision-making motives differently from the patients [23,24]. Clinicians' adherence to SDM was however less than optimal even in an intervention of active education and routine outcome monitoring [26]. Patients' and clinicians' co-operation has, as well, been successfully used to create outcome measures for psychiatric disorders [27].

### *The context and questions of this study*

The concept, practice and use of SDM in psychiatry has received attention in research recently [15,16,28]. The literature has covered particularly the SDM in decisions concerning the complex risk-benefit assessments in deciding on psychotropic medication and diagnosis [17,19,20,29–31]. In addition, the patients' perspective on SDM in mental health care has been investigated [4,7,10,32].

The general thrift in the previous literature on SDM in psychiatry is to take the distinction between the paternalistic and the autonomous model of decision making as a starting point for the analysis. In this article, we seek to provide a more nuanced analysis on SDM by taking into account the ways these two models intermingle and take various forms according to what is considered as the aim of the interaction. In this article, we are interested in the ways clinicians try to implement the ideal of SDM in their daily clinical practice amidst different demands and challenges. So, to complement the discussion on SDM in psychiatry, this article provides the clinicians' view on the possibilities of SDM in community mental health care in Finland.

This article utilizes data from thematic semi-structured interviews with psychiatrists and uses discourse analysis to detail the experiences they have with SDM. In psychiatric practice, the clinicians need to balance patient's individual needs and goals with the ideal of SDM, as well as the other requirements governing mental health care, such as evidence-based treatment guidelines, justice in delivering medical resources or organizational guidelines [30,31]. In order to balance the diverse aspects, the clinicians need to take a mediating position in the decision making. We are interested in how the clinicians try to achieve the ideal of SDM and the other goals in clinical decision making in the varied situations that come up in the specialized care clinics. We ask: How do the clinicians view conflicts between the demands of good care and the empowered patients?

The study this article reports, has been conducted in the context of Finnish specialized mental health care. In Finland, similarly to elsewhere in the western world, last decades have shown a transition from hospital-based treatment to a community mental health care policy, where outpatient care and prevention are emphasized [33]. The Finnish mental health care system is today separated to primary health care, mostly provided by public health centers and occupational health care units, and specialized care in hospitals and outpatient clinics. Specialized mental health care, in majority, takes place in the public sector units.

## Materials and methods

### *Participants*

The interviews took place during the years 2010–2012. One researcher, H. H., was by the time resident in psychiatry, and carried out this research in her three different working places along with her work by interviewing other physicians working at the same organization. The participants viewed her as a colleague which often seemed to benefit the interview in the way of collegial intercourse and common understanding of the working environment. The disadvantage could be that the clinicians may experience pressure to report their practice as medically justifiable. Permission for research was obtained from the City of Helsinki Health Center and the Helsinki University Hospital. Because the subjects were health-care professionals, no Ethical Board approval was needed [34]. Clinicians working in these organizations received an e-mail invitation for voluntary interview. Altogether 13 clinicians, of which 4 were male and 9 female, working in the field of psychiatry, gave their consent and participated in the study. The participants worked in general psychiatric outpatient clinics (5), day hospital (2), tertiary outpatient clinics (5) and psychiatric hospital (1). Six of them had a leading or consultation roles. Most of the clinicians (10) were specialized, three (3) being still residents. The institutions did not have a certain SDM procedure, but the practice is guided by the Finnish Patient Law: The patient must be treated in consensus. If she rejects an offered treatment, she should be treated in some other medically acceptable way if available. The patient does not have the right for any kind of treatment she wishes.

### *Interviews*

The interviews were semi-structured and proceeded from general to personal. If new repetitive themes emerged in the conversation, new questions were targeted towards them. The interview questions were addressed to get understanding of how physicians view patients' activity in expressing their views and requirements and how they describe to answer to patients in situations where they need to balance patients' individual need and goals and different kinds of medical and organizational viewpoints. The questions

concerned the clinicians' view of their own practice rather than theoretical aspects of SDM. They entailed the following topics: How the clinician experienced patients' wishes and requirements. Had she noticed a change in time in patient's activity? Which positive and which negative aspects did the clinician see in patients' increased activity? How patients' activity influenced their care? What did the clinician consider as patients' needs in SDM? What practices did she use in the negotiation? How did she work with other personnel in this negotiation? How did the clinician see the role of media in patient empowerment? Did she feel that patients in general trusted their care? Did the clinician feel that she got enough support and education to practice the negotiation? The aspects of non-voluntary care were not included as the patients' capability to make decisions in these situations is restricted and the decision-making situation is therefore different. The interviews lasted for 30–90 min. We wanted to give the participants abundant time to be able to express what they felt was important in this topic. The interviews were limited to 13, as the saturation point, where similar answers are repeated, was reached [35]. The interviews took place in the participants' work places. The interviews were recorded, transcribed verbatim, anonymized and coded (F for female, from F1 to F9 and M for male from M1 to M4).

This study is limited in that the interviewed participants represent only specialized care. The interviewed clinicians might be in general more interested to discuss the themes, leading to over or under representation of certain positions. As the questions concerned the clinicians' view of their own practice and therefore their clinician identity, this can cause a bias to report their practice in a more positive way, which was taken into account in the theoretical frame of the analysis.

### *Analysis*

Two researchers, a psychiatrist and a sociologist, listened and read the interviews for several times to obtain a holistic sense of the participants' view. They discussed and compared their views in order to test their interpretation of each physician's talk. The aim was to conduct an interdisciplinary analysis to provide both medical and sociological understanding of the context of the psychiatrists talk and to avoid interpretation from a restricted point-of-view. The researchers identified meaning units such as words, sentences, expressions or descriptions that contained important aspects of how the physicians viewed the different participants, their roles and activities, purposes of discussion and factors affecting the discussion. The meaning units were compared regarding differences and similarities and grouped to categories. The researchers discussed and compared their views to clarify that the categories were generalizable to the whole material.

A discourse analytic frame was used in the analysis. In interview studies that investigate the participants' opinions and activities, social bias affects their answers and a social constructive frame of reference is often more beneficial. Discourse analysis is a qualitative study frame that is derived from discursive psychology and considers talk as constructive rather than providing factual descriptions of the interviewees' inner state or their actions in clinical practice [36]. According to this frame, people constantly choose from different cultural meaning systems to present their attitudes and activities as meaningful. In this sense the interviewees can choose from among many discourses concerning mental health care and psychiatry in order to construct meanings for the discussion and decision-making. These discourses frame certain positions for the clinicians and for others. In this article, the interest is in those positions the clinicians describe for themselves in the interaction with the patients. In the analyses of this article, the discourses have been generated from the interviewees' talk to provide the reader thematic conclusions of the clinicians' experiences in doctor–patient encounters. In the results, these general discourses are illustrated using extracts from particular clinicians' interview talk. In order to translate the meaning in the extracts from Finnish to English, the quotations are not represented verbatim.

## Results

Most of the clinicians saw a timely increase in patients' wishes and requests and felt that it was part of their expertise to correspond to this in a constructive manner. According to the clinicians, patients' increased activity included both positive and negative aspects. One of the interviewees described the change as follows:

> Maybe the treatment practices and culture have changed during the years and more and more we have started to take these issues into account in psychiatry and the ideology has changed. Like before when psychiatric care was really hospital-centered and now the outpatient care has increased. ( … ) And it depends so much on how the patient is willing to commit to the care. F2

The clinicians emphasized the benefits of open discussion. They mentioned that patients' activity facilitated SDM and better realization of what they themselves wanted. It also increased patients' understanding of their illness and adherence to treatment. The patients' activity had the potential to improve diagnostics and treatment. For instance, discussing the side effects of medication promotes patients' well-being and prevents situations in which clinicians are not aware of the patient quitting the medication on their own. The negative aspects included increased work load and complaints or patients contacting the media. The clinicians saw, that patients could also acquire misinformation from the internet and were worried that difficulties in the treatment relationship could be externalized to demanding behavior.

In the interviews, the clinicians used three different ways of viewing conflicts in the doctor–patient encounters. We termed them: the medical standpoint, the psychodynamic standpoint and the patient's experience standpoint. A particular discourse was usually dominant in an individual clinician's talk, but most of them applied more than one discourse and often changed from one positon to another.

### *The medical standpoint*

This discourse views a conflict between patient goals and medical facts. It emphasizes medical decision-making based on evidence-based guidelines and research, within the limits of the organization structure and resources in mental health care. The clinician has the responsibility to implement good medical practice, even though the patients' goals would contradict to this.

In the interviews the clinicians stressed psycho-educative work when encountering a patient with many demands. Providing psycho-educative information, was seen to help the patient to understand and accept the diagnosis and adhere to medically appropriate treatment.

> Well yeah, of course it is the doctor's role to listen to demands of benzodiazepines, sick leaves and what not. But I think that we are experts in this field, so what I think is needed, is information and discussion. It means reasoning, reasoning, and once more reasoning, with the patient on why I can't consent to the demands. F8

In this extract the clinician described how she needs to respond to patients' demands by not only providing information, but also explaining and reasoning the medical grounds of the treatment decision.

The clinicians described situations, where patients had acquired information from the Internet or other media and the clinician needed to contextualise this knowledge. The following extract illustrates this aspect of the medical standpoint discourse:

> … we need to know what goes on in the Internet and media about mental illnesses, disorders and psychopharmaceuticals. In order to argue our scientific and clinical knowledge to the patient, we need to get understanding on the knowledge on the other side in order to base our counterarguments. M2

In the medical standpoint discourse knowledge is essentially understood as medical information. The clinician has to evaluate the patient's knowledge base and correct possible inaccurate information gained from the media or other sources. The clinician's competence depends on maintaining a high level of expertise to be able to answer even the most challenging questions of the patients' and base their answers in evidence-based science. The clinician's role in SDM is to reason with the patient in order to maintain the medically justified decisions even in situations where the patient's view differs.

### *The psychodynamic standpoint*

This discourse states that patient's psychodynamic state can complicate medical decision-making. In this discourse the clinician's competence is built on understanding the patient's psychological dynamics, facilitating therapeutic interaction and understanding the subjective illness experience.

Clinicians discuss the patients' difficulties to accept their disorder and give up illness behaviour. It is the clinician's task to explore emotional dynamics in order to alleviate this difficulty. When asked about when to align with the patients' demands, one clinician provided an example of how she works with the most inhibited patients who need extra encouragement to more actively involve in their lives.

> When inhibited patients become more actively involved, I might even accept things like being late and not adhering to the treatment plan. It's like letting the patients to take responsibility of themselves now when they are finally able to, even though in similar situations with other patients I would need to set limits. F5

The clinician describes how her evaluation of the patient's psychological dynamics guides her interaction and decision-making with the patient.

In the psychodynamic standpoint discourse, the clinicians themselves are viewed as subjective actors, whose capability to encounter demanding patients is grounded on their personality and experience.

> At least some of the doctors who wind up in psychiatry, aim to please their patients, like thinking that they want to support people. This exposes them to negative encounters with demanding patients and to complying with the demands. On the other hand, some of us are too self-esteeming to comply with even justified demands. M3

In this extract the interviewee discusses the influence of the clinicians' own dynamics on patient encounter. Essentially, the psychodynamic standpoint discourse reflects the psychodynamic aspects of doctor–patient interaction and treatment cultures in psychiatry. This was an expected discourse since psychotherapy both as a treatment form and a frame of reference is substantial in psychiatry. It is however interesting how the discourse allowed the clinicians to reflect both the patients' demands and their own reactions to those demands in therapeutic terms.

### *The patient's experience standpoint*

This discourse reflects on the interplay between the medical and the patient's expertise. It emphasizes that patients' goals may contradict with medical issues of the decision-making. It also considers the need for SDM in clinical encounters, which might include the family or next of kin. The clinician's competence is grounded in empathetic, interested and humane attitude and being at the same level with the patient. Clinicians at times need to compromise, search for alternatives and find flexible and individual solutions in order to support the patient's motivation for treatment. This discourse stresses the understanding of patients' views and emotions, and the clinician needs to clarify them and respond in an appropriate manner. This first extract illustrates the clinicians' overall attitude towards the patients:

> Well, it is probably the interest in the patients' issues, that you are interested in what the patient talks and listen to her and, like, try to genuinely find solutions to the patient's problems. So the genuine interest is conveyed to the patient … and if the patient notices that the doctor is interested and committed, she probably pays more attention to what the doctor says and is more compliant to these treatments. M4

This attitude is made more tangible in the way one of the interviewees describes a situation where the patient wishes for a longer sick leave than is indicated. In this extract the

clinician describes how she assesses the patient's view on an emotional level to negotiate a mutual understanding between the patients' goal and a medically indicated solution:

> In the discussion with the patient, we need to evaluate her worries, if there's something she fears to bring about, and her views on why she can't return to work. And only from this we could move on to discuss the doctor's view to the pros and cons of either returning to work or staying home. It's really just discussing and evaluating all the aspects, instead of just categorically stating that the sick leave will not continue, which I don't think would really serve the co-operation between us or her ability to stay at work. F1

In this discourse, the clinicians can also appear as subjective actors who experience situations on an emotional level and may need the support from colleagues. In this extract, the clinician describes this aspect:

> Maybe it's like this particularly in psychiatry, I mean that we, like, reflect these issues in the work community. I would think that there's a more natural and longer tradition in psychiatry in this… but I would assume that in somatics there would be a similar need to discuss these issues on some forum, just to get the support and advice from colleagues without needing to fear the label of a lousy doctor because of difficulties with a patient or the family. F1

The clinician describes the psychiatric work culture by comparing it to other medical specialties and emphasizes also the clinicians' needs for understanding, support and advice.

### *Changing from one discourse to another*

Even though a particular discourse of the three was usually dominant in an individual clinician's interview talk, most of them applied more than one discourse. They also changed the discourse even within short descriptions of events in their talk.

> Providing knowledge to the patient and facing her disappointment and anger when the psychiatric resources cannot meet her demands. And still these 20 minutes' appointments are insufficient when we need to both hear the patient and reason the decision. It's important to accept the patient's frustration, so that it will not end in a formal complaint, but it stays in the situation. So I think the time and manner of interaction are crucial. F8

In this extract, the clinician discusses psychoeducation and resource allocation, which is characteristic to medical standpoint discourse, as well as the need for emotional support, which is typical to both patent's subjective experience discourse and psychodynamic standpoint discourse.

The discourses we have extracted from the clinicians' interview talk are ideal types representing the treatment cultures in current psychiatry. The medical standpoint discourse represents a biomedical frame in which evidence-based knowledge, organizational guidelines and resource allocation are important. The psychodynamic standpoint discourse, in turn, reflects the psychodynamic aspects of doctor–patient interaction and the need for therapeutic encounter. The patient's subjective experience discourse connects these views to a more holistic approach where patient-centeredness is important.

The general thrift in the previous literature on SDM in psychiatry is to take the distinction between the paternalistic and the autonomous model of decision making as a starting point for the analysis. In this article, we seek to provide a more nuanced analysis on SDM by taking into account how the observed conflict and it's magnitude between patients' individual goals and other affecting issues affects how the clinicians choose their discourse.

## Discussion

In their talk about shared decision-making, the clinicians apply three discources, termed the medical standpoint, the psychodynamic standpoint and the standpoint of the patient's experience. By this they view conflicts and their solution between the diverse expectations from both the patient and the mental health care system, such as the ideal of patient-centeredness, EBM, therapeutic interaction and organizational requirements.

The psychiatrists' interview talk depicts a continuum from paternalistic and clinician led to autonomous and patient informed communication and decision making. In the literature, it has been shown that clinicians are balancing their medical authority with the sensitivity of maintaining a therapeutic treatment relationship with the patient [30,31]. The interaction between the clinician and the patient is placed somewhere on the continuum and the autonomy or paternalistic decision making takes different forms in the three discourses analyzed in this article.

Previous studies show how the difficulties in SDM stem from the clinicians being more task-oriented in their communication, when the patients emphasize being seen and heard individually [4,7,10,32,37]. Also, clinicians seem to favour SDM when patients are well informed and when the decisions are related to psychological issues rather than medication [8,19,20]. This study confirms some of these observations, but shows how the interaction aims at several ways of conducting SDM. The clinicians' attitudes towards SDM stem from the wider treatment cultures in psychiatry, that provide the clinicians three different ways to position themselves in clinical encounter.

The medical standpoint is close to a traditional paternalistic model of decision making and conveys medical and organizational objectives of psychiatric care. It emphasizes distinct diagnostic categories, psychoeducation and evidence-based medicine. It also takes into account the resource allocation and the priorities of the treatment. The medical standpoint responds to clinicians' need for task-orientation as well as patients' need to be well-informed [10].

The psychodynamic standpoint centers on the dynamical aspects of doctor–patient interaction and treatment cultures in psychiatry. The discourse also takes into account the clinician's own dynamics. The therapist position resembles the earlier psychoanalytic frame where the clinician takes a neutral rather than supporting stand and the understanding of

the situation and patient's needs rests on the clinician's interpretation [38,39].

The idea of SDM is most evident in the standpoint of the patient's experience. It emphasizes the need to negotiate a mutual understanding on the treatment decision. It also responds to the patients' need for individual encounter. This stnadpoint mediates between and combines different aspects such as medical demands and patients' perspectives [30,31].

Decision-making in clinical practice needs to correspond to several requirements such as EBM, SDM, patients' need for individual encounter, therapeutic interaction, providing information and organizational demands. In order to answer these requirements, the clinicians use the three discourses, which differ in the requirements they emphasize.

The psychodynamic standpoint and the standpoint of the patient's experience both stress patient-centeredness and aim to construct a therapeutic relationship with the patient to enhance SDM. The medical standpoint, in turn, employs more direct way to proceed in the SDM. In order to provide evidence-based care, the medical standpoint aims to implement the guidelines and the research evidence into the treatment, whereas the standpoint of the patient's experience attempts to apply the guidelines with the consideration of the patient's individual goals and psychosocial needs. The therapist values clinician's experience and clinical judgement over the EBM guidelines.

The clinicians change from one discourse to another when they describe different treatment situations. Most of the clinicians apply several discourses. This reflects the diverse aspects and purposes of psychiatric decision-making. Similar discourses and position-shifts are evident in somatic medicine, for instance in clinicians' discussions on end-of-life decision-making [40]. This reflects the general nature of the different discourses in psychiatric treatment culture.

All the discourses emphasize EBM as the goal of decision making to a major or at least some extent and in this sense, they do not reflect patient empowerment, but rather describe positions of negotiation between the different goals in psychiatric treatment. For the clinicians, SDM is an ideal they try to implement into the discussions with the patient of the risk-benefit assessments of treatments or diagnostic decisions [4,9,29] and it is not an easy task to achieve amidst the various other demands for the treatment [26].

In Finland, there are several Evidence-based Clinical Practice Guidelines for mental disorders, which bind the clinicians' practice also legally. In addition to the demands of evidence-based care, the clinicians also have to take into account various organizational demands stemming from the mental health care system and limited resources of time and treatment options available. This interview study focused on the clinicians' attitudes towards SDM and it was not possible to focus on the actual practice, which would require a different kind of study protocol. SDM has several benefits such as improved patient satisfaction and active participation in care [23–26]. However, as EBM guidelines and the limits of the mental health care system bind the clinicians' practice, they need to coordinate SDM with the other goals of medical decision making.

## Disclosure statement

H-M.H. and L.H. have no interest of conflict. J.K.: Honoraries: Lundbeck, Sunovion, Biocodex. Member of advisory board of Jansen-Cilag. Congress travels with Lundbeck and Servier.

## Notes on contributors

***Hanna-Mari Hilden*** MD, PhD, is Associate Chief Physician in Helsinki University Hospital, Psychiatry, Mood Disorders Department. Her research mainly focuses on medical ethics and social medicine.

***Lotta Hautamäki*** PhD, is a post-doctoral researcher at Tampere University. Her research draws from science and technology studies, medical anthropology and sociology to understand the interplay between patients and professionals in psychiatry.

**Jyrki Korkeila** Professor of psychiatry in the University of Turku since 2007, chief psychiatrist in Harjavalta hospital, and a private practice psychotherapist and psychiatrist. Research interests: clinical epidemiology, psychiatric services.

## References

[1] Armstrong D. Professionalism, indeterminacy and the EBM project. BioSocieties. 2007;2:73–84.
[2] Charles C, Gafni A, Whelan T. Decision-making in the clinician-patient encounter: revisiting the shared treatment decision-making model. Soc Sci Med. 1999;49:651–661.
[3] Cooper B. Evidence-based mental health policy: a critical appraisal. Br J Psychiatry. 2003;183:105–113.
[4] Eliacin J, Salyers MP, Kukla M, et al. Factors influencing patients' preferences and perceived involvement in shared decision-making in mental health care . J Ment Health. 2015;24:24–28. DOI: 10.3109/09638237.2014.954695.
[5] Goossensen A, Zijlstra P, Koopmanschap M. Measuring shared decision making processes in psychiatry: skills versus patient satisfaction. Patient Educ Couns. 2007;67:50–56.
[6] Goss C, Moretti F, Mazzi MA, et al. Involving patients in decisions during psychiatric consultations. Br J Psychiatry. 1993;5:416–421.
[7] Maassen EF, Schrevel SJC, Dedding CWM, et al. Comparing patients' perspectives of "good care" in Dutch outpatient psychiatric services with academic perspectives of patient-centred care. J Ment Health. 2016;26:84–94. DOI: 10.3109/09638237.2016.1167848.
[8] Caiata-Zufferey M, Schulz PJ. Physicians' communicative strategies in interacting with internet-informed patients: results from a qualitative study. Health Communication. 2012;27:738–749.
[9] Hautamäki L. Uncertainty work and temporality in psychiatry: how clinicians and patients experience and manage risk in practice? Health Risk Soc. 2018;20:43–62. DOI: 10.1080/13698575.2018.1442918.
[10] Hill SA, Laugharne R. Decision making and information seeking preferences among psychiatric patients. J Ment Health. 2006;15:75–84. DOI: 10.1080/09638230500512250.
[11] Rose N. Disorders without borders? The expanding scope of psychiatric practice. BioSocieties. 2006;1:465–484.
[12] Speed E. Discourses of consumption or consumed by discourse? A consideration of what "consumer" means to the service user. J Ment Health. 2007;16:307–318. DOI: 10.1080/09638230701299210.
[13] Toiviainen H, Vuorenkoski L, Hemminki E. Physicians' opinions on patients' requests for specific treatments and examinations. Health Expect. 2005;8:43–53.

[14] Thomson S, Doody G. Parallel paths? Patient and doctor priorities in psychiatric outpatient consultations. J Ment Health. 2010;19: 461–469.

[15] Drake RE, Deegan PE. Shared decision making is an ethical imperative. Psychiatr Serv. 2009;60:1007. DOI: 10.1176/ps.2009.60.8.1007.

[16] Drake RE, Deegan PE, Rapp C. The promise of shared decision making in mental health. Psychiatr Rehabil J. 2010;34:7–13. DOI: 10.2975/34.1.2010.7.13.

[17] Mikesell L, Bromley E, Young AS, et al. Integrating client and clinician perspectives on psychotropic medication decisions: developing a communication-centered epistemic model of shared decision making for mental health contexts. Health Commun. 2016;31:707–717.

[18] Koivusalo M, Ollila E, Alanko A. Johdanto. In: Koivusalo M, Ollila E, Alanko A, editors. Kansalaisesta kuluttajaksi. Markkinat ja muutos terveydenhuollossa. Helsinki: Gaudeamus; 2009. p. 9–20.

[19] Hamann J, Mendel R, Cohen R, et al. Psychiatrists' use of shared decision making in the treatment of schizophrenia: patient characteristics and decision topics. Psychiatr Serv. 2009;60:1107–1112. DOI: 10.1176/appi.ps.60.8.1107.

[20] Hamann J, Mendel R, Bühner M, et al. How should patients behave to facilitate shared decision making-the doctors' view. Health Expect. 2012;15:360–366.

[21] Sigrunarson V, Moljord IEO, Steinsbekk A, et al. A randomized controlled trial comparing self-referral to inpatient treatment and treatment as usual in patients with severe mental disorders. Nord J Psychiatry. 2017;71:120–125.

[22] Strand M, von Hausswolff-Juhlin Y. Patient-controlled hospital admission in psychiatry: a systematic review. Nord J Psychiatry. 2015;69:574–586.

[23] Ellegaard T, Bliksted V, Lomborg K, et al. Use of patient-controlled psychiatric hospital admissions: patients' perspective. Nord J Psychiatry. 2017;71:370–377. DOI: 10.1080/08039488.2017.1302505.

[24] Moljord IEO, Lara-Cabrera ML, Salvesen Ø, et al. Twelve months effect of self-referral to inpatient treatment on patient activation, recovery, symptoms and functioning: a randomized controlled study. Patient Educ Couns. 2017;100:1144–1152. DOI: 10.1016/j.pec.2017.01.008.

[25] Ellegaard T, Mehlsen M, Lomborg K, et al. Use of patient-controlled psychiatric hospital admissions: mental health professionals' perspective. Nord J Psychiatry. 2017;71:362–369. DOI: 10.1080/08039488.2017.1301548.

[26] Metz MJ, Veerbeek MA, Twisk JWR, et al. Shared decision-making in mental health care using routine outcome monitoring: results of a cluster randomised-controlled trial. Soc Psychiatry Psychiatr Epidemiol. 2019;54:209–219. DOI: 10.1007/s00127-018-1589-8.

[27] Kristensen S, Mainz J, Baandrup L, et al. Conceptualizing patient-reported outcome measures for use within two Danish psychiatric clinical registries: description of an iterative co-creation process between patients and healthcare professionals. Nord J Psychiatry. 2018;72:409–419. DOI: 10.1080/08039488.2018.1492017.

[28] Hamann J, Leucht S, Kissling W. Shared decision making in psychiatry. Acta Psychiatr Scand. 2003;107:403–409.

[29] Colombo A, Bendelow G, Fulford B, et al. Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. Soc Sci Med. 2003;56:1557–1570.

[30] Seale C, Chaplin R, Lelliott P, et al. Sharing decisions in consultations involving anti-psychotic medication: a qualitative study of psychiatrists' experiences. Soc Sci Med. 2006;62:2861–2873.

[31] Angell B, Bolden GB. Justifying medication decisions in mental health care: psychiatrists' accounts for treatment recommendations. Soc Sci Med. 2015;138:44–56.

[32] Gee A, McGarty C, Banfield M. Barriers to genuine consumer and carer participation from the perspectives of Australian systemic mental health advocates. J Ment Health. 2016;25:231–237. DOI: 10.3109/09638237.2015.1124383.

[33] Helén I, Hämäläinen P, Metteri A. Komplekseja ja katkoksia: psykiatrian hajaantuminen suomalaiseen sosiaalivaltioon. In: Helén I, editor. Reformin pirstaleet: mielenterveyspolitiikka hyvinvointivaltion jälkeen. Tampere: Vastapaino; 2011. p. 11–69.

[34] Ethical Board internet guideline of the University Hospital of Helsinki. Available from: https://www.helsinki.fi/en/research/research-ethics

[35] Silverman D. Doing qualitative research: a practical handbook. London: Sage; 2000.

[36] Potter J, Wetherell M. Unfolding discourse analysis. In: Wetherell M, Taylor S, Yates SY, editors. Discourse theory and practice: a reader. London: Sage; 2001. p. 198–209.

[37] Noble LM, Douglas BC, Newman SP. What do patients expect of psychiatric services? A systematic and critical review of empirical studies. Soc Sci Med. 2001;52:985–998.

[38] Wallerstein RS. Merton Gill, psychotherapy, and psychoanalysis: a personal dialogue. J Am Psychoanal Assoc. 1997;45:233–256.

[39] Parsons M. 2000. The dove that returns, the dove that vanishes. Paradox and creativity in psychoanalysis. London: Routledge.

[40] Hildén HM. Making decisions in the face of death: physicians' and nurses' views of end-of-life decision-making and patient participation. Helsinki: Yliopistopaino; 2005.