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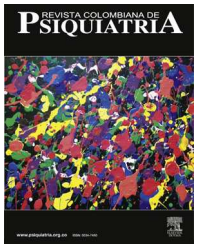

Editorial

Shared Decisions

Decisiones Compartidas

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One of the most important and complex processes of transforming medical activity began to develop in the second half of the 20th century. This change involves what is currently known as "shared decision making" (SDM). For centuries, it was the physician's prerogative to define the health problem and decide for the patient (and/or the relatives, or even in the face of what other health professionals or society sectors believed) what the most appropriate course of action to solve the problem would be. This attitude has commonly been called medical paternalism and was, in its time, seen as correct from the epistemological (the physician is the one who knows the most about health and disease), the ethical (the physician's intention is always good) and the moral point of view (society bestows this prerogative to the doctors). However, just as with other aspects of health and disease, the historical moment is decisive when interpreting the events that affect human beings and when organising the transactions among the various sectors of society. This transformation has been attributed to erosion of confidence in medicine as a profession, in addition to ever-greater doubts as to the integrity of the institutions, organisations and systems that provide health services. In turn, this situation has been linked to multiple factors, among which the following stand out: a) nowadays, individuals confront traditional authority in numerous fields and in medicine people now consider not only the expert's knowledge to be important, but also their own experience as a valid and necessary element for making decisions; b) there is a tendency to consider that doctors put their own interests above those of their patients; c) the increasingly widespread vision that patient access and participation are restricted by economic interests of both pharmaceutical firms as well as the many stakeholders in the health systems (for example, medical carriers and health promotion companies, among others); d) the unrealistic expectations transmitted to society (stemming from the idea of ever-increasing medical progress as a type of happily inevitable destiny) that medicine offers and guarantees progressively more and better results in its interventions; and e) the practical, ethical and conceptual difficulties derived from shifting the emphasis from cure (related to acute disease) towards emphasis on management (involving chronic disease). In this new context, SDM is being strengthened; SDM, that is defined as the involvement of the patients in the decisions that concern them with respect to diagnosis, prevention, treatment and rehabilitation. Such joint decision making is a significant source of reflection, doubts and problems as to its conception and implementation in psychiatry. As Villagrán et al indicate, modern psychiatrists find themselves divided between "unjustifiably side-stepping the autonomy of the patients to safeguard their welfare, and unjustifiable respect for their autonomy at the cost of that welfare". This balance is undoubtedly difficult and depends on our conceptual open-mindedness, our communication with the patients, our competence and possibilities of assessing the patient's capacity when it becomes time to make a specific decision, and, finally, the assessment of the risk (for the patients themselves and for third parties) that accompany the disease. The good news is that empirical studies tend to support SDM as an effective, safe and ethical way to reach decisions, capable of being implemented even with patients that suffer from severe, persistent mental illnesses. However, we should ask ourselves whether in Colombia we psychiatrists have:

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- space (both during training and in carrying out the profession) to think about SDM and acquire the skills for its implementation
- a social and health system setting favourable to SDM
- a legal and ethical setting that backs the doctor and the patient in making decisions jointly.

The invitation is thus to reflect and try to create the possibilities so that our profession, without having to sacrifice some of its basic principles, can adapt to the new models of relationship and help for patients and society.