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Navigating Challenges in Shared Decision-Making in Danish Patient Care

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Abstract

Patient-centered care and patient choice are reshaping management practices in the Danish public healthcare sector. Patients are becoming more involved in their treatment and assuming greater control over their healthcare decisions. This transformation redefines relationships among patients, professionals, and the state. It raises important inquiries into how healthcare professionals navigate their new roles and responsibilities within this changing landscape. In this paper, we interviewed ten health professionals to delineate how they handle user involvement in daily clinical practice. Utilizing a sociology of profession framework for thematic analysis, our research revealed the disparities between the ideal and the actual implementation of patient-centered care. It highlighted the challenges healthcare professionals encounter in integrating shared decision-making practices and ensuring patients are adequately informed. We conclude that uncertainties regarding responsibility allocation and the boundaries of healthcare professional involvement often overshadow shared responsibility between healthcare professionals and patients.

Keywords

Deliberative democracy, patient choice, patient responsibility, proto-professionalism, shared decision-making

Background

The transformation towards greater patient choice is reshaping the relationship between patients, healthcare professionals, and the state. It has led to a redefinition of roles and responsibilities, as evidenced in studies by Dent (2006) and Dent & Pahor (2015). In the past, health organizations were perceived as interconnected systems consisting of various professions with distinct divisions of labour, reflecting the interests and goals of the professions themselves (Freidson, 1988). Within a hierarchical structure, medicine occupied the top position, while other health professionals had supporting roles and limited involvement in diagnosis and treatment planning (Freidson, 1988). Patients were once viewed as passive recipients of care, while physicians exercised therapeutic privilege to make decisions on their behalf. However, this traditional view of healthcare professionals, which emphasizes their monopolistic control over specialized knowledge and skills, fails to capture the complexities of modern healthcare systems (Kelley, 2005). As patient involvement increases, understanding how healthcare professionals respond to this shift becomes crucial. This study investigates how nurses and physicians engage with patients in shared decision-making.

There has been a notable shift in the perception of patients, transforming them from passive objects into active participants in their own care (Rose, 1996, p. 119). This shift is supported by healthcare policies that promote choice and involvement, particularly through informed consent and shared decision-making, encouraging patients to take an active role in their healthcare processe**s** (Edwards & Elwyn, 2006; Sandman & Munthe, 2009). Informed consent and shared decision-making are not synonymous. Informed consent refers to the process of educating patients about their treatment options, including the associated risks and benefits, enabling them to make voluntary and informed healthcare decisions (Slim & Bazin, 2019). While informed consent is a critical component of the healthcare interaction and serves a moral and legal obligation, it does not inherently indicate an active shared decision-making process. Informed consent can occur independently of shared decision-making, as patients may consent to treatment without fully engaging in a collaborative decision-making dialogue.

On the other hand, shared medical decision-making is defined as “a process by which patients and providers consider outcome probabilities and patient preferences and reach a health care decision based on mutual agreement” (Frosch & Kaplan, 1999, p.285). Shared decision-making involves a deeper level of patient engagement, wherein patients not only receive information but actively participate in the decision-making process regarding their care. Despite policies promoting user involvement, the dynamics of shared decision-making can be empowering yet disempowering. Healthcare professionals significantly influence these interactions, often focusing predominantly on biomedical topics in consultations and thus overlooking broader aspects of the patient's illness management (Franklin et al., 2019; Say et al., 2006). Furthermore, research indicates that patients' ability to engage in shared decision-making may be hindered by insufficient knowledge, and healthcare professionals often lack the necessary resources—such as time—to facilitate meaningful involvement (Rose et al., 2017; Sjöberg & Forsner, 2022). In addition, studies indicate that healthcare professionals predominantly focus on biomedical topics in treatment consultations, often overlooking broader aspects of the patient's management of their illness (Jensen et al., 2016).

Proto-professionalization among patients

Patient participation in clinical decisions is an integral part of the broader framework of patient-centered care, which emphasizes the importance of individual patient needs and values in healthcare delivery. This approach is fostered by legal principles that aim to mitigate physicians' liability by considering the risks and potential adverse events associated with treatment options (Childress & Childress, 2020). Additionally, ethical considerations have driven the pursuit of shared decision-making to create a collaborative environment where patients and health professionals exchange information and jointly make decisions (Childress & Childress, 2020). The goal of respecting and promoting patients' autonomous choices aligns with the principles of *deliberative democracy*, which encourages equitable power distribution and recognizes the patient perspective as vital in healthcare planning (Safaei, 2015). However, as highlighted by Dent (2006), the shift towards responsibilization—where patients are held accountable for their actions—may not yield the intended empowerment. Instead, patients may feel pressured to conform to their physicians' authority rather than actively participate in their treatment decisions. Dent (2006, p. 458) refers to De Swaan (1988) to explain that patients and their families experience a process of "proto-professionalization," influenced by contextual factors in clinical settings. These factors encompass the transmission of values, norms, and attitudes that shape interactions between healthcare professionals and patients, often without explicit acknowledgment. Many patients may not fully recognize these dynamics. For example, some patients intentionally override physician prescriptions and make their own treatment decisions. This phenomenon, termed intentional or intelligent non-adherence, occurs when a patient consciously opts to forgo, skip, or alter recommendations made by a healthcare professional (Lehane & McCarthy, 2007; Náfrádi et al., 2017; Wroe, 2002). In this context, health literacy plays a crucial role, defined as the degree to which patients can process essential health information and services needed for informed decision-making. Health literacy encompasses a range of skills—reading, writing, numeracy, communication, and critical thinking that individuals need to effectively navigate the healthcare system and engage in their care (Chinn, 2011; Schulz & Nakamoto, 2013).

Despite the recognized importance of informed consent and patient involvement as integral concepts of quality care, there remains a significant knowledge gap regarding how these concepts interconnect and influence patient-health professional interactions. Specifically, we lack empirical insights into the strategies healthcare professionals employ to engage patients in shared decision-making and how they consider health literacy in these interactions (Whitney et al., 2004). The extent to which these professionals prioritize patient involvement in decision-making processes remains unclear, underscoring the need for further empirical research to explore these dynamics. Drawing on professions-theory and the concept of deliberative democracy (Dent 2006, Elster 1998, Newman 2001), this study aims to investigate how healthcare professionals—specifically nurses and physicians—respond to varying levels of patient involvement in clinical practice. By examining their approaches to informed consent, risk communication, and shared decision-making, we seek to understand the evolving dynamics of the healthcare professional-patient relationship, particularly in relation to responsibility distribution and the perception of patients' resources and autonomy in decision-making. We ask:

How do healthcare professionals interpret their roles and responsibilities in the context of evolving patient engagement and the dynamics of shared decision-making?

Empirical context—The regulation of Danish health professionals

Like its Scandinavian counterparts, Denmark has implemented a public health service model in which regions own and operate hospitals. The financing of this system relies on general taxation, and access to care is largely free of charge. Historically, physicians and nurses have held influential positions within the healthcare system, enjoying significant autonomy (Kirkpatrick et al., 2011). Physicians have traditionally held a dominant position, while nursing and administrative roles have operated separately (Hindhede & Larsen, 2018). Presently, most health professionals in Scandinavia work as salaried employees in public hospitals. Their employment contracts outline their responsibilities and rights, while the public hospitals have the authority to organize and manage their work. Administrative and political accountability are supported using clinical performance data, patient experience data, and activity data at several levels (Vrangbæk, 2018).

Patient involvement in the Scandinavian health system is achieved through the mechanisms of choice, voice, and co-production (Dent et al., 2011; Vrangbæk, 2015). In Denmark, *choice* includes the ability for patients to select a public hospital when referred. *Voice* involves the establishment of formal rights for citizens within their relationship with the health system. For example, hospitals are obligated to provide patients with information regarding treatment options and associated risks, as well as obtain informed consent before proceeding with treatment. The Danish Healthcare Act §15 (Ministry of Health, 2024) explicitly states that patients should receive continuous, understandable, and customized information regarding their treatment options, including preventive measures and the consequences of not receiving treatment. Patients should also be informed about the potential risks involved in refusing to disclose or collect health information. Healthcare professionals have a responsibility to provide necessary information to patients unless the patient explicitly declines it. These formal rules regarding informed consent are part of a broader model for shared decision-making, which is also observed in Australia, Canada, England, Germany, and the Netherlands (Vrangbæk, 2018). *Co-production* relates to the active involvement of citizens in producing public services together with public organisations, such as bringing together health professionals and patients in the development of clinical guidelines (Dent et al., 2011). In Denmark, this particular aspect of health services is frequently lauded, but according to Vrangbæk, it often falls short of expectations (Vrangbæk, 2018).

Methods

The study is part of a larger research project aimed at gaining insights into how illness can affect people's everyday lives and how it impacts their thoughts and actions regarding their well-being. Questionnaires have been completed among various patient groups receiving treatment at hospitals in the capital region, totalling 500 responses.

In this sub-study, we employed a qualitative research design to explore healthcare professionals' approaches to informed consent, risk communication, shared decision-making, and their perceptions of responsibilities in the context of increasing patient involvement. We contacted the management of the wards that had facilitated access to the questionnaire component of the project (see Table 1), and they provided contact names of healthcare professionals for interviews who had experience with clinical decision-making processes.

Semi-structured interviews were conducted with 10 respondents individually at their respective wards (see Table 1). The interviews were conducted by the first and last author, who had no prior relation to the respondents. They focused on several key areas: the process of obtaining informed consent, strategies for risk communication, and methods of shared decision-making with patients. We also explored the professionals' views on their own responsibilities compared to those of patients, particularly in situations where responsibilities were shifting. To anchor the discussion, we asked respondents to provide a specific example of patient involvement by referencing their most recent patient encounter. The interviews were audio-recorded and transcribed immediately afterwards.

The data analysis process followed an abductive approach (Timmermans & Tavory, 2012). First, the transcribed interviews were imported into NVivo 14 software. The data was then initially coded using predefined subthemes derived from a profession-theoretical framework, which served as a starting point for analysis. However, throughout our coding process and subsequent analysis, we remained attentive to the emergence of new subthemes that extended beyond the confines of the theoretical framework. In doing so, we aimed to acknowledge the significance of potentially unexpected empirical findings and ensure respect for our respondents' statements.

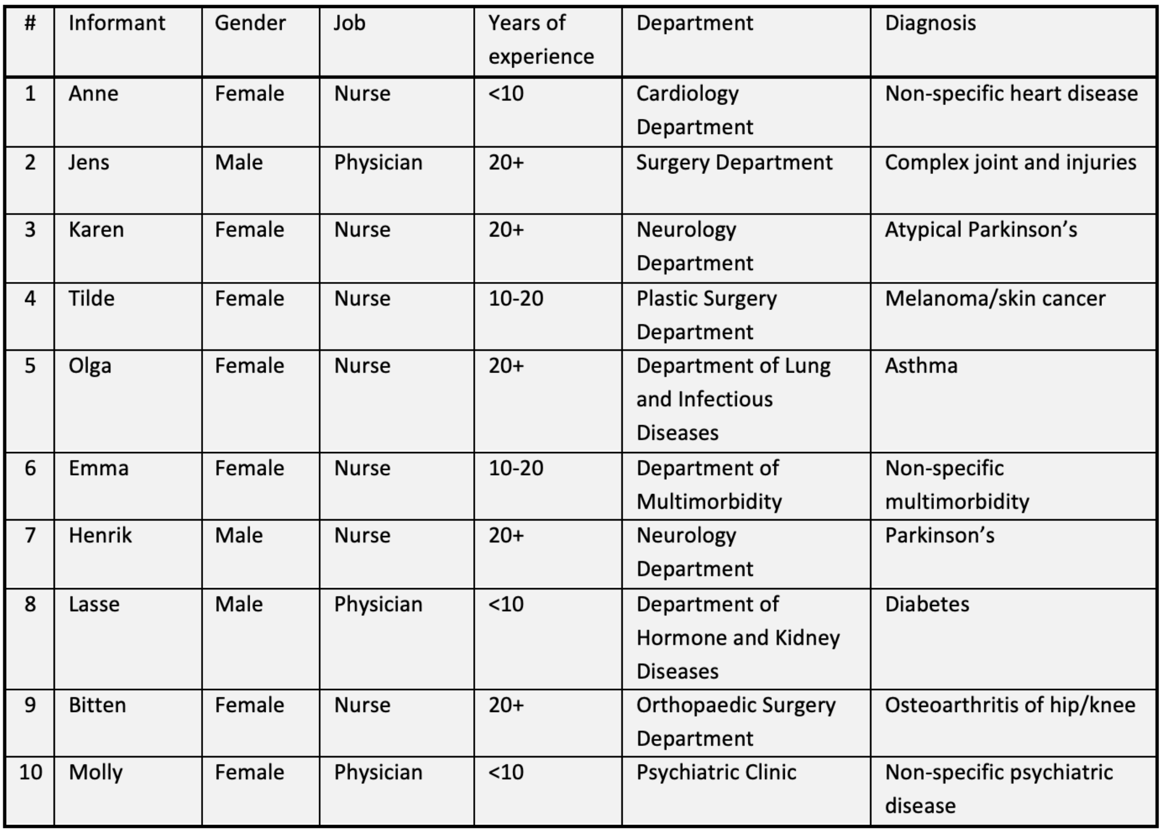
Ethics

Our study was conducted in compliance with the standards of the Helsinki Declaration (World Medical Association, 2013). Informed consent was obtained from all participants prior to their participation in the study. The participants were assured of their confidentiality and the anonymity of their responses, and pseudonyms were used to protect the identity of the respondents in all research outputs. The data collected from the interviews was securely stored and accessible only to the research team.

The project is registered in the Research Project Registry of the Capital Region (no. P-202-764) in accordance with Article 30 of the General Data Protection Regulation and was registered in Clinical Trials.

Table 1

Respondents



#	Informant	Gender	Job	Years of experience	Department	Diagnosis
1	Anne	Female	Nurse	<10	Cardiology Department	Non-specific heart disease
2	Jens	Male	Physician	20+	Surgery Department	Complex joint and injuries
3	Karen	Female	Nurse	20+	Neurology Department	Atypical Parkinson’s
4	Tilde	Female	Nurse	10-20	Plastic Surgery Department	Melanoma/skin cancer
5	Olga	Female	Nurse	20+	Department of Lung and Infectious Diseases	Asthma
6	Emma	Female	Nurse	10-20	Department of Multimorbidity	Non-specific multimorbidity
7	Henrik	Male	Nurse	20+	Neurology Department	Parkinson’s
8	Lasse	Male	Physician	<10	Department of Hormone and Kidney Diseases	Diabetes
9	Bitten	Female	Nurse	20+	Orthopaedic Surgery Department	Osteoarthritis of hip/knee
10	Molly	Female	Physician	<10	Psychiatric Clinic	Non-specific psychiatric disease

Findings

We identified three main themes that capture the key findings of our analysis, illuminating the evolving relationship between healthcare professionals and patients, especially regarding responsibility distribution and decision-making involvement:

1. Informed consent in practice. This theme explores the different practices of informed consent among healthcare professionals across different departments, highlighting the factors that influence these variations and the implications for patient engagement.

2. Objectives of patient information sharing. This theme explores the motivations and reasoning behind sharing information with patients, focusing on how healthcare professionals perceive the role of patient knowledge in healthcare decision-making and the challenges they encounter in communicating "effectively."

3. Ambiguities in responsibility assignment. This theme addresses the ambiguities surrounding the delineation of responsibility in patient care, examining how healthcare professionals and patients negotiate their roles in the decision-making process and the implications for collaborative engagement.

1. Informed consent in practice

Across departments, healthcare professionals had widely different approaches to *patient-centered care*, and there was no systematic approach in the healthcare professionals' enactment of patient choice. While physicians were the ones with jurisdiction over clinical decision-making, this was often done in union with the group of nurses. When healthcare professionals distributed information to patients, it depended on both the healthcare professional's belief in terms of the right type and amount of knowledge, as well as what they assessed the patient wanted in terms of information. However, a common practice among all respondents was a stated intention for the patient to leave the department well-informed and ready to make decisions and act upon them.

1.1 Information conveyed in writing

The method of information delivery varied significantly not only between departments but also internally within the respective department. When asked whether a standardized brochure or information was given to patients, Anne responded: "No, it is a bit difficult to provide such one. It's not like we all do it the same way, so we don't have a guideline that everyone should be informed about this or offered that in a precise manner." Anne expressed that there is no specific way to practice informed consent, but it is instead up to the individual healthcare professional to assess whether a brochure or another oral or written offer is relevant to the patient. This indicates significant differences in how healthcare professionals handle shared decision-making. Anne explained how some of her colleagues preferred to provide large amounts of brochures for the patient to sort through themselves, while others orally conveyed information. The choice of providing a large amount of written information was something respondent Tilde had doubts about:

> We often discuss whether we hand out too many brochures, but patients say that they would rather have everything and then sort through it themselves. We don't hand out any brochures until we have a final diagnosis. When we have patients in the outpatient

> clinic before they receive the diagnosis, we also try to advise them not to go out and Google everything.

Tilde had an idea that knowledge distribution to the patient should be individualised. She sought a collaborative relationship with the patients, considering their needs and offering guidance where necessary. Furthermore, her suggestion to advise patients not to rely solely on internet searches shows an understanding of patients' challenges in interpreting (medical) information. While there are different viewpoints on patients seeking information independently, Tilde acknowledged the difficulty in determining what is right for everyone. This recognition of individual needs and circumstances reflects a deliberative approach that values individual autonomy by tailoring information to suit each patient's specific situation. The dilemma of providing too many brochures versus allowing patients to sort through information themselves aligns with deliberative democracy theory, emphasizing patient autonomy and the right to access information.

1.2 Information conveyed orally

Contradictory approaches to knowledge sharing became particularly evident when the respondents discussed orally delivered information. Jens stated that his practice primarily relied on oral delivery methods. When asked if he expected patients to remember the information provided orally, he responded: “Never believe what a patient says, the doctor said, because [...] they can't, they can't process that much.” Jens expressed doubts about patients' ability to grasp the orally provided information. However, he also explained his method of practicing shared decision-making with young, physically active patients making decisions about returning to football post-surgery: “Yeah, I set up scenarios for if they go back (to playing football), there are these risks, and what is the consequence if they do it anyway. [...] As much as possible with a small percentage.” Contradictions arise in these quotes; Jens doesn't believe patients can process large amounts of information, yet engages them in decision-making involving complex risk assessments. Understanding options in this context requires significant health literacy, which can be demanding for many patients—something Jens acknowledged, as many preferred him to make the decision. From Dent's perspective on choice, Jens' approach to knowledge sharing may be disempowering. In contrast to the nurses interviewed, he appeared to have elevated expectations regarding patients' ability to comprehend and act on the information, concluding: “Well...mixed. I expect that they understand it.” Although unsure whether patients truly understood the information, he nonetheless expected them to do so. This tension between professional expectations and patient understanding contributes to the complexities of responsibility distribution.

Karen reinforces this issue by discussing the difficulty patients face when they disagree with physicians, especially regarding treatment decisions. She states:

> And it is really hard when you have to say no to a doctor, who offers you treatment for a UVI. Even though we have had the conversation here, and our patient has said, when that time comes, I do not want treatment, because I want this to end.

This suggests that patient expression of their own needs can be particularly challenging when interacting with authoritative figures in healthcare. According to Karen, this can lead to disempowerment, forcing a sense of responsibility onto patients about physician recommendations that may not align with their desires.

Interestingly, while some respondents illustrated disempowering knowledge-sharing practices, empowering approaches also emerged. According to the respondents, when healthcare professionals provided detailed information about patients' upcoming choices and adapted their practices to better meet individual patient needs, they effectively empowered patients in the decision-making process. Emma described her patients as positive when receiving specific instructions, even if they didn't intend to follow them: "I also think that those who wish not to follow the instructions are positive about the knowledge sharing or recommendation, and when one explains why." Emma's emphasis on explaining the reasoning behind recommendations demonstrates respect for patient autonomy and supports empowering decision-making regarding health outcomes.

2. Objectives of patient information sharing

The consensus among all respondents was that patients should have the necessary information to make informed decisions and act accordingly. While there was a clear desire for patients to be well-informed, some uncertainty remained regarding how to ensure this is consistently achieved.

2.1 A well-prepared and autonomous patient

One objective of achieving a highly informed patient was ensuring they were prepared to make independent decisions about future treatments. As Karen stated: "So if someone wants to eat everything because it brings the most quality of life, then that's what they should do. But then they need to be equipped to make that choice by knowing the consequences." However, it remained unclear how to define a well-informed patient and whether this could be achieved through straightforward communication, regardless of the patient's wishes, or through communication tailored to their preferences. Most respondents expressed uncertainty about balancing comprehensive information delivery—often meant to safeguard their practices—against being attuned to individual patient understanding. Tilde voiced this struggle:

> No, because they can't, they can't receive that. There is just too much, they are overwhelmed, and they have been told that they have a cancer diagnosis. Yeah. So, I don't think it does any good. Except that I can check it off my list and say I have lived up to my obligation of providing information.

Tilde described the difficulty of finding a balance between being honest and adapting the amount of information provided. While there is a desire to check off the information provided on the list to cover her practice, Tilde believed that the patient's condition and receptiveness take precedence over this need. Anne also acknowledged this dilemma but addressed the necessity for the patient to understand the situation in a different manner:

> If you sense that they haven’t fully grasped the seriousness of it, it’s important to talk about this being “a really serious, uhm, what’s it called, illness you have,” and you can say, “now you’re getting some medication, and you’ve had a balloon angioplasty, but there are also some things you need to do to prevent this from happening again.”

These diverse approaches to defining and achieving a well-informed patient reflect the underlying power dynamics in patient-professional relationships, where healthcare professionals ultimately determine the flow of information.

2.2 The health literacy-information link

The interviews also underscored the considerable influence of a patient’s health literacy on various aspects of healthcare professionals’ interactions with them, ranging from communication method selection to the patient’s comprehension and adherence to treatment. This impact was especially pronounced in specialized departments such as Neurology, which focuses on Atypical Parkinson’s disease, emphasizing how thorough knowledge of one’s diagnosis can enhance the treatment journey. When patients displayed signs of lacking understanding about the diagnosis progression and the recommended interventions, inadequate health literacy regarding the diagnosis emerged as a contributing factor:

> I actually think for the most part, it’s about the difficulty understanding because neurology is hard to grasp, the brain is difficult to comprehend. And the symptoms are hard to understand. [...] It requires a lot of knowledge. It requires extremely extensive knowledge.

In the quote, Karen emphasized the importance of high health literacy in the patient’s understanding of the disease. By understanding the nature of their condition, it could become easier for patients to accept its progression and, thus, act in accordance with the current recommendations. A proactive attitude towards one’s own health also proved to be significant. The patients’ willingness to invest in their own health was positively acknowledged by several respondents and was linked to the responsibility placed on the patient. When Jens was asked whether patients needed to take the lead in managing their illness, he responded: “Yes, you have to take initiative. Absolutely. And what we really emphasize is that the patient is interested in managing their own situation.” Jens explained that a patient’s initiative and engagement in their own health are crucial for how the illness progresses. While it is difficult to interpret specifically what this entails, it carries positive connotations. However, the fact that some patients may lack the means to take on this role may contribute to deteriorating communication and treatment outcomes.

2.3 Patient engagement through coproduction

In exploring patient engagement in health choices using Dent's concept of coproduction, the interviews revealed both empowering and disempowering approaches. All respondents demonstrated an awareness of empowering methods to promote specific health behaviours and shared how they attempted to apply this understanding. This was accomplished through mutual knowledge exchange: health professionals shared their expert insights on the patient's situation while aligning with the patient's actual needs and capabilities for implementing the recommendations. However, a challenge emerged as written information often proved ineffective, resulting in health professionals struggling to ensure that their communicated recommendations were both comprehensible and feasible for the patient. Henrik highlighted this issue when discussing interdisciplinary collaboration:

> When a doctor prescribes something as if it were chiselled in stone, acting like a puppet master directing the patient to the pharmacy, that way of working is not acceptable in my opinion. You must have motivational talks with the patient to understand where they are and whether they even think this is important.

Henrik prioritized understanding the patient's unique circumstances and rejected prescribing treatments without certainty about their relevance to the individual. He advocated for motivational discussions to endorse treatment recommendations, emphasizing the importance of tailoring treatment based on the patient's preferences. Henrik's approach can be viewed as empowering the patient's voice, aligning with Dent's concept of patient participation, where listening to the patient's desires takes precedence over assuming educational needs. The interdisciplinary challenges were further corroborated by nurse Emma, who highlighted the complexities arising from differing professional perspectives:

> It is easy to write that a patient should do (health instructions), and then you think, why hasn't this been streamlined? There is just a long way from it being written in a doctor's note, to a patient who does not want to do (health instructions).

Our respondents highlighted interprofessional differences in the approach to prescribing treatments. Physicians tended to focus on issuing prescriptions with the expectation that these would be understood and followed, whereas nurses emphasized motivational dialogue and considered the patient's individual circumstances.

Despite the intent to uphold an empowering collaborative approach evident in all interviews, the reality did not always align as perceived. Some respondents assessed past recommendations and reflected on why they might not have been effective for the patient. This evaluation often hinged on the extent of patient compliance with the prescribed treatment, potentially leading to a disempowering dynamic in patient care. A tendency towards paternalistic attitudes can surface when healthcare providers overly emphasize patient compliance.

3. Ambiguities in responsibility assignment

Patients and healthcare professionals, respectively, engaged in the negotiation of responsibility assignments. It was clear throughout that ambiguities surrounding the holders of responsibilities and the boundaries in-between actors were present and complicated the process of achieving shared decision-making.

3.1 Assuming responsibility: Patients as primary responsibility holders

According to all the respondents, the patient was seen as a major holder of responsibility, both in terms of making decisions regarding treatment and following treatment instructions. However, navigating the recommended body investments and prioritizing them can be challenging for a patient who does not have the necessary resources. Anne stated that it is largely up to the patient to decide what makes sense for them:

> […] medication is not enough, you also must make changes in your lifestyle if you don't want this to happen again. It's...you could say it's a choice they have to make, whether they want to do it, whether they think it's important enough or whether they think it doesn't matter.

Anne expressed that the patient is responsible for determining what is important. In this quote, the patient is told that they must follow recommendations if they do not want to be admitted again for the same heart condition or symptom. The patient is assigned the responsibility for preventing future illness, which is extensive and requires significant lifestyle changes. The patient may end up in a situation where the responsibility is imposed, but managing that responsibility can be difficult. However, Anne also expressed her own role in the dilemma and how she was unsure about the boundaries of her involvement in the patient's adherence to body investment recommendations:

> But sometimes you also wonder how much you should...how much should you? We shouldn't persuade them, I mean, it's just about informing them why it's relevant for them to quit smoking and what it can mean to continue smoking, and based on that, the patient must make a choice about what they prefer.

This can be understood as the healthcare professional feeling uncertain about when their guidance with the patient has been sufficient. The boundaries between the patient's responsibility for their own treatment and the healthcare professional's responsibility to convey and support the recommendations may seem unclear. The healthcare field the patient must navigate has implicit values, and patients who know the rules are better able to manage the received knowledge. The enforced responsibility could, in the case of a resourceful patient, be seen as a personal advantage, when having the capability to handle it. This was clear when

Bitten reframed the word responsibility when discussing the patient's rising responsibility as a result of accelerated patient courses: "Yeah, responsibility or also, you know, freedom." A resourceful patient may perceive the increased responsibility associated with accelerated patient courses as a form of freedom, thereby giving the patient a sense of empowerment. However, when a patient lacks the capacity to manage this responsibility, it may result in responsibilization and disempowerment.

3.2 Shaping responsibility: The role of healthcare professionals

Every informant reflected on their own role in the distribution of responsibility, and Jens, Anne, and Karen expressed uncertainty about the allocation of responsibility. The uncertainty often stemmed from their desire for patients to make choices regarding the various body investments, but with the understanding that their professional influence greatly influenced the outcome:

> Yeah, some people say, "oh, you just put the responsibility on me, right?" (imitates patient). And it's like, yeah, I do, because it's your knee, so it's you who must make the decision, right? There are probably many people who want you to make the decision for them, and to some extent you do. It's not that you make the final decision because they have to say yes to it, but you recommend something, and they usually listen, especially if you appear reasonably trustworthy, they usually follow your recommendation.

In this quote, Jens illustrated a dual reality in which, on one hand, it is expected that the patient shows independence and takes responsibility for deciding whether to undergo surgery. On the other hand, Jens explained that he often assumed a guiding role in the direction the decision took and that he almost determined it in his guidance. While the intention to achieve shared decision-making can be observed, the healthcare professional's perspectives appear to significantly impact the final decision. Thus, there is a push for responsibilization, but where the idea of *choice* is transformed into a mere rhetoric. This dynamic can create confusion for patients as they navigate between a healthcare professional with a clear agenda and their own desire to demonstrate initiative and willingness in making health-related decisions. Thus, the quote illustrates uncertainty regarding the allocation of responsibility between the patient and the healthcare professional. Similar uncertainty was also observed between departments. Anne stated: "And sometimes we just have to do the best we can and hope that...that someone picks it up at the other end or that they themselves gather the things they need when they go home, right?" In addition to uncertainty between the patient and the healthcare professional, there can also be uncertainty about which department is responsible. Anne explained that although lifestyle changes were a significant part of the Cardiology department's treatment, they did not provide guidance on it. They hoped that the cardiology outpatient clinic would address lifestyle changes, but she did not have confirmation that they did.

Discussion

We found that the approaches to informed consent (Theme 1) impact the objectives of patient information sharing (Theme 2) and subsequently influence the assignment of responsibility (Theme 3). Based on our findings, we will discuss the nuances of risk communication, variability in patient knowledge, and the broader challenges faced in fostering meaningful patient involvement in decision-making.

Pursuing shared decision-making in clinical practice

It was evident that the practice of presenting treatment options and asking patients to make a choice is commonplace. However, the interviews also revealed that the level of guidance by healthcare professionals is often underestimated. For instance, physicians explained that when the risk of not pursuing treatment is significant, they would specifically emphasize risks, especially if the patient appeared inclined to decline treatment. Such risk communication is—according to Edwards & Elwyn (2009)—part of clinicians' everyday practices and lie at the heart of helping patients make informed choices between treatment options. Dent (2006) argues that the idea of *choice* is transformed into a mere rhetoric and a series of management practices, which certain individuals within the profession perceive as undermining their role as independent, authoritative, and knowledgeable health advisors.

We also found that the kind of knowledge patients brought to these shared decision-making encounters varied from that of the health professionals. De Swaan's concept of "proto-professionalization" suggests that patients and their families undergo a process of being socialized into a certain professional culture within the clinic or consulting room. As a result of this, some patients learn to internalize medical norms previously confined to the professional domain, and they learn to express their concerns using a limited range of terms derived from the professional vocabulary. Professionalism has been "responsibilized" within the new managerial rhetoric, becoming more of a disciplinary framework than a result of autonomous expertise. According to Dent (2006), proto-professionalism may indicate systematically distorted communications between patients and health professionals and should not be mistaken for a broader loss of confidence in the medical profession or health care services in general.

When patients as consumers are faced with responsibilization, they are confronted with the task of acquiring a wide range of knowledge. The healthcare system, built on providing expertise to healthcare providers, has developed entrenched professional power within this expert-based service system (Anderson et al., 2016). Even when patients as consumers are motivated to learn, formal educational structures may be necessary to assist them in their participatory processes. Access to resources, such as additional time with healthcare providers to enhance consumer expertise or the ability to access and understand medical knowledge, becomes crucial. In our data, it was clear that time pressure prohibited this. The lack of readily available information and effective methods for its implementation highlights an additional area of expertise that patients, as consumers, must acquire without a structured support system to guide them. Moreover, as seen in the interviews, limitations in understanding the disease may constrain the types of self-experimentation that patients as healthcare consumers attempt (e.g., when continuing to play football despite increased risk of joint diseases), as their own understanding of behaviours that could impact their health determines the focus of their self-experimentation efforts.

Establishing common ground in patient-professional collaboration

An emphasis on the wishes of patients as *users* is seen as a means to the end of good quality care (Dent 2006). We found that patients' social support in consultations, according to our respondents, also has an impact on shared decision-making, which aligns with the study of Holmes-Rovner and colleagues (2000). Shared decision-making in the present Danish healthcare system faces conceptual, normative, and practical challenges. In its truest sense, shared decision-making occurs only when real choices are available, and the physician involves the patient in the decision-making process. However, it may not always be suitable to employ shared decision-making, particularly when the available options are limited (Edwards & Elwyn, 2006; Whitney et al., 2004). Fragmentation within the healthcare system and the presence of multiple and conflicting discourses from providers can overwhelm patients as they navigate this process. They may lack the ability to compare and manage the extensive amount of information coming from various sources, making it challenging to determine what to test to evaluate its effects on their well-being.

When examining the driving forces behind these changes, it is essential to underscore the agency of professions, as well as the role of external forces: "opening and losing areas for jurisdiction and by existing or new professions seeking new ground" (Abbott, 1988, p.90). Furthermore, the evolution of regulatory frameworks, such as deliberative democracy, has the capacity to reshape divisions of labour independently of the influence of professions. Consequently, these forces have the potential to undermine the positions of professions, ultimately leading to a loss of status and autonomy (Kirkpatrick et al., 2011).

In our study, we discovered that while health professionals offer information resources, knowledge, perspectives, and action strategies, the information shared between patients is often more experimental than the information provided by clinicians. This means that the shared information may or may not be consistent with each other. Another challenge patients face in their efforts towards taking responsibility for their health is that even with access to health information, they frequently find themselves lacking the necessary expertise. Anderson et al. (2016, p.270) refer to this ability as "appropriation," which involves health consumers' capacity to handle vast amounts of information, transform it into expertise, and effectively apply those resources to enhance their well-being. Without the appropriation of knowledge from experts within the healthcare system, patients as consumers are less likely to achieve their desired well-being outcomes. Our findings included cases in which patients were portrayed as giving precedence to personal values and preferences, as argued in existing literature (Lehane & McCarthy, 2007; Náfrádi et al., 2017; Wroe, 2002), emphasizing the value of achieving shared decision-making and thus aligning patient-needed and professional- recommended care.

Communication approaches and interprofessional variations

The literature on treatment decision-making (Franklin et al., 2019; Say et al., 2006) often conceptualises physicians' interaction styles as situated along a continuum from paternalism to the promotion of patient autonomy, with the former frequently regarded as less desirable. However, in our study, the health professionals did not explicitly question the problematic aspects of the patient-physician relationship encouraged by current decision-making practices. Health professionals' narratives revealed that patients with varying perspectives on the physician-patient relationship may approach the common practice of presenting treatment options and asking the patient to decide in different ways. Furthermore, our study revealed differences between nurses and physicians in their approach to patient treatment choices. Nurses tended to prioritize motivational talks and suiting treatment to the patient's individual circumstances, whereas physicians often had high expectations regarding the patient's knowledge and ability to both choose and adhere to the prescribed treatment. While all respondents demonstrated an understanding of empowerment-focused approaches, there was a notable tendency for these ideals to be challenging to implement in practice with barriers as time limitations and unclear role assignment, which have been identified as barriers to improve shared decision-making (Rose et al., 2017). The interprofessional variations were particularly highlighted by the group of nurses, who explicitly acknowledged the differing approaches to achieving shared decision-making, whilst commenting upon the negative impact of working with paternalistic physicians.

As argued by Whitney et al. (2004), the core of informed consent lies in a meaningful dialogue between physician and patient about the proposed treatment, alternative treatment options, nontreatment, as well as the associated risks and benefits. Unlike a mere form-signing activity, informed consent is an ongoing process that unfolds over multiple encounters between the physician and the patient. In our study, we also found that it is possible to build up such a dialogue in the departments where patients see the same health professional several times. However, patients are mostly allocated short times with health professionals, which makes the encounter where shared decision-making takes place a stressful encounter.

Limitations

This study has several limitations. First, it focuses exclusively on the perspectives of healthcare professionals, thereby excluding valuable patient insights that could provide a more comprehensive understanding of treatment recommendations and the perceived value of resources. Second, with the research was conducted in a specific healthcare setting, so the findings may not be generalizable to other contexts. Nevertheless, considerations of generalizability must be understood as an epistemological condition in research grounded in more fluid ontological assumptions, where knowledge is conceived as situated, contingent, and context-dependent rather than universally transferable.

While we opted for semi-structured interviews due to their flexibility and ability to allow participants to elaborate on their experiences, this method hinges on the interviewer's skill in facilitating open dialogue. On the other hand, participant observation would be advantageous for capturing real-time interactions and behaviours, providing a richer understanding of how healthcare professionals practice patient choice and responsibilization. Observing both doings and sayings (Bourdieu, 1990; Garfinkel, 2023) would enrich the analysis, offering insights into the complexities of these encounters. Unfortunately, this study did not have access to such observations, but incorporating them would certainly be a valuable avenue for future research.

Furthermore, this study's reliance on only 10 respondents limits the breadth of perspectives, as it may not fully represent the diversity of experiences within the healthcare profession.

Conclusion

Our analysis sheds light on the challenges present in the implementation of patient-centered care and informed consent among Danish hospital-based healthcare professionals. The concept of responsibilization, which emphasizes shared responsibility between healthcare professionals and patients, is often overshadowed by uncertainties surrounding the allocation of responsibility and the boundaries of healthcare professional involvement. The notion of proto-professionalism further complicates these dynamics, as healthcare professionals navigate their roles in guiding patients while striving to respect their autonomy amidst time constraints, potentially leading patients to acquire forms of knowledge that diverge from the intended treatment goals.

The implications of these findings are significant for both the study of patient-centered care and the sociology of professions. First, they underscore the need for a more nuanced understanding of how responsibility is distributed and perceived within healthcare settings, suggesting that effective patient engagement requires more consistent practices and frameworks that account for varying professional interpretations. Additionally, our findings highlight the discrepancies between the ideals of patient-centered care and the realities faced by healthcare professionals, particularly for patients with fewer resources who may struggle to engage meaningfully in their care.

This research emphasizes the importance of closing the gap between theory and practice by fostering an environment that enables healthcare professionals to implement shared decision-making effectively. Enhancing training and support for professionals may better equip them to communicate with and involve patients, ensuring that the principles of patient-centered care become a lived reality rather than an aspirational goal. Ultimately, our study contributes to ongoing discussions about the evolving roles of healthcare professions, advocating for greater adaptability and responsiveness to patient needs in increasingly complex healthcare landscapes.

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