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Scientific Contribution

Shared decision-making, gender and new technologies

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Abstract. Much discussion of decision-making processes in medicine has been patient-centred. It has been assumed that there is, most often, one patient. Less attention has been given to shared decision-making processes where two or more patients are involved. This article aims to contribute to this special area. What conditions need to be met if decision-making can be said to be shared? What is a shared decision-making process and what is a shared autonomous decision-making process? Why make the distinction? Examples are drawn from the area of new reproductive medicine and clinical genetics. Possible gender-differences in shared decision-making are discussed.

Key words: decision-making, gender-differences, genetics, reproductive medicine, shared autonomous decision-making, shared decision-making

Introduction

Much discussion of decision-making processes in medicine has been patient-centred (Carlsen and Aavik, 2006; Ford et al., 2006; McCarthy, 2006; Parker, 2000). It has also been assumed that there is, most often, one patient. This can no longer be assumed to be the case, at least not in the quickly developing area of reproductive medicine. In this area, conditions for shared decision-making and conditions for autonomous shared decision-making need to be explored. This is particularly important since empirical research has indicated a number of complicating aspects in patients' decision-making processes, in this area (Zeiler, 2005).

Consider the situation of decision-making in medicine in general. Here is most often one patient. Whereas this patient may choose to discuss her or his situation with others such as family, friends, or other experts in the field, s/he need not do so. The patient can choose to keep the diagnosis to her- or himself. Even if the patient chooses to discuss with others what to do and whether to undergo treatment, these others are not involved in the same sense. Though the consequences of a patient's choice can be very significant for certain others, such as partner and/or children, these others will not necessarily undergo treatment themselves. If the patient chooses to undergo surgery, the person treated for a disease is also the one who has the disease. These aspects of medicine in general are either not as straightforward or different in the new reproductive medicine.

Ex-corporeal assisted reproductive technology such as homologous in vitro fertilisation (hereafter referred to as homologous IVF), i.e. IVF without a donor necessarily involves at least two persons. When IVF is used, it is also possible to use pre-implantation genetic diagnosis (hereafter referred to as PGD). PGD implies a genetic testing of embryos. Its aim is to identify the presence of genes that will or might result in a particular genetic disease. It allows selective transfer and implantation of embryos into a woman's uterus. I will use these two technologies as examples that highlight the need for a better understanding of shared decision-making processes. Indeed, I will argue that medical professionals need to encourage such shared processes – and they need better to understand the implications of shared decision-making processes.

When IVF and PGD are used, the ''patient'' is not one person, but at least two persons who cannot and/or dare not conceive a child together without technical and medical means. Neither of the so-called patients needs to have a manifest disease, but one or both of them need to be carriers of a disease. Also, if one or both of the patients have a manifest disease, and even if the disease is the reason why they approach the hospital, their disease will not be treated, nor necessarily will consequences of that disease be treated. Furthermore, in homologous IVF both patients/partners need to be involved in the discussion of whether to undergo treatment, and if so which treatment.[1] This is the case even when the woman undergoes the lion's share in terms of physical risks and harm during the treatment. Furthermore, in IVF and PGD, the medical team is involved in the process of deciding whether to offer treatment for a particular genetic disease to a particular couple to a larger extent than in many other medical contexts. In the UK, physicians who participate in IVF and PGD have a statutory obligation to consider the interests of the future child (Human Fertilisation and Embryology Act, 1990; HFEA, 2005). In this sense, they have an obligation to take part in the reflection concerning what to do, including whether to offer the techniques to a particular couple or not. They have a duty to consider the welfare of the child.

IVF and PGD highlight the importance of a better understanding of shared decision-making processes that involve at least two patients. Furthermore, I suggest, these new medical technologies highlight the need for a distinction between decision-making/shared decision-making on the one hand and autonomous decision-making/ autonomous shared decision-making on the other. A distinction needs also to be made between shared decision-making and individual simultaneous decision-making. Reasons why this is the case will be discussed in the article.

Other studies have focused on what factors are considered important in the decision-making process in the medical context, such as expected quality of life, expected health outcome, the patients' wishes and so forth (Street et al. 2000). This article offers discussion of the conditions that need to be met i) for someone to be said to be engaged in a decision-making process, ii) for two or more persons to be said to be engaged in a shared decision-making process, iii) for two or more persons to be said to be engaged in an autonomous shared decision-making process.

Conditions for decision-making

Engaging in a decision-making process involves more than the actual choice of P or non-P. Furthermore, while it might be argued that I have no real choice if I cannot act on my decision, I can be engaged in a decision-making process even if I, at a later point in time, realise that I have not the opportunity to act on my decision. I can also be engaged in a decision-making process even if I do not come to a decision. In order to be in a decision-making process, I shall suggest, I need to *be able, have the opportunity and the intention to come to a decision*.

Consider the following scenario that highlights some necessary abilities for individual decision-making. Peter has been very tired for the last 6 months. He visits the local GP and the doctor suggests that a blood sample should be taken. The doctor also asks Peter if he accepts that part of the blood sample is stored in a national biobank. "It's for future research," she says.

If Peter can be said to be in a decision-making process as regards whether to consent to this particular request, he needs to have an ability for at least minimal deliberation on alternatives (whether to consent or not) and an ability to perform the mental act of deciding which alternative to go for. This implies an ability to understand that he is in a situation of choice, an ability to understand basic differences between the alternatives, an ability to intend a certain outcome and an ability to decide.[2] These abilities are included in the abilities for coming to a decision. If Peter does not have these abilities, he cannot be said to be in a decision-making process.

Likewise, Peter needs to have the necessary opportunities to come to a decision. These include an array of opportunities, such as an opportunity to understand that he is in a situation of choice (hampered if no one informs him of the alternatives) and an opportunity to understand the basic differences between the alternatives. He needs, for example, to have the opportunity to understand basic differences between the act of consenting and the act not to consent. If he is given no time to reflect on the matter, at all, he has no opportunity to come to a decision.

Whereas abilities and opportunities are graded concepts, the third condition of intentionality is not graded. Intentionality distinguishes decisions from mere accidental events. As another example, if I am not allergic to certain antibiotics, but when filling in a health form I accidentally tick the box for allergy, I do not decide to misinform the medical staff nor to tick the box. I had no such intention – it was not a decision. Intention is a mental state that precedes all acts. I take a decision to be one kind of mental act and, as such, it is preceded by the intention to come to a decision. Intention indicates the presence of volitional aspects crucial to it being possible to say that I am engaged in a decision-making process.[3] To intend to come to a decision in a particular situation implies that someone is so disposed that s/he will decide in one way or the other, when this is possible.

Conditions for shared decision-making

What then about shared decision-making processes? In a shared decision-making process, at least two people need to be engaged. Each of them needs to be in a situation of choice in which there are at least two alternatives that s/he perceives as alternatives (P and non-P). Furthermore, each of them needs to be able to listen to the other partner and to communicate their own, basic deliberation. Both partners need to engage in a decision-making process together that they, as individuals and as a couple, find acceptable.

This understanding of shared decision-making needs to be distinguished from what can be called *simultaneous individual decision-making*. The latter type of decision-making need not be shared. It only means that each partner can, on her or his own, come to a decision – at the same point in time. An example can clarify the meaning of simultaneous individual decision-making. Whereas it seems improbable that a woman and a man within a couple would come to an IVF clinic, get the relevant information available, go home and come to a decision without discussing the issue together, it may be less improbable in the case of prenatal diagnosis and selective termination of pregnancy. Maybe the male partner does not know of the pregnancy. Maybe the female partner has told him about the pregnancy, but she does not want him to take part in the decision whether to continue the pregnancy or not – or he does not want to take part in the decision. Legally, the decision whether to go on with the pregnancy resides with the woman. She need not discuss the issue with anyone else. Even if each of the partners considers the situation and even if each of them comes to a decision, this does not qualify as a shared decision-making process. As long as they do not discuss the issue together and take part in a shared process of deliberation, this is just simultaneous individual decision-making.

Consider another scenario. Amanda and John know that they are at high risk for a particular genetic disease. They have been to genetic counselling and during that counselling they have discussed different reproductive alternatives. John wants to use homologous IVF and PGD in order to have a biological child, without a particular genetic disease that he is a carrier of, together with Amanda. Amanda is hesitant as to whether she really wants to use these technologies. The more they discuss the matter, the more negative she becomes. In the end, she says that she does not want to use them.

This scenario raises the question of what shared decision-making means. If Amanda and John are to use homologous IVF together, this presupposes that both of them agree to do so. If Amanda does not want to use IVF and PGD and if she shall not be forced into so doing, John has to accept this. He cannot use homologous IVF with Amanda without her. If so, can his acceptance of the only viable alternative qualify as shared decision?

It should be noted that the notion of acceptance can be used in situations where John accepts Amanda's decision but where he has a negative attitude towards this decision, as well as in situations where he accepts and has a positive attitude towards Amanda's decision. Regardless of John's attitude towards Amanda's decision, if Amanda says that she does not want to use PGD, John may accept her decision. In this regard, he has been involved in a decision-making process. If both Amanda and John have the abilities, the opportunities and the intention to come to a decision that both of them find acceptable, and if they take part in a shared process of deliberation, they are engaged in a shared decision-making process.[4]

The example highlights that shared decision-making processes may indeed be psychologically complex and even painful. John's negative attitude to Amanda's decision (as well as Amanda's attitude to John's decision) may influence their shared decision-making process. Possibly, this could have clinical implications: in some cases of shared decision-making, those engaged in it may benefit from discussing not only with each other, but also with professionals such as psychologists.

It should also be noted that even if a decision-making process is shared, it does not necessarily mean that it is equally shared. If the shared decision-making process results in a shared decision, this decision can be, and is probably often, the result of compromises. Still, as long as both partners have the abilities needed for deliberation and decision-making, as long as they can communicate their own, basic deliberation and engage in a decision-making process that both of them find acceptable, they can be said to be engaged in a shared decision-making process.

What we find acceptable varies, but as one criterion, the basic deliberation of those involved in shared decision-making must not be disregarded, if the decision-making process is to qualify as shared.

Abilities, intention and opportunities in shared decision-making processes

The importance of abilities for shared decision-making becomes particularly clear when they are lacking. If either of the partners lacks the ability to understand that s/he is engaged in a shared decision-making process, there will be no such process. Furthermore, if certain alternatives are considered deeply undesirable in a particular society and if either or both partners have internalised this, they may be unable to imagine the said alternatives in a particular area. This being the case, they are not engaged in a decision-making process as regards these alternatives – at all.

We need also to ask how the necessary abilities come about. Minimal abilities for decision-making in general are, if not acquired in social relations, developed, shaped and possibly thwarted in such relations (Dodds, 2000), and often so in close relation with those with whom we share our early years of childhood. In this sense, abilities for decision-making are causally relational. Minimal abilities for decision-making, such as an ability for deliberation, are also "constitutively relational" (Friedman, 2000) in the sense that they partly consist of traditions and norms, held by others in the context in which we live, which we have integrated into our thinking and which we cannot fully question without also questioning the necessary ability for minimal reflection. An ability for deliberation is, in the words of Marilyn Friedman (2000:41), "always partly constituted by communal traditions and norms that we cannot call entirely into question without at the same time voiding our very capacities to reflect".[5]

The question of how the crucial abilities involved in decision-making come about is important since much theoretical discussion of choice in medicine has centred on possible ways for professionals to inform patients of their particular condition and of different treatment alternatives, to discuss the condition and the treatment alternatives, to propose a certain treatment and to receive the patient's informed consent. Less often have ways to strengthen and support these abilities been topics of discussion (Dodds, 2000). This is even more important in the case of shared decision-making since sharedness is complex and since shared decision-making is an area of potential power play.

As regards different kinds of genetic testing, it has been claimed that women have come to be seen as bearers of responsibility for genetic risks (Steinberg, 1996). A study on the experience of women who underwent genetic testing for breast cancer also showed that women perceived themselves as having a genetic responsibility to their kin: they underwent genetic testing for the sake of "doing the right thing" for others, in order to determine risks and take steps to control them in some way (Hallowell, 1999). When do gendered socio-cultural ideas and assumptions such as these hamper an equally shared decision-making process? Here, it needs also be asked whether and if so in what contexts shared decision-making is something to strive for. It needs also be asked whether and if so when medical professionals should try to enable shared decision-making and possibly lighten the burden of women as bearers of genetic responsibility.

Should medical professionals try to encourage shared decision-making?

Should medical professionals try to encourage shared decision-making when IVF/PGD are used? If the final decision whether to use prenatal diagnosis and selectively terminate a pregnancy rests with the woman, and rightly so, why is this not also the case with IVF/PGD? In other words, are there any ethically relevant differences between these uses of medical technologies that matters to the decision-making process?

There are similarities and differences between these two scenarios. The often proclaimed and in my view strongest argument for the woman's right to decide in the prenatal diagnosis scenario is that the foetus is part of the woman's body (Raymond, 1995). She has a right to make decisions as regards her body. She has a right to her bodily integrity. Therefore, though a thorough shared discussion of what to do can be psychologically positive for both the woman and the man, the final decision should rest with her.

This is different in the IVF scenario. The embryo is not part of the woman's body at the time of the decision. At this time, there is no embryo at all. Therefore the woman's right to bodily integrity is not violated and she should not have the final say in the decision. It should be a shared decision.

Against this, it could be claimed that there are ethically relevant similarities between the prenatal scenario and the IVF/PGD scenario, which could justify a similar view of the issues of decision-making. In both cases, the relevant technologies will be used on the woman. As a consequence, the decision as to what to do necessarily involves her physical-psychological being to a larger extent than it involves her partner's. She is the place where a new life already is embedded (in the case of prenatal diagnosis) and she is the one who will, if the embryo successfully implanted, carry it to term (in the case of IVF/PGD). Therefore, it could be claimed, the final decision as to what to do should be hers to make, in prenatal diagnosis as in IVF/PGD.

This may seem plausible at first sight. But if it is ethically relevant how much one physically is engaged, there is after all a difference between IVF/PGD and prenatal diagnosis and selective termination. The woman takes the lion's share of the physical and psychological turmoil an IVF treatment can mean. For this reason, it is certainly important that she should be able to influence the decision-making process, and have a veto, if she does not want to use the technologies. However, she cannot use homologous IVF by herself. This is a key to the understanding of the importance of shared decision-making in homologous IVF/PGD. In the IVF scenario, there is not already a human life in development. The male partner needs to contribute sperm. This makes a difference and this is the reason why a simultaneous individual decision-making is insufficient in this scenario. In line with the previous reasoning based on bodily integrity, both the woman and the man have rights to bodily integrity. What is needed is a shared decision-making process that results in a shared decision.

The language of rights may be misleading. It can make the discussion look like a power struggle where one party has a right and another one has a duty. Possibly, this language not only hides the context in which the decision-making takes place (Raymond, 1995), it may also seem contradictory to shared decision-making processes. This being the case, we need another ethical language. The issues here are better framed in terms of a shared ethical reflection and a shared responsibility for the decision-making process as well as the results of that reflection in which both partners are responsible for their own reflection and for the shared decision-making process, without taking over the responsibility from the other partner. A shared decision-making can enable a shared responsibility for the child to be, and this is a possible psychological and ethical benefit.

Since these are medical technologies used in medicine, since shared decision-making processes are complex, since it is important that the final decision as to whether to use homologous IVF/PGD should be the result of a shared decision-making process, I suggest that medical professionals should do what they can to encourage this process in the case of IVF/PGD. Furthermore, I will soon argue, medical professionals should try to enable an autonomous shared decision-making. Such decision-making, empirical research has shown, is not always present (Zeiler, 2005). Before discussing autonomous shared decision-making, it should be noted that the case of IVF/PGD also evokes questions of shared decision-making that involve patients and medical professionals.

Compare again the scenario of prenatal diagnosis/possible abortion and of IVF/PGD. In the first scenario, once a woman is pregnant, she can decide whether or not to use prenatal testing and to determine whether she wants to carry the child to term. In the IVF/PGD situation, this is not the case. Once embryos are fertilised, and if there are only affected embryos, the patient(s) may "lose control" over the next measures taken (see Draper and Chadwick, 1999). This is so if the PGD team decides that implanting a particular embryo, even if they have been given a licence to do so, is not for the best of the future child. Though such a situation can only come about in the UK, because of the amendment that professionals who participate in fertility treatments have a statutory obligation to consider the future child's interest, it raises the question of whether there is a new power shift at stake, from women/men to professionals. Though a shared decision-making that involves patients and medical professionals is described as an ideal by some geneticists and gynaecologists (Zeiler, 2005), a certain woman and man who want to have also affected embryos implanted cannot make the PGD team do it. If no agreement is found in this regard, it has been stated, the final decision as to whether to use PGD seems to reside with the clinician and not the woman (Draper and Chadwick, 1999) nor, as I have argued should be the case, with the woman and the man. Such may be the case if a woman and a man want to have only embryos with congenital deafness implanted. As shown by Draper and Chadwick (1999:116), the parents may argue that the quality of life for a deaf child will be better than for a hearing child, in their family, and in the deaf community to which they belong.

This matters to the present discussion. It needs to be asked whether the discussion between patients and professionals, when professionals in the end state that affected embryos should not be implanted though the patients wants it, can be qualified as a shared decision-making process. It could also be asked i) whether the decision-making process is shared enough and ii) whether it is enough that the decision-making process is shared (when the final decision is not shared). Still, if patients and professionals have the necessary abilities, opportunities and the intention to come to a decision that all of them find acceptable, and if they take part in a shared process of deliberation, they are engaged in a shared decision-making process even if they do not come to a shared decision.

Shared decision-making – autonomous or not?

Why distinguish between shared decision-making and shared autonomous decision-making? Is it not sufficient to say that we, when we can come to a decision, are autonomous with regard to the decision-making process?

The benefit in making the distinction can be highlighted by some questions. What if we live under oppressive structures through which we have been so socialised that we, when facing alternatives P and R, are only able to imagine ourselves choosing between P and non-P and not R or non-R? Or, what if our experiences in a particular field are relevant with regard to our choice of P or non-P, but these experiences are silenced in a number of different ways to the extent that we start doubting whether they are relevant or, worse, whether we did have these experiences? What if we can come to a decision under these circumstances – need that decision and the decision-making process that has preceded it not be differentiated from decision-making processes and decisions made in contexts in which experiences are acknowledged and discussed? These are the benefits of the distinction: it allows discussion of different kinds of decision-making and it allows a more precise discussion of *degrees* in constraints on conditions of decision-making. If autonomous decision-making is understood as present as long as we can decide and if no distinction between decision-making in general and autonomous decision-making is elaborated, decision-making made in oppressive or in some other sense hampering relations qualifies as autonomous as long as we are not *so* oppressed that we can no longer in fact come to a decision. I take this to be too rough a definition. A decision-making process may not be autonomous even if we can come to a decision.

Compare the following three situations: (1) a woman and a man who are at risk for a particular genetic disease want to use genetic testing on embryos, but are not given as much time as they want to reflect on the alternatives PGD, prenatal diagnosis and adoption if their condition allows them to adopt; (2) a woman and a man who are at risk for a particular genetic disease want to use genetic testing on embryos and they are given the time to reflect on what they really want; (3) a woman had undergone several PGD treatments and each time experienced "her daughters' death again" (Zeiler, 2005:116). These situations are different, not only in terms of the possible degrees of constraints but also in terms of what conditions of decision-making processes are constrained. If we have to come to a decision under time-pressure, we may not have the opportunity to reflect on what really matters to us with regard to the area of decision. It could also be asked if some experiences, such as those of the woman described in the last scenario, are not so painful that they hamper our ability to reflect clearly on what we really want. (However, it could also be claimed that the painful experiences, rather than hampering the ability to reflect clearly, could be seen as informing the decision-making process).

Distinguishing between the basic decision-making process and the autonomous decision-making process enables a precise discussion of constraints on these processes.

Shared autonomous decision-making

Autonomous decision-making, I suggest, is a special type of decision-making. Autonomous shared decision-making is present only when the conditions for shared decision-making in general are met *and* we can perform a particular reflection on what really matters to us and to our partner with regard to the area, can reflect on whether what really matters to us and our partner in this area is promoted in an acceptable way by the alternatives present, and can decide on the basis of that reflection. This procedural account is inspired by the procedural account of autonomy put forward by Diana T. Meyers (1987, 1989, 2000).

Meyers develops an account that attempts both to explain possible hampering influences of socialisation on autonomy and explain why socialisation need not hamper autonomy. Such can be the case if someone has been oppressively socialised, Meyers holds, if this person still has developed an "autonomy competence" that involves a number of coordinated skills, such as skills of self-discovery, self-direction and self-definition, *and* exercises this competence (Meyers, 1987). It is only through the exercise of these skills that autonomy is achieved. Skills for "autonomy competence" may be more or less developed or be ill-coordinated; this being the case, autonomy may be partial. In Meyers' discussion, what matters if we are to be said to choose autonomously, is that we are able to identify and reflect on what really matters to us with regard to the particular area of choice *and* do so (Meyers, 1987, 1989). Though I consider Meyers' discussion to be very helpful, my account of autonomous decision-making is different. I take autonomous decision-making processes to be present when I *can* reflect on what values, beliefs and norms I hold to be really important with regard to the particular area of choice, when I *can* reflect on in what ways particular alternatives promote, hamper or hide these values, beliefs and norms and whether what really matters to me, in the particular area, is promoted in an acceptable way by the alternatives present. I need not do so. Autonomous shared decision-making is present when I can reflect also on what really matters to me and to my partner, on whether particular alternatives promote, hamper or hide these values, beliefs and norms that really matter to me and to him or her, in an acceptable way, when we both can articulate our deliberation, and when we can be engaged in a decision-making process, as individuals and as a couple, that both of us find acceptable.

In autonomous shared decision-making, those involved need to have the ability to identify what they and their partners value, believe, care about with regard to a particular area of choice, also the ability to reflect on whether these values etc. are what they really hold as important and whether they are promoted in an acceptable way by the alternatives present. They need also have the ability to come to a decision on the basis of that reflection. As before, I take abilities such as these to be developed in social relations; abilities are both causally relational and constitutively relational. An array of opportunities for autonomous decision-making need also to be present, such as the opportunity to reflect on what those involved in the decision-making value with regard to the particular area of choice, the opportunity to decide and the opportunity to develop previous abilities.

It has been suggested that there may be a gender-bias of relevance to situations of decision-making. Women, as a group, some suggest, may be more responsive to unspoken needs or unexpressed discomfort than men, as a group (Donchin, 2001). If accurate, this raises the question of whether and, if so, in what sense shared decision-making is shared. It also raises the fundamental question of what kind of counselling hampers or enables shared decision-making, shared decisions and shared autonomous decision-making/decisions.

A gender difference was present in an empirical study of how women and men, in the case of couples where one partner was infertile, reasoned about and evaluated reproductive alternatives such as adoption or IVF. Men were more hesitant than women when it came to the idea of adoption; women's willingness to undergo treatment was often motivated by the wish to do this "for their husbands" (Lasker and Borg, 1987). Furthermore, negotiations take place not only in the context of IVF and PGD but also in the context of prenatal diagnosis, as when a woman described that for her husband, genetic testing of the foetus was a condition if they should try for pregnancy in the first place, as was abortion if the foetus had a particular genetic disease. This woman stated that though this was not what she wanted, she accepted it for the sake of trying for pregnancy [(Zeiler, 2005).

In such a situation, reflection on what each of the partners holds to be really important may well take place; the woman and man may reason about goals as well as about means of achieving certain goals. Both of them or one of them may also compromise on what is the acceptable or desirable goal as well as the acceptable or desirable means of achieving the agreed goal. Even if such situations do qualify as situations of shared autonomous decision-making as long as both persons involved consider the decision-making process to be acceptable, this brings out the fact that if such a decision-making has taken place it need not reflect all that mattered to both of those involved in it. It can also be both psychologically and morally complex. Though shared, the decision-making process and the final decision need not be shared in an equal manner. Furthermore, in the IVF and PGD scenario, neither of the alternatives present may be understood as particularly desirable by either of those who engage in the decision-making process as to whether to use the technologies. When reflecting on what matters to them with regard to each of the alternatives, a woman and a man at risk for a certain genetic disease may conclude that neither of the alternatives is desirable. They may conclude that neither alternative harmonises with values they hold to the extent that they wish it did. Still, under present conditions, one alternative is less bad – less undesirable – than the other. Though neither alternative harmonises with what they value etc., their decision-making process and their final decision can be shared and autonomous. This is so since decision-making and decisions are shared and autonomous if the described reflection can take place, and if they come to a decision that both of them find acceptable.

In situations of shared autonomous decision-making and decisions, the notion of compromise is important. Reaching a compromise implies that a decision is reached that both partners find acceptable and that both found the decision-making process that resulted in the final decision acceptable. The partners involved in shared autonomous decision-making may disagree about goals and means, they may disagree about whether certain alternatives really promote what matters to them, they may have different understandings of what really matters in a particular area, and so forth. However, I suggest, as long as they can reflect on what matters to themselves individually as well as to the partner and as long as they are able and have the opportunity to "give and take" in their reasoning and come to a decision that both of them find acceptable, they can be said to be engaged in shared autonomous decision-making. The issue of compromise underlines the intersubjective dimension of these choices.

Conclusions

A shared decision-making process can take place when those involved in it have certain abilities, certain opportunities and the intention to come to a decision. Engaging in a decision-making process involves more than the actual choice of P or non-P. Two persons can be engaged in a shared decision-making process even if they later realise that they are not able to act on the decision. They can also be engaged in the decision-making process even if they do not come to a decision. Autonomous shared decision-making is present only when the conditions for shared decision-making in general are met *and* we can perform a particular reflection on what really matters to us and to our partner with regard to the area, can reflect on whether what really matters to us and our partner in this area is promoted in an acceptable way by the alternatives present, and can decide on the basis of that reflection. In autonomous shared decision-making, those involved need to have the ability to identify what they value, believe, care about with regard to a particular area of choice, together with the ability to reflect on whether these values etc. are what they really hold as important and whether they are promoted in an acceptable way by the alternatives present. They need also to have the ability and opportunity to engage in a decision-making process that both of them find acceptable.

The benefit of the distinction is that it allows discussion of different kinds of decision-making. It allows a more precise discussion of degrees in constraints on conditions of decision-making. It also enables a discussion in terms of what conditions of decision-making processes are constrained.

Notes

1. In homologous IVF, both partners are physically involved in treatment, though the woman has the lion's share.
2. Compare Nordenfelt (2000), when he argues that abilities such as these are abilities constituting autonomy and not abilities regarding decision-making in general.
3. The intention can come about as a result of wants that I have. My understanding of intention is different from the understanding of intention as something that can only occur (or primarily occurs) as a result of a decision. Intentions need *not* be preceded by decisions. In this sense, I also avoid the risk of infinite regress: if intentions are always the result of decisions and if decisions are intentional (as other acts are), such infinite regress seems unavoidable. However, while the decision to X is preceded by the intention to decide X, the decision to X also results in the intention to act on the decision to X. Also, while intention is not graded, wants and wishes that I may have can so be.
4. However, John does not have the choice to use IVF and PGD as a shared action.
5. As stated by Friedman [(2000) in a discussion of reflective capabilities for procedural autonomy; I take this to be accurate for all abilities relevant to deliberation.

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