are able to make the best decision regarding disease-modifying therapies taking into account their personal needs and preferences regarding treatment options.

Shared decision-making, self-care and self-management may be considered as different aspects of person-centred care (Ahmad et al. 2014). Shared decision-making, self-care and self-management share some key features; for example, they all reflect collaborative approaches, emphasise the achievement of a two-way dialogue between patients and professionals, and recognise the different skills and assets that each party brings, however, the distinction between the concepts is in terms of the context and their intended outcomes in clinical practice (Lhussier et al. 2013). The Quality Ambitions set out in the Healthcare Quality Strategy for NHSScotland state that ‘mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making’ are needed to provide person-centred care, and are all inherently linked (The Scottish Government 2010b). Edwards et al. (2009) cite consumerism as one reason for increased demand for shared decision making; consequently, expectations of their role in decision-making in health care consultations have changed to one where patient involvement and patient choice are usually desired.

Research suggests that many different theories exist amongst health professionals and patients regarding what shared decision making consists of and to what extent it is occurring (De Silva 2012, Kasper et al. 2011). A three-step model for shared decision making was proposed by Elwyn et al. (2012), consisting of a) introducing choice, b) describing options, often by integrating the use of patient decision support, and c) helping patients explore preferences and make decisions. Elwyn et al. (2012) do, however, note that this model presents a significant simplification of a ‘complex, dynamic process’, yet its simplicity may assist in training and simulation of shared decision making. Elwyn and Charles (2009) described several features which may exist in shared decision making, including ‘identifying and clarifying the issue, identifying potential solutions, discussing options and uncertainties, providing information about the potential benefits, harms and uncertainties of each option, checking that patients and professionals have a joint understanding, gaining feedback and reactions, agreeing a course of action, implementing the chosen treatment, arranging follow-up and evaluating outcomes and assessing next steps’. There is, however, no one widely accepted prescriptive formula for carrying out shared decision-making in clinical areas. De Silva (2012) proposes that healthcare professionals should focus on ‘fostering a real partnership, whereby the health professional is seen as an expert on the effectiveness and potential benefits and harms of treatment options and the patient is viewed as an expert on themselves, their circumstances, attitudes to illness and risk, values, preferences and the extent to which treatment options might fit within their lifestyle’, rather than simply following a series of steps.