

One Patient Can Have Several Legitimate Treatment Priorities That Cannot All Be Maximized: Negotiating Trade-Offs and Revisable Agreements in Interdisciplinary Medication Management

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Abstract

Medication management in multimorbidity can require choosing among several legitimate aims rather than maximizing one clinical endpoint. Patients may value symptom control, independence, longevity, treatment simplicity, affordability, and freedom from adverse effects, while clinicians must consider safety, expected benefit, feasibility, and continuity. These aims may become mutually constraining when one medication decision advances some priorities while compromising others. This article develops a Deliberative Medication Trade-Off Model for interdisciplinary medication management. The model distinguishes identifying competing priorities, making trade-offs explicit, negotiating a provisional agreement, allocating responsibility for enactment, and documenting conditions for revisiting. It also treats disagreement and uncertainty as possible continuing states rather than defects that must always be converted into consensus. The contribution is conditional: elaborate deliberation adds little where one option is clearly dominant, unavailable, or already aligned with a stable priority. Where legitimate priorities materially conflict, however, medication decisions should be judged by whether competing aims, sacrifices, responsibilities, and conditions for revision have been made sufficiently explicit.

Keywords: Multimorbidity, Medication management, Shared decision-making, Treatment burden, Patient priorities, Deprescribing

Introduction

Medication management becomes difficult when appropriate care cannot be reduced to maximizing a single endpoint. People living with multiple chronic conditions may face several relevant goals, while clinicians must weigh expected benefit, burden, prognosis, interactions, feasibility, and the patient's priorities. Multimorbidity guidance therefore emphasizes aligning decisions with individual priorities rather than applying disease-specific recommendations

independently [1]. Patient Priorities Care further shows that values, outcome goals, and care preferences can be incorporated into ambulatory decision-making [2].

Priority alignment, however, does not remove conflict. Treatment itself creates work through medication taking, monitoring, appointments, adverse-effect management, costs, and coordination [3]. Shared decision-making in multimorbidity accordingly includes complex trade-offs and iterative evaluation, not merely information exchange [4]. The harder problem arises when more than one legitimate aim points toward different actions.

This article develops a Deliberative Medication Trade-Off Model for that problem. Its focus is the interval between recognizing what matters and acting on a medication plan. It does not assume that one preference must dominate, that clinical optimization settles the issue, or that shared decision-making must end in full consensus. Instead, it separates priority identification,

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trade-off articulation, provisional settlement, responsibility allocation, documentation, and revisiting. The model is most relevant when competing priorities materially affect medication choice or burden; it is less useful when one option is clearly unsafe, unavailable, or overwhelmingly aligned with the patient's stable goals.

Why multiple legitimate goals cannot always be simultaneously maximized

Under multimorbidity, different health goals can imply different priorities for care processes. Multi-criteria work shows that the relative importance of health-care activities changes according to the goal being pursued [5]. Prioritization is therefore an allocation problem among competing goods, not simply a scheduling exercise.

Patients' reasoning reinforces this point. A qualitative systematic review of older adults with multimorbidity found that choices are shaped by symptoms, independence, relationships, trust, information, prior experience, and the wider context of treatment [6]. Outcome-prioritization research likewise shows that older patients do not uniformly rank life extension, independence, pain reduction, and symptom relief in the same way [7]. A patient can reasonably value several of these at once even when available strategies cannot fully protect all of them.

Conflict can also arise across actors. Patients, caregivers, clinicians, staff, and organizational leaders may identify overlapping but nonidentical priority challenges [8]. Such differences do not automatically indicate misunderstanding. Patients may foreground daily burden, clinicians preventable harm, caregivers feasibility, and services resource constraints. Some medication decisions are therefore distributive: they allocate benefit, burden, risk, uncertainty, professional effort, and opportunity among legitimate aims. Deliberation becomes necessary because a choice to continue, stop, switch, intensify, or simplify treatment can embody a judgment about which priority will be protected now and which will be accepted as less fully realized.

Multimorbidity, preference conflict and treatment burden

Multimorbidity intensifies trade-offs because regimens consume patient capacity. Treatment burden includes health-care tasks and social, emotional, and financial consequences, while ongoing prioritization remains incompletely captured by many measures [9]. Burden is

therefore not merely an inconvenience considered after clinical benefit; it can itself become a legitimate decision priority.

Medication value illustrates this interaction. Older patients and caregivers describe value in terms extending beyond pharmacologic effectiveness to quality of life, cost, adverse effects, and relationships with prescribers [10]. A clinically indicated medicine may be experienced as low value if it compromises function or imposes monitoring demands that conflict with another priority. Conversely, a medicine with modest average benefit may remain highly valued when it protects a personally important goal.

Structured medication review can surface these tensions. The SPiRE trial incorporated multimorbidity, polypharmacy, deprescribing, and patient priorities in primary-care medication review [11]. Yet medication review does not automatically resolve goal conflict. A systematic review and meta-analysis of medication review and deprescribing in older inpatients found outcome-specific effects and important risk-of-bias concerns [12]. Technical optimization and deliberative acceptability are therefore related but distinct. Within the present model, burden is neither automatically subordinate to benefit nor automatically a reason to reduce treatment; its significance depends on the patient's goals, capacity, alternatives, and willingness to accept particular forms of work or risk.

Deliberative foundations of shared decisions

Priority conflict requires more than an exchange of information. Shared decision-making involves cognitive, emotional, and relational work, especially where illness and professional authority affect patient agency [13]. Deliberation includes interpreting what outcomes mean, identifying acceptable sacrifices, and determining whether an agreement is authentic enough to guide action.

Conceptual distinctions also matter. Shared decision-making, the working alliance, and patient-centered care overlap but are not interchangeable: shared decision-making is primarily a decision process, the alliance is relational, and patient-centered care is broader [14]. The present model is located mainly in the decision process but depends on relational conditions that allow ambivalence, disagreement, and refusal to be expressed. Context outside the consultation also shapes deliberation. A scoping review of variation in experienced shared decision-making identified influences at micro, meso,

and macro levels [15]. Time, workflow, role clarity, organizational support, and policy conditions can determine whether participation is feasible. Treating shared decision-making as a complex intervention similarly emphasizes interacting actors, settings, and adaptations rather than one invariant sequence [16].

The model therefore adopts three foundations. Patient priorities must be elicited in a form usable for a concrete decision; trade-offs must be discussable rather than hidden within professional judgment; and the resulting agreement must be feasible enough to enact while remaining revisable when evidence, burden, feasibility, or goals change.

Identifying competing treatment priorities

Priority identification begins by separating values, outcome goals, and care preferences. Values express what matters; outcome goals describe desired states; care preferences indicate how a person wishes to pursue them. A feasible process for eliciting these dimensions has been developed for older adults with multiple conditions [17], and later mixed-methods work indicates that Patient

Priorities Care can be implemented across several clinical settings [18].

For trade-off deliberation, however, identifying a “top priority” is insufficient. The relevant task is to detect when two or more priorities prescribe incompatible actions. A patient may seek stronger symptom control and greater alertness, lower long-term risk and a simpler regimen, or maximum prevention and fewer monitoring demands. The conflict becomes important only when available medication options require sacrifice among these aims. Evidence from priority-aligned care shows that elicited priorities can influence clinical decisions [19], while feasibility work shows that priorities can be documented in the electronic record and made available to clinicians [20].

The model therefore distinguishes a priority from a trade-off. A priority is an aim, value, preference, or burden that matters for the decision. A trade-off exists when pursuing one priority materially constrains another under available options. This distinction prevents preference elicitation from being mistaken for settlement.

Table 1. Detecting when medication priorities become genuine trade-offs

Analytical unit	Signal that a trade-off is present	What remains open for deliberation	Error to avoid
Desired health outcome	Two desired outcomes favor different medication strategies	Which outcome deserves greater protection now	Treating one disease target as automatically dominant
Treatment burden	Additional expected benefit requires burden the patient considers consequential	Which burden is acceptable, for how long, and for what gain	Assuming burden always justifies de-intensification
Functional or life priority	A regimen threatens a valued activity or capacity while benefiting another aim	Whether the threatened function changes the acceptable balance	Treating quality-of-life priorities as secondary
Risk tolerance	Reducing one risk increases another risk, uncertainty, or burden	Which uncertainty is acceptable given the patient’s goals	Treating population risk estimates as self-interpreting preferences
Team feasibility condition	A preferred option exceeds available capability, authority, continuity, or resources	Whether responsibilities or the plan can be reconfigured	Letting system limits silently redefine the patient’s preference
Cross-actor priority	Legitimate priorities remain nonidentical after information is shared	Whether accommodation, sequencing, or explicit nonagreement is defensible	Treating persistent disagreement as proof of misunderstanding

Making trade-offs explicit

Once competing priorities are identified, the next task is to state the sacrifice implied by each option. Deprescribing is a clear example because continuation and discontinuation may each protect legitimate interests. A scoping review found substantial variation in how shared decision-making functions are incorporated into

deprescribing interventions for older adults with polypharmacy [21]. Merely calling a conversation “shared” therefore does not specify how the trade-off was handled.

Conceptual work on deprescribing distinguishes the decision from the process of implementing that decision and locates both within patient, prescriber, and system

influences [22]. The distinction applies beyond stopping medicines. A team may agree that treatment should change while remaining uncertain about timing, tapering, substitution, monitoring, or who will manage emerging problems. Trials of structured prescribing optimization also show that systematic medication assessment does not uniformly improve every outcome [23]. Taken together, deprescribing and optimization evidence indicates that clinical appropriateness, preference elicitation, negotiated choice, and implementation are distinct functions [21–23].

The model proposes four questions for making trade-offs explicit: Which legitimate priority does each option protect? What valued outcome, burden, or opportunity does that protection compromise? Which uncertainties are decision-relevant? What change in evidence, burden, feasibility, or goals would make the present balance unacceptable later? These are not scoring rules. They make visible what would otherwise remain an implicit professional balancing act.

Explicitness also clarifies disagreement. If participants dispute expected clinical consequences, more evidence may narrow the gap. If they agree on consequences but value them differently, additional information may not resolve the conflict. If the preferred option cannot be safely implemented, the problem concerns feasibility as well as preference. Different disagreement types therefore call for different responses.

Development of the deliberative practice model

Uncertainty is not simply what remains after shared decision-making fails. It can be embedded in expected benefit and harm, the stability of preferences, and the feasibility of implementation. Conceptual and empirical work shows that uncertainty can function as a driver, content, and consequence of shared decision-making [24]. A deliberative model must therefore accommodate uncertainty throughout the decision process.

Theory specification is equally important. A systematic review and formal representation of shared decision-making models found substantial variation in how constructs and hypothesized relationships are defined [25]. The present model must therefore do more than redraw familiar elements of patient-centered care. Its theoretical contribution lies in distinguishing operations that change what can be observed and compared.

The Deliberative Medication Trade-Off Model comprises five linked operations. First, identification surfaces values, desired outcomes, care preferences, treatment burden, risk tolerance, and feasibility conditions for a concrete medication decision. Second, trade-off articulation states which priority each option protects and what it compromises. Third, provisional settlement determines what balance is acceptable now without requiring the underlying value conflict to disappear. Fourth, responsibility allocation assigns the work needed to enact, monitor, communicate, and support the agreement. Fifth, longitudinal memory documents the rationale, unresolved uncertainty, and conditions for revisiting.

These operations do not form a rigid sequence. New information may reopen priority identification; implementation barriers may reopen the trade-off; adverse effects may make a previously acceptable burden intolerable; and a patient may revise the weight placed on outcomes. The central construct is therefore the provisional agreement: a settlement justified for a particular configuration of priorities, evidence, burden, feasibility, and uncertainty. Revisability does not imply weak commitment. It acknowledges that the grounds of an agreement can change.

In medication decisions involving genuine priority conflict, movement toward action depends on how patient priorities, clinical goals, treatment burden, uncertainty, and feasibility are translated into an explicit trade-off and a revisable settlement (**Figure 1**).

Deliberative Practice for Competing Medication Priorities

From what matters to a workable plan, with ongoing reconsideration

Multiple legitimate priorities.
Thoughtful trade-offs.
Ongoing dialogue.

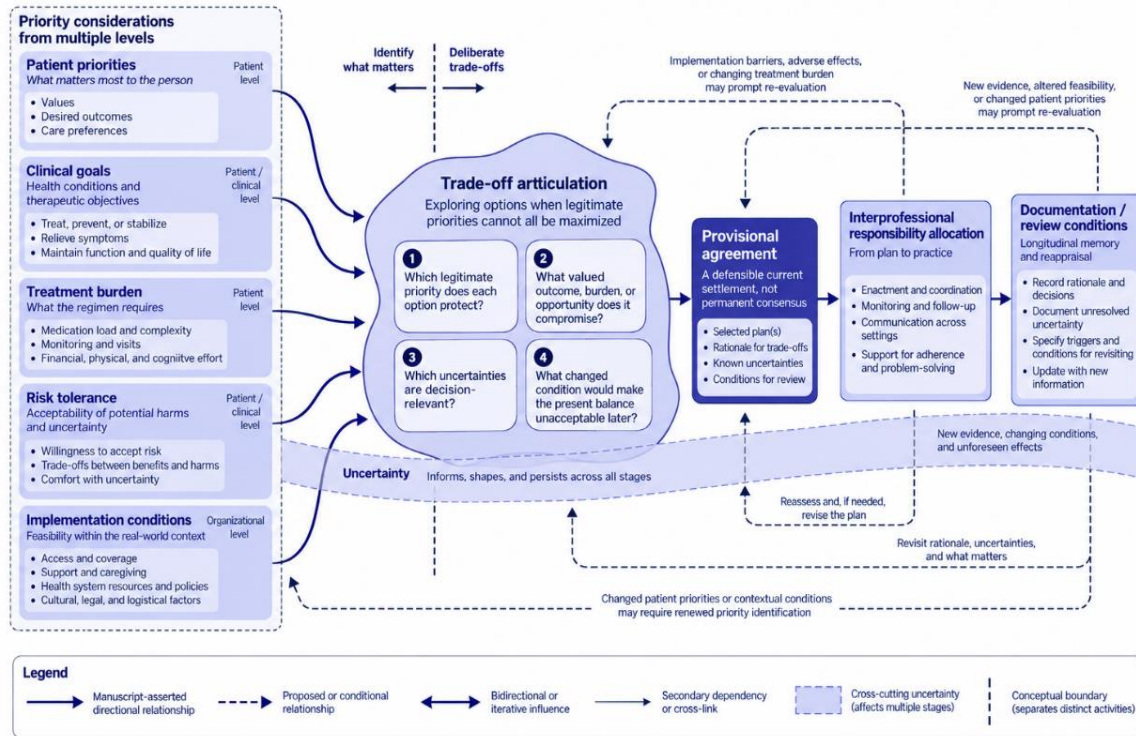


Figure 1. The deliberative practice field for competing medication priorities

Negotiating a provisional agreement

A trade-off becomes actionable when participants determine what balance is acceptable under present conditions. This settlement need not remove the value conflict that produced the decision. Realist evidence from medication discontinuation shows that collaborative decisions depend on context and mechanisms rather than a universally transferable form of agreement [26]. The appropriate endpoint may therefore be a qualified commitment: continue a medicine while a valued benefit remains evident, reduce treatment while burden remains excessive, or defer a change while uncertainty is investigated.

Provisionality requires specificity. Participants should know which priority is being protected, which competing priority is being less fully realized, what uncertainty remains, and what development would justify reopening the decision. This differs from vague compromise because the reasons for accepting the current balance remain identifiable.

Agreement should also not be inferred merely from apparent acceptance. After hospital-initiated medication changes, patient experience can diverge from clinicians'

perceptions of shared decision-making, with information, trust, power, and conflicting professional advice influencing acceptance [27]. A patient who follows a regimen may still remain unconvinced about the trade-off on which it rests. The model therefore treats settlement as sufficiently shared only when the current decision and its important sacrifices are understood well enough to guide action, even if disagreement persists.

Allocating interprofessional responsibilities

A defensible agreement can fail when no one owns the work required to implement it. Older patients describe gaps in information, collaboration, and support during medication transitions, showing that a medication decision does not itself establish continuity [28]. Responsibility allocation should therefore follow, rather than be conflated with, deliberative settlement. The relevant responsibilities depend on the decision. They may include changing a prescription, monitoring symptoms or laboratory values, supporting adherence, explaining contingencies, communicating with another professional, or responding if burden becomes unacceptable. Assignment must distinguish

responsibility from practical authority: naming an actor does not ensure access to information, organizational permission, time, or resources.

Implementation evidence from Patient Priorities Care similarly identifies workflow, documentation, leadership, and clinician participation as conditions affecting integration [29]. A provisional agreement is consequently incomplete as a practice arrangement until its required work has plausible owners and channels of communication.

Documenting and revisiting decisions

Revisability requires longitudinal memory. Implementation across organizations suggests that sustaining priorities-aligned care depends on continuing support and accountability rather than a single successful conversation [30]. Documentation should therefore preserve enough reasoning for another clinician, and for

the patient later, to understand why the present balance was chosen.

The record need not reproduce the whole discussion. It should identify the priorities in conflict, the current medication decision, the principal accepted sacrifice, important unresolved uncertainty, allocated follow-up responsibilities, and conditions that would justify reassessment. Earlier work demonstrates that patient priorities can be elicited in a structured form [17]. Evidence on priority-aligned decisions, elicitation, and implementation further supports making priorities usable across subsequent care rather than leaving them confined to one encounter [17, 19, 29].

The purpose of a revisit trigger is not to create an arbitrary timetable. A decision should be reconsidered when its justification materially changes—for example, when benefit becomes less credible, burden increases, patient priorities change, implementation proves infeasible, or new uncertainty becomes consequential.

Table 2. Preserving the reasoning needed to revisit a medication trade-off

Decision-record element	Minimum information retained	Condition that may reopen deliberation	Responsibility question if the condition occurs
Competing priorities	Which legitimate priorities could not all be fully protected	A priority changes in importance or a previously minor concern becomes consequential	Who will recognize and communicate the change?
Current settlement	What medication action is acceptable now and why	The accepted balance no longer protects the priority it was intended to protect	Who has authority to reconsider the medication plan?
Accepted sacrifice	Which burden, risk, inconvenience, or foregone benefit is being tolerated	The sacrifice becomes greater or less acceptable than anticipated	Who monitors whether tolerance has changed?
Residual uncertainty	What remains materially unknown	New evidence resolves, increases, or changes the relevance of uncertainty	Who interprets the new information with the patient?
Enactment responsibilities	Who performs monitoring, communication, implementation, and support	A required task is delayed, unavailable, or exceeds an actor's authority or resources	Who reallocates or escalates the responsibility?
Revisit condition	What change would justify reopening the decision	The specified condition occurs or an unforeseen material change arises	Who initiates renewed deliberation and ensures the prior rationale is visible?

Managing disagreement and uncertainty

Shared decision-making does not guarantee equal influence or genuine equipoise. Clinicians describing treatment-escalation decisions with older adults reported constraints arising from urgency, power asymmetry, and the range of options considered clinically reasonable [31]. Medication management can encounter analogous limits: some options may be unacceptable on safety

grounds, while other disputes reflect legitimate differences in how uncertain benefits and burdens are valued.

Uncertainty can remain present throughout deliberation rather than disappearing before a decision is made [24]. The model therefore distinguishes several defensible states. Participants may converge on one option, reach provisional accommodation despite continuing

differences, defer a choice while information is sought, retain explicitly unresolved conflict, or reassess an earlier settlement. Context-sensitive evidence from deprescribing similarly cautions against assuming that collaborative processes produce one invariant endpoint [26].

These states should not be ranked automatically from success to failure. Forced consensus can conceal disagreement that is clinically or ethically important.

Conversely, continued disagreement does not require indefinite inaction when a safe temporary arrangement can be justified and reviewed. What matters is whether the unresolved issue, current action, responsibility, and conditions for reconsideration are made visible.

Figure 2 represents disagreement and uncertainty as branching states with possible return routes rather than as obstacles that must always terminate in consensus.

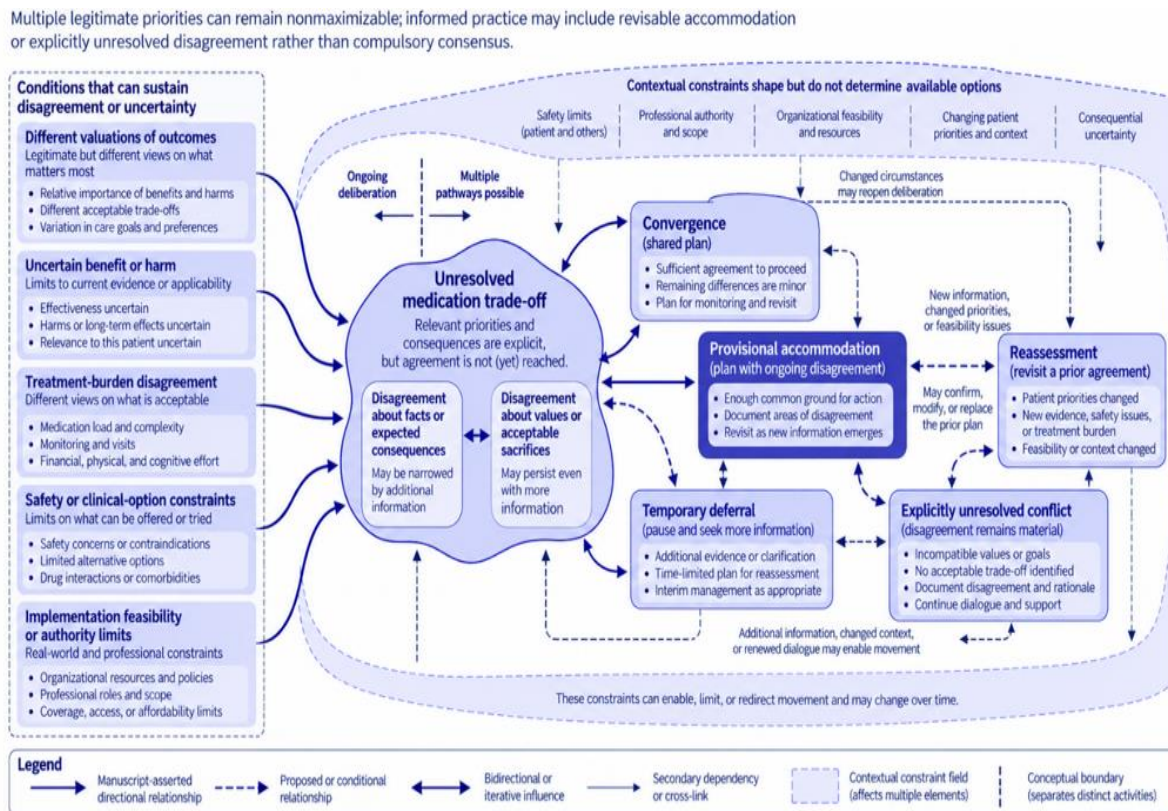


Figure 2. Branching states of medication agreement under persistent disagreement and uncertainty

Implications for medication management

The model suggests that medication review should distinguish three questions that are often compressed into one: whether a medicine remains clinically appropriate, whether the resulting option accords sufficiently with patient priorities, and whether the agreed plan can actually be implemented. Deprescribing research demonstrates substantial variation in how shared decision-making is operationalized [21], reinforcing the need to specify what deliberative work has occurred.

Transitions between professionals and settings deserve particular attention because information and role discontinuities can destabilize an otherwise acceptable

agreement [28]. Medication records should therefore carry the rationale and revisit conditions as well as the medication change itself.

Longitudinal implementation also requires organizational support. Experience with large-scale priorities-aligned care shows the importance of sustained engagement and accountability [30]. The practical implication is not a new mandatory checklist for every medication decision. More elaborate deliberation is warranted when legitimate priorities materially compete; routine decisions without meaningful conflict should remain proportionate.

Results and Discussion

This article addresses a gap between identifying what matters and deciding what to do when several legitimate priorities point in different directions. Multimorbidity guidance already recognizes the need to consider patient priorities, burden, benefit, prognosis, and feasibility [1]. The Deliberative Medication Trade-Off Model adds a narrower theoretical claim: when priorities materially conflict, their incompatibility should itself become an explicit object of deliberation.

Its strongest rival is that established priority-alignment methods and ordinary shared decision-making already provide sufficient guidance. That explanation should be preferred when identifying a dominant priority is enough to determine an acceptable action. The additional model becomes useful only when elicitation leaves a consequential conflict unresolved. Evidence concerning uncertainty, context-dependent deprescribing processes, and constrained shared decision-making supports preserving this possibility rather than treating consensus as inevitable [24, 26, 31].

The model also has important boundaries. Shared decision-making varies across patient, relational, organizational, and wider contextual levels [15], so a negotiated preference cannot guarantee that the necessary option is available or implementable. Clinical safety, law, professional obligations, urgency, and resource constraints may legitimately narrow the choice set. Nor should every minor preference difference trigger elaborate trade-off analysis.

The framework remains conceptual. Its proposed distinctions require empirical testing against simpler alternatives. Studies could examine whether explicit trade-off articulation changes the traceability of medication decisions, whether provisional agreements are revisited more appropriately than undocumented compromises, and whether responsibility allocation reduces failures between decision and enactment. Patient Priorities Care already shows that priorities can be incorporated into clinical decision-making [2]; the next discriminating question is whether making conflicts and conditions for revision explicit produces additional value when priorities genuinely compete.

Conclusion

One patient can have several legitimate treatment priorities without there being a single arrangement that

fully maximizes them all. In those circumstances, good medication management requires more than identifying what matters or selecting the technically strongest option. Competing priorities must be made visible, the sacrifices attached to available choices understood, and any settlement treated as justified for present conditions rather than permanently settled.

The Deliberative Medication Trade-Off Model therefore defines agreement as potentially provisional and revisable. It also recognizes accommodation, deferral, reassessment, and explicitly unresolved disagreement as possible outcomes when uncertainty or legitimate value conflict persists. Its central claim is conditional: where important priorities genuinely compete, the quality of interdisciplinary medication management depends partly on whether the trade-off, current settlement, responsibilities, and conditions for reopening the decision have been made explicit.

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