Society of Medical Education & Research

2026, Volume 6, Issue 1, Page No: 11-20

ISSN: 3108-5059

Asian Journal of Ethics in Health and Medicine

Who Owns a Shared Decision? Distributed Responsibility in Interprofessional Clinical Judgment

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Abstract

Shared decision-making is commonly described as a collaborative clinical ideal, yet collaboration does not by itself determine who owns the responsibilities generated by a decision. In interprofessional care, patients, physicians, nurses, consultants, family members, and institutions may contribute different forms of knowledge, influence, authority, implementation work, and retrospective answerability. This philosophical analysis examines that unresolved ownership problem by treating the clinical decision episode, rather than a single moment of consent, as the relevant unit of analysis. It distinguishes epistemic, communicative, procedural, and moral contributions from implementation responsibility and retrospective accountability, and argues that these dimensions can overlap without becoming interchangeable. The analysis further proposes that responsibility may be distributed across persons, professions, institutions, and phases of care without being diluted into collective nonresponsibility. On this basis, the article develops a proposed Decision-Ownership Framework for identifying who knew, communicated, authorized, influenced, acted, and remains answerable within a shared decision. The framework is intended as a conceptual and normative aid rather than a validated clinical tool, legal allocation rule, or quantitative method for apportioning blame. Its usefulness is therefore bounded by differences in capacity, professional authority, institutional structure, jurisdiction, clinical urgency, epistemic power, and the changing configuration of responsibility across time. The central claim is that a shared decision can be genuinely co-produced while still generating differentiated and sometimes overlapping obligations. Accordingly, ownership should be reconstructed as a pattern of responsibility relations rather than a single transferable status attached to one decision-maker.

Keywords: Shared decision-making, Interprofessional care, Responsibility, Accountability, Clinical ethics, Relational autonomy

Introduction

Shared decision-making is often treated as if the adjective “shared” settles the question of responsibility. It does not. A decision may be shared because several parties deliberate, because patient preferences affect the chosen option, because clinicians exchange recommendations, or because multiple actors must act for the decision to become effective. Engelsma’s analysis is useful precisely because it separates sharing a decision from merely sharing a decision-making process [1]. The ownership problem begins where that distinction becomes ethically consequential: participation in a common process does not tell us whether authority, obligation, and accountability are also shared, or whether they remain differentiated.

Contemporary accounts of shared decision-making emphasize invitation, deliberation, and responsiveness to the patient’s preferred degree of participation [2]. Yet

Access this article online https://smerpub.com/

Received: 14 October 2025; **Accepted:** 19 January 2026

How to cite this article: Müller H, Schmidt A, Weber T. Who Owns a Shared Decision? Distributed Responsibility in Interprofessional Clinical Judgment. Asian J Ethics Health Med. 2026;6(1):11-20. https://doi.org/10.51847/qe0JPE52ri

interprofessional care adds a second layer of complexity. Professional collaboration can coexist with medical dominance and unequal epistemic standing, meaning that nominally shared discussion may still privilege some contributions over others [3]. Empirical work also suggests that health professionals differ in their willingness to assume or relinquish responsibility within collaborative practice [4]. Relationship-centred models further indicate that decisions are formed within ongoing interpersonal and organizational contexts rather than through isolated exchanges between abstractly equal agents [5].

This article argues that the unresolved question is therefore not simply who "made" a shared decision. The more precise question is which responsibilities arise from which contributions, at which stage, and for whom. The proposed answer rejects both a single-owner model and the opposite assumption that every participant owns every consequence equally. Instead, ownership is reconstructed as multidimensional, temporally extended, and sensitive to role, capacity, authority, influence, and undertaken obligation. The analysis remains philosophical: it does not claim that the resulting framework has been empirically validated, legally codified, or shown to improve clinical outcomes. Nor does it assume that moral accountability mirrors professional hierarchy. A senior clinician may possess decisive procedural authority while another participant bears a distinct duty arising from knowledge, communication, implementation, or institutional control.

The clinical decision episode as the unit of analysis

A responsibility analysis becomes distorted if the decision is reduced to the moment at which a patient says yes or no. Shared decision-making has been described as a method of care rather than a discrete technique, emphasizing that deliberation is embedded within an ongoing clinical relationship [6]. That temporal insight matters for ownership. Knowledge may be supplied before authorization, communication may continue after an apparent choice, and implementation or monitoring may generate new obligations that were not visible at the point of consent.

Interprofessional clinical decision-making is likewise better understood as a process involving contributions from different professionals rather than as a single act attributable to one person [7]. This article therefore proposes the clinical decision episode as the unit of analysis: the temporally extended sequence through which a clinically consequential choice is initiated, interpreted, deliberated, authorized, implemented, monitored, and later reviewed. The exact phase structure is proposed here rather than treated as an established empirical taxonomy. Its purpose is analytic—to make visible when responsibility is acquired, transferred, retained, or left unowned.

The episode can also include repeated micro-decisions. In hospitalized dementia care, nurses describe shared decision-making as part of daily care rather than only as a formal one-time event [8]. This illustrates why downstream work cannot be treated as ethically secondary. A physician may authorize a plan, a nurse may identify that it is no longer tolerable, a family member may supply new contextual knowledge, and an institution may control the mechanism through which concerns are escalated. Responsibility can therefore shift in salience without disappearing. A phase-sensitive account is needed because the person who had authority at one moment may not be the person who later possesses the knowledge, opportunity, or duty required to prevent an avoidable failure. The episode thus provides a common temporal frame within which these changing responsibilities can be compared without assuming that they are identical.

Shared agency and the fragmentation of responsibility

Shared agency does not imply that the clinical team functions as one undifferentiated moral subject. Healthcare systems can support forms of collective responsibility while still preserving individual responsibility for particular contributions and omissions [9]. This matters because a shared decision is often produced by a network whose members possess unequal competencies, different professional mandates, and varying opportunities to affect what happens next. Collective language is therefore useful only if it does not conceal the responsibilities of identifiable actors.

Fragmentation becomes especially visible when epistemic contributions conflict. Analysis of peer disagreement in AI-supported diagnosis shows that responsibility becomes difficult to attribute when competent sources recommend different courses of action and no single source has uncomplicated epistemic priority [10]. The AI context is distinctive, but the underlying conceptual point transfers cautiously: disagreement can separate the person who contributes important knowledge from the person who ultimately

authorizes action. The final decision may thus be singular while the reasoning that produced it remains distributed.

Responsibility-gap scholarship provides a second stress test. Ferlito and colleagues argue that distributed agency in healthcare AI can create apparent gaps in which conventional individualistic models struggle to identify an adequate bearer of responsibility [11]. The present analysis does not assume that ordinary interprofessional teams generate the same problem. Instead, it distinguishes three possibilities. First, there may be a genuine attribution gap. Second, an obligation may be practically orphaned because no one has accepted forward-looking responsibility for it. Third, several actors may have overlapping duties, even though retrospective narratives later portray the failure as belonging to only one person.

The normative danger lies at both extremes. A single-owner model can misattribute responsibility to the actor with the most visible formal authority while ignoring the roles of others. A fully collectivized model can permit diffusion, because everyone's involvement becomes a reason to identify nobody's particular obligation. The stronger position is that shared agency can generate differentiated, concurrent responsibilities whose content depends on what each actor knew, could do, was authorized to do, undertook to do, and was reasonably expected to communicate. Fragmentation, on this account, is not itself a defect; it becomes ethically problematic when differentiation is obscured, unacknowledged, or reconstructed only after harm.

Epistemic, communicative, procedural, and moral contributions

The first step in avoiding responsibility diffusion is to separate forms of contribution that are often collapsed. Epistemic contribution concerns decision-relevant knowledge: diagnosis, prognosis, experiential knowledge, functional observation, contextual knowledge, and the credibility assigned to each. Work on epistemic injustice in healthcare shows why contribution cannot be assessed merely by asking who spoke; the standing accorded to a contribution is itself ethically significant [12]. Epistemic contribution, however, does not automatically confer procedural authority.

Communicative contribution concerns enabling understanding, eliciting preferences, translating technical options, disclosing uncertainty, and making disagreement visible. Procedural contribution concerns formal powers to authorize, order, consent, refuse, or activate institutional processes. Moral contribution concerns reasons and value judgments that shape what participants regard as acceptable or obligatory. Clinical ethics consultation clarifies the distinction: facilitation can materially shape deliberation while aiming to preserve the moral agency of those whose decision is at issue [13]. Influence is therefore not equivalent to ownership of the final judgment.

The article proposes that these forms of contribution should be mapped separately from two further dimensions: implementation responsibility and retrospective accountability. A participant may be central in one dimension and peripheral in another. This prevents the misleading inference that the most influential person necessarily possessed formal authority, or that the person with formal authority necessarily performed the downstream work on which the decision's safety depended and is shown in **Table 1**.

Table 1. Distribution of clinical contributions and responsibilities across participants in shared decisions

Participant	Epistemic contribution	Communication	Procedural authority	Moral influence	Implementation responsibility	Retrospective accountability
Patient	Values, goals, lived experience, burden tolerance	Preferences, questions, assent or refusal	Central where decisionally authorized; context-dependent	Usually central to value-sensitive judgment	Agreed self-management or participation	For voluntary undertakings, not professional duties
Physician	Diagnosis, prognosis, treatment options	Explanation, recommendation, deliberation	Often substantial but jurisdiction- and task-dependent	Recommendation may strongly shape choice	Orders, referrals, treatment duties	Professional accountability for role-specific acts and omissions
Nurse	Continuous observation, feasibility, functional context	Elicitation, translation, advocacy, escalation	Variable by scope and decision	May shape practical and relational judgment	Frequently substantial in enactment and monitoring	Nursing accountability for undertaken duties and escalation

Consultant	Specialist or ethical expertise	Advice, interpretation, facilitation	Often advisory; depends on remit	Can materially reframe reasons	Limited unless treatment task is assumed	Accountability for consultation quality and scope
Family/ supporter	Biographical, contextual, caregiving knowledge	Support, interpretation, preference communication	Conditional on capacity, authorization, law, and context	May exert substantial relational influence	Caregiving tasks if undertaken	Tied to actual role, not relationship alone
Institution	Protocols, records, staffing, infrastructure	Enables or constrains information flow	Allocates procedures, scopes, escalation routes	Shapes norms and feasible options	Provides continuity systems and resources	Organizational and forward-looking responsibility where capacity exists

Note: The six-column distinction is an original proposed synthesis. Role patterns are context-dependent and do not constitute fixed legal allocations.

Distributed responsibility without diluted accountability

A distributed account should not be mistaken for a mathematical division of responsibility. Brown and Savulescu show why healthcare responsibility may extend across agents and across time rather than attaching exclusively to the person closest to the final act [14]. The implication is not that responsibility becomes smaller as the number of contributors increases. Rather, different agents may remain fully answerable for different obligations within the same decision episode.

Collective forward-looking responsibility sharpens this point. Müller and colleagues argue that collective responsibility depends on relevant forms of agency, capacity, and opportunity to act [15]. Applied cautiously to clinical institutions and teams, this means that responsibility should not be attributed merely because an actor belongs to a group. A hospital may possess a responsibility to design escalation pathways because it controls the infrastructure; a nurse may possess a responsibility to escalate because she observes deterioration; a physician may possess a responsibility to reconsider treatment because he holds the relevant clinical authority. These responsibilities overlap without becoming interchangeable.

The distinction between authority and accountability is especially important. Empirical-ethical work on clinical decision support shows that participants do not treat decision-making authority and responsibility as automatically identical [16]. Although that evidence arises from a technology-mediated context, it supports the conceptual need to analyse the two dimensions separately. Formal authority can justify heightened accountability, but accountability can also arise from knowledge, control, undertaking, or a duty to communicate.

The proposed principle is therefore distributed responsibility without diluted accountability. Shared decision-making can disperse the production of judgment while preserving specific answerability for role-dependent contributions and omissions. This principle also resists retrospective simplification. After an adverse outcome, identifying a "decision owner" may be tempting because institutions need an intelligible narrative. Yet a morally adequate analysis asks a more demanding set of questions: who possessed relevant knowledge, who could authorize, who influenced deliberation, who undertook implementation, who had the opportunity to detect failure, and which obligations persisted after authority shifted? Distribution is not exculpation; it is a demand for more precise attribution. The normative task is therefore not to restore a fictive single owner, but to preserve the visibility of distinct responsibilities throughout a genuinely shared process.

Responsibility gaps, duplication, and retrospective blame

The language of a "responsibility gap" can be useful, but it can also prematurely convert an attribution problem into an absence of responsibility. Recent analysis of medical AI argues that causal selection and authorship-like attribution can refine judgments that would otherwise be described as gaps [17]. The technological setting is distinctive, yet the philosophical lesson is broader: before concluding that no one owns a failure, analysis should determine which actor made a causally and normatively relevant contribution, possessed the capacity to intervene, or assumed an obligation that remained unfinished.

Digital-health scholarship similarly indicates that technologies can alter the relations through which moral responsibility is assigned [18]. This should not be

generalized into a claim that technology itself creates every gap. In interprofessional judgment, responsibility can also become obscured through handoffs, overlapping scopes, ambiguous escalation routes, or the separation of deliberation from implementation. A gap may therefore be genuine, apparent, or organizationally produced. The framework proposed here treats "orphaned obligation" as distinct from a metaphysical absence of responsibility: a task can remain ethically necessary even when no participant has explicitly accepted it.

A useful diagnostic consequence follows. A responsibility gap should not be declared merely because no actor controlled the entire episode. Control may be distributed by design. The more specific inquiry is whether each morally relevant obligation can be connected to an actor or institution with the knowledge, authority, capacity, or undertaking that makes the obligation intelligible. Where that connection exists, the problem is attribution rather than absence; where it does not, the framework identifies a candidate structural gap without presuming who should bear it.

Clinical decision support provides an additional test because meaningful human agency may persist even when recommendations are technologically mediated [19]. The same caution applies to human teams. Retrospective blame should not simply migrate toward the most visible clinician after harm, nor toward the last actor in the causal chain. Appropriate attribution requires attention to prior authority, knowledge, opportunity, undertaken tasks, and institutional control. Duplication presents the opposite problem: several actors may assume the same responsibility while another essential task remains unattended. The relevant question is therefore not how many people were "responsible," but whether every responsibility generated by the episode had an identifiable bearer and whether retrospective accountability tracks the responsibilities actually held prospectively. **Table 2** presents modes in distributed clinical responsibility.

Table 2. Failure modes in distributed clinical responsibility and their accountability implications

Failure mode	Proposed meaning	Accountability implication
Responsibility diffusion	Multiple participants are treated as grounds for weaker individual answerability	Participation obscures role-specific obligations
Orphaned obligations	A necessary future task has no recognized bearer	Forward-looking responsibility remains unallocated
Authority–accountability mismatch	Control and answerability fall on different actors	Attribution may become unfair or incomplete
Duplication	Several actors assume the same duty while another remains uncovered	Overlap does not guarantee complete responsibility coverage
Retrospective displacement	Blame shifts after an outcome without tracking prior role, knowledge, or control	Backward attribution diverges from prospective responsibility
Documentation failure	Records do not preserve reasoning, commitments, transfer, or pending action	Continuity and later attribution become unreliable
Unowned follow-up	Monitoring or review responsibility disappears across a transition	A nominally completed decision retains unfinished obligations

Note: These categories are analytical distinctions proposed in this article; they are not validated clinical failure classifications or estimates of prevalence.

The decision-ownership framework

Clinical responsibility cannot be reconstructed adequately by asking only who signed, consented, ordered, or spoke last. A more useful philosophical analysis must remain responsive to the particular case rather than functioning as a mechanical allocation rule. Clinical pragmatism supports this contextual orientation by treating ethical inquiry as responsive to the concrete features of a case [20]. The proposed Decision-Ownership Framework therefore asks six questions: Who supplied relevant knowledge? Who enabled communication? Who possessed procedural authority? Who materially influenced the judgment? Who undertook implementation or monitoring? Who remains appropriately answerable afterward?

These questions are deliberately non-hierarchical. Epistemic contribution can be decisive without authorization; procedural authority can be extensive despite limited first-hand knowledge; implementation can create new duties after deliberation has ended. Retrospective accountability should therefore be reconstructed from the configuration of the episode

rather than inferred from title or seniority alone. The framework also permits several actors to answer the same question for different reasons. Overlap is not a conceptual defect if the obligations remain specified and if one participant's responsibility is not used to cancel another's.

Ethical pluralism also limits any attempt to turn those questions into a deterministic algorithm. Pragmatist approaches to clinical ethics recognize that morally reasonable perspectives may remain in tension even after structured deliberation [21]. A shared clinical decision may thus be jointly produced while its responsibilities remain differentiated across participants, temporal stages, and collective structures [1, 14, 15]. The framework does not resolve every disagreement about responsibility; instead, it makes the grounds of disagreement visible. It asks whether accountability is being attributed because of authority, knowledge, influence, undertaking, capacity, or some defensible combination of these.

Communication deserves particular attention because procedural accounts can understate its moral significance. Analyses of what shared decision-making asks from clinicians emphasize relational and communicative qualities beyond formal completion of decisional steps [22]. The framework accordingly treats communication as responsibility-relevant without assuming that communicative influence grants authorization. Its six dimensions are proposed analytical distinctions, not measured variables, legal categories, or a hierarchy of professional worth.

Figure 1 synthesizes the proposed Decision-Ownership Framework by separating six responsibility-relevant dimensions within a shared clinical decision: epistemic contribution, communicative contribution, procedural authority, moral influence, implementation or monitoring responsibility, and retrospective accountability. Rather than assigning the decision to a single actor, the figure depicts how these dimensions may be distributed unevenly and overlap across patients, clinicians, supporters, and institutions while remaining analytically distinct. It therefore makes visible the article's central claim that participation in a shared decision can be genuinely distributed without making authority, obligation, or answerability interchangeable.

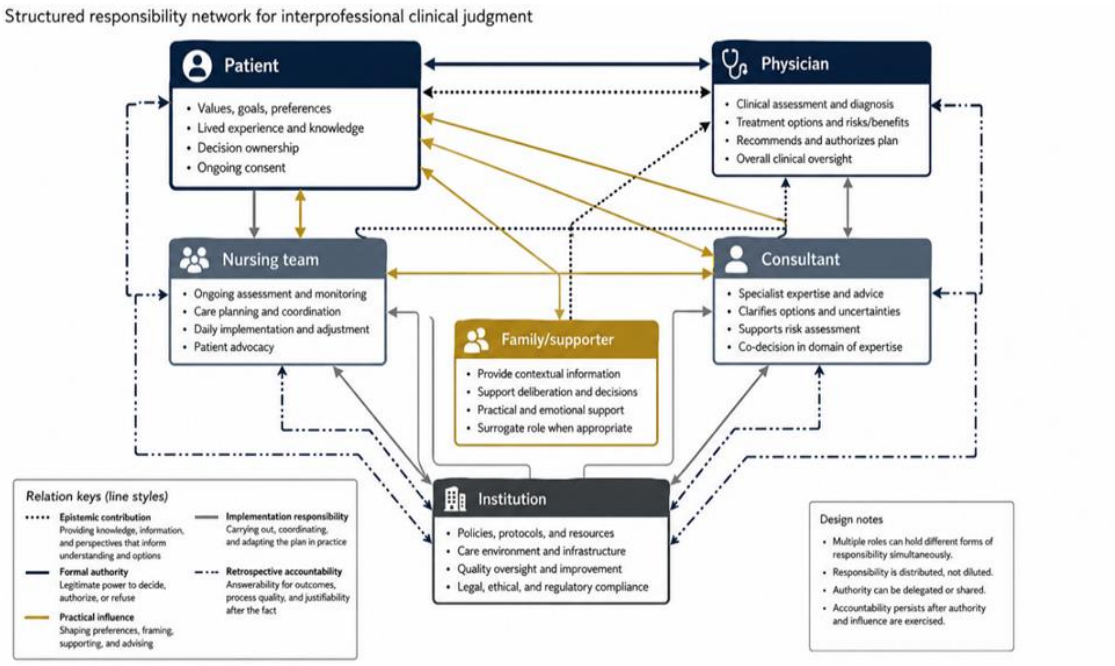

Figure 1. Distribution of authority, influence, contribution, and accountability in shared clinical decisions

Application to interprofessional clinical scenarios

The framework can first be applied to an oncology multidisciplinary meeting. Structured observation of oncology meetings shows variation in the information and deliberative quality available to team decisions [23]. Within the proposed framework, the clinician who chairs

or records the recommendation need not be treated as the sole owner. One participant may contribute imaging expertise, another treatment knowledge, another knowledge of the patient's condition, while procedural authority and later implementation remain elsewhere. The framework asks which contribution generated which responsibility instead of converting multidisciplinary participation into equal accountability.

Palliative cancer care provides a different configuration. Patients, family caregivers, and clinicians can experience shared decision-making through distinct but interdependent roles [24]. A family supporter may have substantial practical influence and unique biographical knowledge without acquiring the patient's procedural authority. A nurse may carry communication and monitoring responsibilities without owning the treatment choice as a whole. Conversely, respecting patient authority does not release professionals from obligations to explain, recommend, implement, or reconsider when circumstances change.

Home and community nursing further illustrates how setting alters responsibility relations. An integrative review indicates that patients' and community nurses' experiences of shared decision-making are shaped by the home-care relationship and context [25]. Here implementation and monitoring may occupy a larger portion of the episode than a brief authorization encounter suggests. Across dementia, palliative, and community-care contexts, the salience of nursing, patient, caregiver, and implementation roles varies rather than following one universal pattern [8, 24, 25]. These examples are applications of the proposed framework, not tests establishing its validity.

Figure 2 extends the framework temporally by mapping responsibility across the clinical decision episode from initiation and interpretation through deliberation, authorization, implementation, monitoring, and retrospective review. The figure shows that responsibility may be acquired, retained, transferred, duplicated, or left insufficiently allocated as the episode progresses, such that the actor holding procedural authority at one phase need not remain the principal bearer of responsibility in later phases. This phase-sensitive representation also identifies the points at which responsibility diffusion, orphaned obligations, authority–accountability mismatch, documentation failure, or unowned follow-up may emerge.

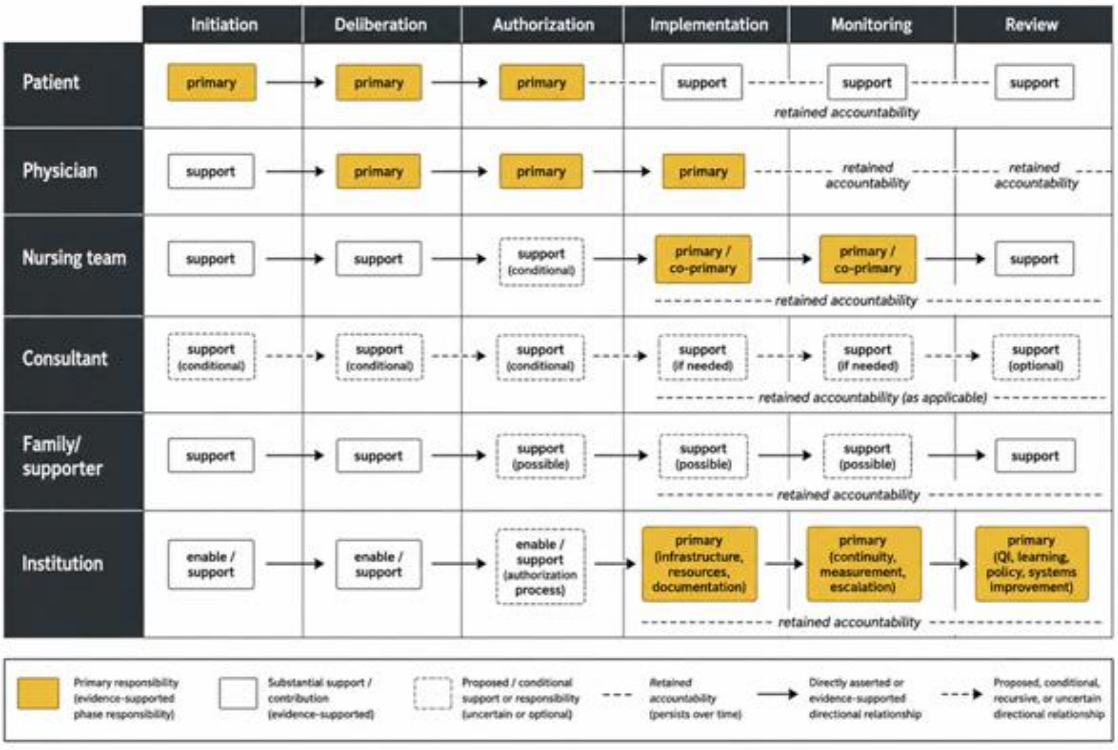

Figure 2. Responsibility allocation across phases of shared clinical decision-making

Documentation and institutional implications

If responsibility is distributed across a decision episode, documentation becomes ethically relevant not because the record creates responsibility, but because it can preserve or obscure its continuity. A scoping review of shared decision-making tools integrated into electronic health records shows that decision-support and shared-decision processes can be embedded within clinical information systems [26]. Such infrastructure may record options, preferences, reasoning, or workflow steps, but its presence does not establish that responsibility has been appropriately allocated. A checkbox confirming "shared decision-making" cannot by itself show who undertook follow-up, which uncertainty remained unresolved, or whose authority governed the final choice. The institutional implication is therefore narrower than prescribing a particular documentation system. Where responsibilities span professions and phases, records should be capable of making consequential commitments and transfers visible. This is especially important when the clinically important obligation emerges after apparent authorization. Evidence on communication of blood-test results in primary care identifies problems surrounding communication, action, and follow-up processes [27]. Those findings do not establish a universal model for all clinical decisions, but they demonstrate how safety-relevant work can depend on what happens after information becomes available.

The proposed concept of unowned follow-up captures this vulnerability. A plan may be deliberated and authorized competently yet remain ethically incomplete if nobody is responsible for checking whether it occurred, interpreting new information, or escalating deterioration. Institutions may therefore bear forward-looking responsibilities when they control routing systems, staffing, documentation fields, escalation procedures, or continuity mechanisms. This does not make an institution the owner of every clinical decision. It identifies organizational responsibility where system design determines whether individual obligations can be recognized and fulfilled. Documentation should consequently support prospective clarity, not merely retrospective blame reconstruction.

Objections and limits

A first objection is that decision ownership may be impossible to generalize because authority depends on capacity, age, law, profession, and jurisdiction. Adolescent healthcare illustrates this difficulty: developing autonomy, parental responsibilities, and clinicians' obligations can produce genuinely multi-party decisions without a single stable pattern of authority [28]. The framework therefore cannot determine legal consent authority or professional liability. It is a philosophical map of responsibility relations that must be interpreted within applicable institutional and jurisdictional rules.

A second objection is that mapping contribution may reproduce existing power rather than correct it. Shared decision-making depends on epistemic participation, and epistemic justice has been argued to be foundational to that participation [29]. A network can therefore appear distributed while systematically discounting the patient, nurse, minority professional, or family member whose knowledge lacks institutional credibility. Nominal inclusion does not guarantee equitable epistemic participation because professional hierarchy, conceptual forms of epistemic injustice, and communicative credibility remain relevant [3, 12, 29].

A further objection concerns moral remainder. Even a detailed allocation may leave participants reasonably disagreeing about whether an obligation was sufficiently demanding, whether another professional should have intervened, or whether institutional constraints excuse an omission. The framework does not eliminate these disagreements. Its testable value would lie in whether it exposes their underlying grounds more clearly than a single-owner vocabulary, not whether it produces unanimous judgments.

Finally, the framework may over-differentiate decisions that clinicians must make rapidly or under uncertainty. That limitation is accepted. The six dimensions are analytical rather than mandatory conversational steps. Emergencies, impaired capacity, resource constraints, and rapidly changing clinical conditions may compress or reconfigure the episode. Empirical work is needed to determine whether observers can apply the framework consistently, whether it identifies responsibilities overlooked by simpler models, and whether its categories require revision across specialties and jurisdictions.

Conclusion

Shared clinical decisions need not have a single owner, but neither are they ethically ownerless. This analysis proposes that ownership is better reconstructed as a pattern of epistemic, communicative, procedural, moral, implementation, and retrospective responsibilities distributed across a clinical decision episode.

Distribution does not entail dilution: different participants may remain fully answerable for different obligations, and institutions may carry responsibilities arising from capacities they uniquely control.

The proposed Decision-Ownership Framework does not allocate legal liability, measure blame, or validate a clinical workflow. Its contribution is diagnostic and philosophical. By separating authority from influence, contribution from implementation, and collective participation from collective exculpation, it offers a way to ask more precisely what a shared decision commits each participant to do. The central challenge is not to identify one person who owns the whole decision, but to ensure that no ethically significant responsibility becomes invisible because the decision was shared.

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

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