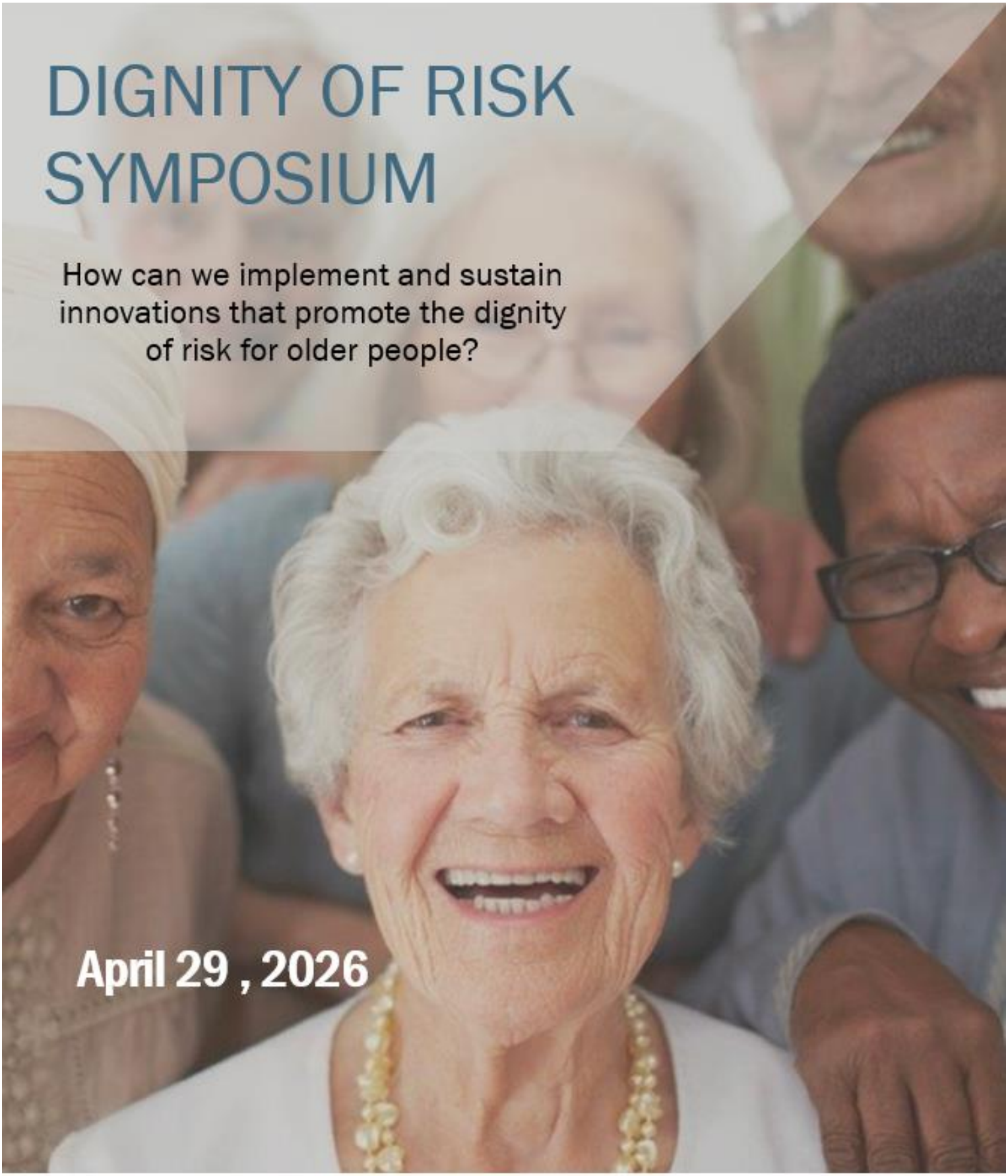
DIGNITY OF RISK SYMPOSIUM

How can we implement and sustain innovations that promote the dignity of risk for older people?



April 29 , 2026

SYNTHESIS OF THE WORKSHOP PARTICIPANTS' COMMENTS

Living with Risk
Research Team

DIGNITY OF RISK SYMPOSIUM

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Preamble

This document presents a summary of what was heard from participants at the Dignity of Risk Symposium, which took place virtually on April 29, 2026, and examined the common barriers to implementing and sustaining a dignity of risk philosophy or innovation into practice*.

For information, 757 people took part in the symposium. Around two-thirds of the participants (67%) were practitioners**, one-quarter were managers (26%) and the rest (7%) were PPROs (Planning, Programming, and Research Officers at Santé Québec), researchers, executive-level advisors, seniors, coroners or administrative staff. The proportions of English- and French-speaking participants were similar, at 53% and 47%, respectively.

Throughout this report, the term "risk" refers to the possibility of both positive and negative consequences. In healthcare, however, discussions about risk often become focused almost exclusively on the possibility of harm. Participants repeatedly challenged this narrow perspective, emphasizing that many decisions involving uncertainty are undertaken because of the potential benefits they offer to the individual's autonomy, identity, quality of life and participation.

Artificial intelligence (AI) was used to support data analysis and the drafting of this report. **In this report, the term **"practitioners" refers to individuals who identified themselves as clinicians or health and social services professionals.*

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BARRIER 1: FEAR OF ACCOUNTABILITY/REPRISALS

At the end of **Part 1 (Fear of Accountability) of the symposium**, participants were asked five questions, to which 284 English speaking and 234 French speaking responded:

1. In your setting (or scenario) where would the fear of accountability show up most in your day-to-day work when applying a dignity of risk approach?
2. What specifically stops you or your team from supporting dignity of risk?
3. At what level (practitioner, team, organization, system) is the biggest barrier?
4. What solutions could you, your team or your organization do to overcome the fear of accountability when adopting a dignity of risk approach?
5. Select the top 3 solutions that would work for you/your team/your organization to overcome the fear of accountability when adopting a Dignity of Risk approach.

Here is a summary of the participant's responses to these questions related to the fear of accountability should they adopt a dignity of risk philosophy, principles or innovation:

1. Fear of accountability or reprisal

Although they recognized a certain fear related to their ability to adequately defend their decision-making process, participants did not primarily describe the fear of accountability as a fear of legal consequences (e.g., lawsuits). Participants refer to it rather as the **fear of being blamed**, **challenged or judged**. Participants feared not only explaining their decision but having to defend that it was a reasonable clinical decision despite a negative outcome. This liability is thus perceived as a professional **vulnerability in everyday life**, rather than as a formal legal risk. This fear may also reflect a misunderstanding of duty of care. Language such as "How will we explain that we allowed it?" positions practitioners as permission-givers and can obscure their parallel responsibilities to respect autonomy, self-determination and reasonable risk-taking. Accountability was perceived as largely one-sided: professionals anticipate being questioned for not preventing visible harm but are less often asked to account for unnecessary restrictions or the harm of not supporting autonomy.

It's not just the fear of an incident happening,
but that of being left alone to explain it and defend one's decision.

Manifestations of this fear

This fear of accountability would arise especially when 1) autonomy involves a **visible risk**; and 2) **in everyday micro-decisions**:

- When the person's choices are deemed "risky" (e.g., declining treatment, leaving a supervised environment, making decisions that could lead to a foreseeable danger such as a fall);
- When an incident is difficult to anticipate;
- When you need to arbitrate between safety and autonomy in daily decisions using your clinical judgment.

The more visible the risk of harm, the lower the organizational tolerance even when the likelihood of that harm is uncertain and the less visible harms of restriction have not been considered.

Amplifiers of this fear

Participants described factors that amplifies their fear.

Retrospective judgment. The fear of accountability arises not only from the risk of institutional reporting or reproach, **but also from the obligation to justify oneself after the fact**. Participants were worried about managers, colleagues, physicians and coroners. Accountability was experienced as multi-directional and fear became relational.

Lack of organizational support. Fear increases when participants doubt that: 1) they will be understood, supported, or defended by the organization; and (2) be recognized as having exercised reasonable judgment. Some also fear that their documentation is insufficient to ensure their defence.

Care Partners. When family or friend care partners express differing opinions about safety and independence, participants fear that they will be held responsible for the final decision.

Impacts of the fear of accountability

This fear may also lead practitioners and teams to close alternative possibilities before fully exploring whether the person's choice could be reasonably supported. Emphasizing a possible negative outcome—even when it is unlikely—can make restriction appear necessary before the benefits of the choice, the harms of restriction and possible risk-mitigation strategies have been considered.

2. Barriers to the application of the dignity of risk

Participants do not question the dignity of risk philosophy. Rather, they describe **a system where *restriction* is often simpler, faster and easier to defend than *autonomy*.**

Observation 1: Culture of risk aversion. According to the respondents, organizations are generally more comfortable preventing, limiting and controlling than negotiating, tolerating or sharing risk of harms. It is not a lack of favorable values, but an

organizational culture that rewards control and the reduction of uncertainty more than support for autonomy. This view is currently embedded in formal frameworks (policies, regulations, compliance requirements), limiting autonomy and fostering a defensive compliance culture. Participants consistently described that choosing the safer option required less explanation and organizational justification than supporting an autonomous choice involving reasonable risk.

Observation 2: Blame culture. The central fear is not that an incident will occur, but that they will be held responsible for not having prevented it or that it will be interpreted as a professional deficiency; thus becomes the anticipation of individual accountability if the risk of harm materializes. This can encourage teams to defend decisions through prevention and restriction rather than through balanced consideration of their responsibilities to both protect and uphold autonomy.

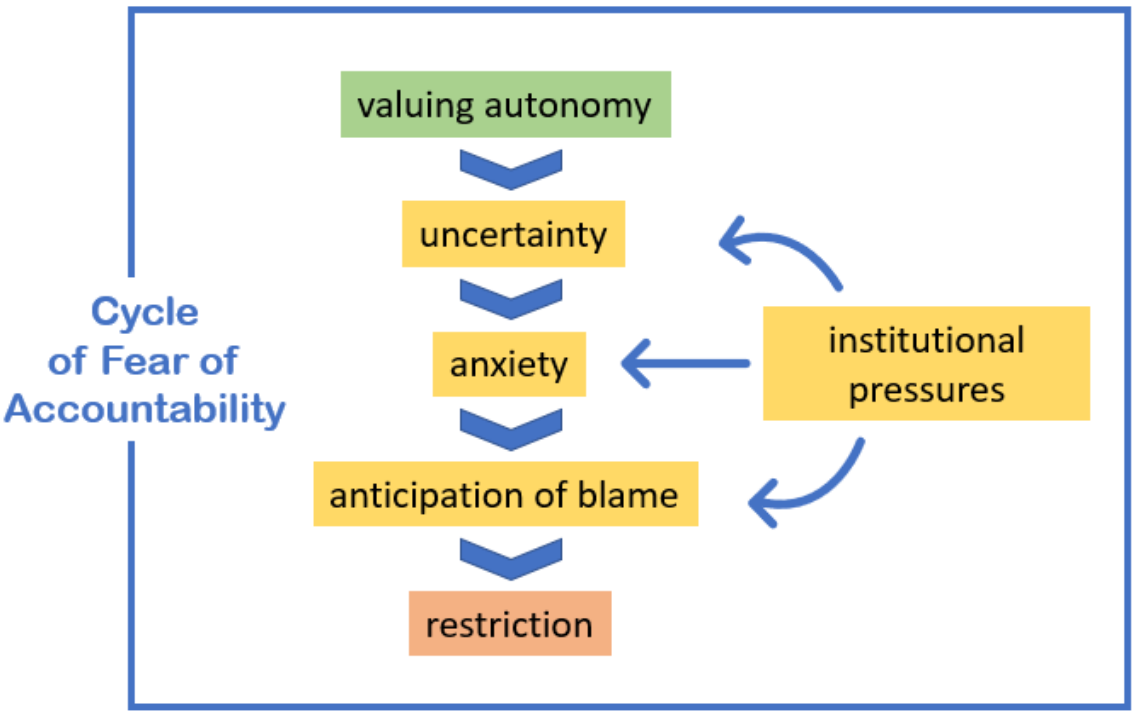
Observation 3: Pressure from care partners. If there is a difference of opinion (e.g., due to different values and risk tolerance, and the fact that each has their own definition of acceptable risk), family or friend care partners can become an active force of restriction, sometimes to the point of questioning clinical judgment. In practice, their influence may weigh more than the preference expressed by the person. When care partners held different perceptions of acceptable risk, practitioners described feeling caught between respecting the person's wishes and responding to the care partner's expectations. These situations are amplified when practitioners lack the time, support or practical skills needed to coach family or friend care partners through uncertainty, negotiate differing risk tolerances and maintain focus on the person's preferences. Without this support, agreeing with an understandably concerned but risk-averse care partner may become the path of least resistance.

Observation 4: Operational constraints. Participants felt that lack of resources, workload and staff turnover make it difficult to apply dignity of risk, which requires more time, presence and follow-up. In a context of pressure, restrictive measures are often preferred, because they are faster and easier to justify.

Observation 5: Lack of tools and benchmarks. Participants point to a lack of knowledge, guidelines and decision-making frameworks to document and support a choice involving potential harms in a defensible way. Guidance is particularly needed on supporting meaningful risk-taking when a person lacks capacity for a particular decision, including how to identify and document the person's values, known wishes, preferences, benefits of risk-taking and harms of restriction.

Participants described that uncertainty, rather than risk itself, was often the greatest source of discomfort.

Dignity of risk requires more effort, coordination, justification and **negotiation** between client and care partners and within the team when there are differences of opinions **while exposing those who support it to criticism**.



3. Level (practitioner, team, organization, system) where the primary barrier to adopting dignity of risk lies

The responses focus on **the organization and the system**, well before the practitioner and the team, therefore dignity of risk is being perceived as an institutional rather than an individual issue. Participants identify the structures (policies, practices, legislative and regulatory frameworks) that frame their actions as the main barrier within their organization and system. The respondents do not refuse to value dignity of risk but acknowledge they work in an environment that makes it difficult to maintain this philosophy. The practitioner is thus the place where the restriction manifests itself, not its source because policies, organizational expectations and regulatory environments shape what practitioners feel able to support.

Participants nevertheless recognized that team dynamics, interprofessional consistency, implicit norms, and variations in risk tolerance play a role, but are not the main obstacles.

4. Suggested solutions

Participants **do not want to reduce the responsibility** for risk-taking or the rigour of the clinical process, but want **to make these processes more explicit, defensible, better supported, shared and collectively supported**.

➡ Structure Improvements

Formalize dignity of risk frameworks, policies and guidelines: A clearly defined and institutionalized philosophy would normalize dignity of risk practices and avoid basing decisions on general values that may lack operational translation.

Equip teams with rigorous and consistent decision-making: Participants felt that dignity of risk still relies too much on individual intuition and instead wanted structured mechanisms such as arbitration processes and explicit means of documenting and justifying decisions. Participants would like to see **more rigorous documentation of reasoning**, choices, risk analysis, consent and trade-offs as a tool for transparency, continuity and justification. These processes should be embedded in routine documentation, policies and team practices so that applying dignity of risk principles does not create unnecessary cognitive or administrative burden.

➡ Strengthening and clarifying support

Participants want clear and consistent support, **visible protection for themselves, and tangible support when decisions, while reasonable, lead to imperfect outcomes.** Formal protection mechanisms ("safe harbour") would be beneficial for professionals. **Organizational support is seen as an essential condition of psychological safety** to make dignity of risk truly practicable. Respondents add the notion of **visible leadership before, during and after the incident** as a possible solution.

➡ Sharing the decision

Collective responsibility: Participants value collegiality and interdisciplinary deliberation. They want the responsibility for the decision to be assumed collectively, avoiding being solely responsible for upholding the dignity of the risk principles when many people are involved in the decision.

Involvement of care partners from the outset: Early and transparent dialogue with care partners, a clearer definition of each person's role and an explanation of the limits of their authority are needed to reduce subsequent disputes. Practitioners also require practical skills in empathic coaching, negotiation and conflict resolution to acknowledge relatives' concerns while keeping the person's values and preferences central.

➡ Transforming the risk culture

Developing a *just culture*:

(1) **The importance of favouring analysis rather than punishment, learning rather than punishment, a constructive review of situations rather than a search for fault.** Establish non-punitive accountability mechanisms (incident reviews, evaluations, investigations) based on clearly defined criteria and focus on improving practices.

(2) A sustainable dignity of risk philosophy or innovation is **incompatible with a punitive culture, as it requires a cultural shift towards a logic of collective learning**;

Building a common culture of risk and valuation of shared decision-making: Participants stressed the importance of training to create a common language around acceptable risk. Training should focus on building practical skills in balanced risk conversations, care partner coaching, value-based decision-making and documentation. The **creation of common benchmarks and the alignment of perceptions** will create a collective framework for interpreting risk in a coherent and balanced way. In addition, respondents mention that valuing and engaging in shared decision-making with the

person could improve relationships and reduce accountability. This could also include formally distinguishing between reasonable risk, duty of care and reckless practice.

Culture change is not seen as a starting point, but as the result of an operational transformation: the training of staff, the structuring of decisions, the provision of tools and organisational support create the conditions for sustainable cultural change. Participants viewed culture change as an outcome of consistent leadership, shared language, clear frameworks and visible organizational support.

➡ Other interesting solutions proposed by the participants

Adapt working conditions to dedicate resources to be able to apply the dignity of risk philosophy.

Mediation mechanisms, in the form of ethical consultation or conflict arbitration, to facilitate dignity of risk when disagreements between practitioners, clients and their care partners.

Reform organizational metrics to reward shared decision-making and acknowledge hidden harms.

Review organizational documentation, policies and indicators to ensure they recognize the benefits of reasonable risk-taking and the potential harms of restriction, rather than measuring safety only through the absence of visible adverse events.

Visible leadership support before, during and after adverse events to stand behind staff, normalize uncertainty, support difficult decisions and avoid retrospective blame.

5. Conclusion – Barrier 1

Overall, participants did not question the principle of **accountability** underpinning a dignity-of-risk approach, but rather the way in which it is currently enacted. Their concern was less about the prospect of legal consequences than about being individually required to justify reasonable clinical decisions made in contexts characterized by uncertainty. They advocated for accountability mechanisms that recognize the value of informed clinical judgment, acknowledge the uncertainty inherent in implementing the dignity of risk, and prioritize learning and collaboration over retrospective blame. Participants also emphasized that they are often at the forefront of restrictive decisions that are influenced by factors beyond their direct control, including organizational culture, internal policies, regulatory requirements, and broader systemic pressures. This helps explain why the main barriers to implementing a dignity of risk approach were identified at these levels. In contexts where performance expectations and retrospective reviews of decisions play a prominent role, it is often easier to justify restricting a person's choices than to support their autonomy. These findings suggest that promoting dignity of risk will require more than education and training initiatives. It will necessitate transforming organizational environments to normalize uncertainty, support shared decision-making, and recognize the often-overlooked harms associated with unnecessary restrictions. In doing so, organizations can become key drivers in the implementation of a dignity-of-risk approach.

In practice, this transformation could be advanced through a revision of both individual and organizational performance indicators. Rather than assessing quality and safety

primarily based on the absence of adverse events, organizations could place greater emphasis on indicators that reflect whether older adults and their care partners feel heard, respected, and meaningfully involved in decisions affecting them. Conversely, indicators focused predominantly on risk avoidance, such as the absence of falls, may inadvertently encourage more restrictive practices. Although such changes may appear ambitious, they can be implemented gradually through coordinated efforts across all levels of the organization. Their success depends on the engagement of a critical mass of key actors, including policymakers, managers, practitioners, care aids, older adults, and their care partners. The goal is not to impose a new perspective, but rather to foster collective commitment to a shared objective: enabling individuals to live in accordance with their values and preferences despite the inevitable presence of some degree of potential risks of harm.

This shift must also be accompanied by greater clarity regarding legal, regulatory, and organizational expectations to better define what should be done, communicated, and documented. The objective is not to burden practice with excessive documentation, but to provide sufficiently clear guidance to support clinical judgment and shared decision-making. In this regard, the organizational courage required to revise these frameworks can be likened to training wheels on a bicycle. When learning to ride a bicycle, the goal is not to eliminate all risks of falling, but to create conditions that allow individuals to move forward with confidence while gradually developing their skills. Over time, actions become more natural, confidence grows, and the training wheels are no longer needed. Similarly, clear organizational safeguards can provide the support needed to initiate practice change until a dignity of risk approach becomes a fully integrated and natural component of care and service delivery.

BARRIER 2: Challenges in Engaging People Living with Cognitive Difficulties in Decisions That Uphold the Dignity of Risk

At the end of **Part 2 (Challenges in engaging people living with cognitive impairment) of the symposium**, participants were asked five questions, to which 284 English speaking and 234 French speaking responded:

1. In your context (if not clinical, use the scenario), where do you struggle the most?
2. What makes it difficult in your setting to engage people with cognitive impairment in risk decisions?
3. What do you feel least equipped to do right now?
4. What solutions could you/your team/organization do to overcome the barrier of adopting a Dignity of risk approach with people with cognitive impairment?
5. Select the top 3 solutions that would work for you/your team/your organization to overcome the fear of liability when adopting a Dignity of Risk approach.

Participants did not view cognitive impairments as the primary barrier to upholding a dignity of risk approach. Instead, they highlighted a complex context in which family and friend care partner expectations, organizational norms, time pressures, and uncertainty about an individual's decision-making capacity can hinder meaningful participation in decision-making. A key question emerged:

How can we support an individual's participation when decision-making capacity fluctuates, work demands require rapid decisions, care partners disagree, and practitioners are striving to balance respect for autonomy with concerns about overprotection and safety?

1. Key Challenges Identified by Participants

The most significant challenge lies in **managing the expectations, concerns, and reactions of family and friend care partners**. Care partners were viewed as essential actors in the decision-making process and as key contributors to determining what constitutes an acceptable level of risk. In practice, implementing the dignity of risk philosophy is negotiated within the dynamic relationship among the individual, care partners, and practitioners. A major challenge lies in the ability of all parties to accept the consequences of supporting the individual's involvement in decisions. In some cases, respecting the individual's preferences may require prioritizing autonomy over safety, a trade-off that can be difficult for care partners to accept.

Participants emphasized the importance of building recommendations through dialogue and compromise. The challenge lies in **identifying responses that are proportional, realistic, and mutually acceptable**. Rather than framing autonomy and protection as opposing forces, participants highlighted the complexity of navigating the "grey areas" that often characterize clinical practice. These grey areas emerge when an individual's decision-making capacity fluctuates and their level of understanding varies over time, making assessment particularly challenging. These situations rarely involve a single

objectively correct answer. Rather, they require balancing competing values and priorities, including autonomy, safety, quality of life, dignity and the individual's own preferences.

Participants noted that while assessing an individual's capacity is difficult, supporting their participation after the assessment may be even more clinically complicated. Ensuring understanding, adapting explanations to the individual's abilities and difficulties (e.g. aphasia, amnesia, anosognosia), and repeating key information when necessary were all identified as essential strategies for meaningful participation. However, practitioners may encounter difficulties in explaining risks in a concrete and accessible manner.

Overall, participants suggested that cognitive impairments can complicate participation in decision-making; however, the primary challenge lies in managing the relational tensions that arise among individuals, care partners, care teams, and organizations, each of whom may have competing or different values underlying their decision of which risk of harm to prioritize.

2. Barriers to the Involvement of Individuals Living with Cognitive Impairments in Risk-Related Decision-Making

Participants identified the **social environment** (including care partners) and **time constraints** as factors that can weaken and gradually reduce individuals' participation in decision-making. According to participants, this is not typically a situation in which individuals are immediately excluded from decisions. Rather, it is a gradual process whereby practitioners increasingly rely on care partners to represent the person's views, often in the interest of efficiency and safety. Participants also noted that uncertainty about an individual's ability to understand their condition (insight) and the risks associated with different options (including appreciating how their limitations affect functioning and safety), combined with fluctuations in capacity over time, made risk discussions particularly challenging—especially given that impaired insight can be a symptom of certain types of dementia. Furthermore, a risk-averse organizational culture, combined with often implicit ageist attitudes and practices may contribute to a progressive transfer of decision-making authority away from the individual and toward relatives or institutional systems.

3. What Is Most Challenging at Present?

Participants identified the central challenge as preserving the individual's autonomy in a **context where both healthcare systems and care partners often tend to prioritize safety**. **Organizational culture** was also perceived as a barrier, as care settings are often reluctant to accept levels of risk that may nonetheless be considered reasonable or acceptable from the individual's perspective and even may be beneficial for them. In addition, limited time, constrained resources, and the fast pace of clinical practice tend to favor risk-averse approaches and safety-oriented decision-making.

Participants also reported experiencing **moral discomfort** when navigating the tension between respecting an individual's wishes and fulfilling their perceived duty to protect. More broadly, the challenge was seen as one of **collective risk tolerance**, involving not only healthcare systems and practitioners, but also care partners and the individual themselves. The extent to which each party is willing to accept and support risk ultimately shapes opportunities for meaningful participation and the realization of the dignity of risk philosophy.

4. Potential Strategies Proposed by Participants to Promote Dignity of Risk Among Individuals Living with Cognitive Impairments

➡ Building Capacity and Shared Understanding

Participants emphasized the importance of ensuring that all people involved share a common understanding of **acceptable risk, autonomy, and participation**. Awareness-raising activities and reflective discussions that includes the benefits of risk-taking involving care teams, care partners, managers, community partners, and the broader public could help foster a shared language and promote the development of a collective culture that supports the dignity of risk.

One of the most important competencies identified for supporting participation is **the ability to adapt communication**. Participants stressed that communication should be tailored to the individual's cognitive abilities, information-processing pace, and personal context to facilitate meaningful involvement in decision-making.

Participants also expressed a need to strengthen skills related to **supported decision-making**, rather than focusing solely on the assessment of decision-making capacity. In their view, practitioners require greater support and training to help individuals participate in decisions to the greatest extent possible, even when cognitive impairments are present.

➡ Supporting Care Partners

Participants suggested that greater attention should be devoted to supporting care partners through awareness-raising about the varying levels of potential harms associated with different options, including both the likelihood of adverse outcomes and the severity of their potential consequences. Increasing awareness of the importance of respecting the individual's autonomy and meaningful benefits of risk taking may also help care partners engage more constructively in discussions about risk.

Recognizing that care partners' resistance may stem from fear, guilt, uncertainty, or anxiety, participants emphasized the importance of viewing care partners as essential partners in the decision-making process. Providing emotional support, guidance, and opportunities for active involvement alongside the individual can help foster trust and facilitate the implementation of the dignity of risk. By supporting care partners in navigating these challenges, practitioners may be better positioned to promote decisions that balance autonomy, safety, and quality of life.

➡ Supporting Shared Decision-Making

Participants highlighted the need for practical tools, guidelines, and documentation to provide clear frameworks, mechanisms, and structures that can support shared decision-making in practice. They expressed a desire for **communication support tools to facilitate difficult conversations**, such as situations in which the individual's preferences differ from those of care partners. Participants also emphasized the importance of increasing the individual's involvement in decision-making by engaging directly with them, learning about their life history, and respecting their values and preferences. To support meaningful participation, they recommended the use of visual aids, adapted communication strategies, and repeated verification of the individual's understanding of

the information provided. These approaches were viewed as essential for enabling individuals living with cognitive impairments to express their preferences and participate in decisions to the greatest extent possible.

➡ Transforming Organizations

Participants noted that, because health and social care organizations are often strongly oriented toward protection and risk prevention, **dignity of risk** may be perceived as a marginal or exceptional practice. They emphasized the need to **normalize discussions about risk for harm**, integrate the dignity of risk philosophy into routine practice, and establish it as a legitimate and institutionally supported approach to care and decision-making.

Participants also highlighted that supporting autonomy in the context of cognitive impairments requires dedicating meaningful relational time to individuals, something that current systems often make difficult. Meaningful participation demands time for repeated explanations, ongoing consent discussions, and continuous adjustments to the pace, language, and communication strategies used. Such flexibility is particularly important given the fluctuating nature of cognitive abilities and decision-making capacity. Participants therefore stressed the importance of organizational structures and resources that enable practitioners to engage in these time-intensive yet essential processes.

➡ Strengthening Interdisciplinary Collaboration

Participants emphasized that decision-making should not rest on the shoulders of a single practitioner. Given the ethical dilemmas, risk-related considerations, cognitive impairments, and care partner tensions that may arise, decisions benefit from the involvement of multiple professional perspectives. They highlighted the importance of **shared responsibility**.

5. Participants' Prioritization of the Top Three Solutions

1. Adopting Nuanced and Individualized Risk Assessments

The prominence given to this solution suggests that participants favor an individualized approach to risk rather than relying on binary models of decision-making capacity (e.g., capable/incapable). Recognizing the complexity and variability of each person's circumstances, abilities, and preferences was viewed as essential. This nuanced approach emerged as the primary lever for implementing the dignity of risk in practice.

2. Training and Supporting Care Teams

Participants emphasized the importance of developing practitioners' capacity to exercise nuanced judgment in complex situations, allowing them to approach uncertainty, competing values, and risk-related dilemmas with confidence. They suggested that training and professional support could help strengthen discernment, tolerance for uncertainty, and relational competencies.

3. Transforming Organizational Culture and Partnering with Relatives

Participants emphasized the need to **normalize discussions about risk for harm**, integrate the dignity of risk into routine practice, and establish it as a legitimate and institutionally supported approach to care and decision-making. Participants therefore stressed the importance of organizational structures and resources that enable practitioners to engage in these time-intensive yet essential processes. Relatives were viewed as valuable **allies** whose involvement can facilitate the implementation of the dignity of risk when they are appropriately supported and engaged.

6. Other Potential Solutions (Not Identified by Participants)

Holding discussions with individuals and their care partners in environments and using communication approaches tailored to the person's cognitive abilities may enhance understanding and retention of information, thereby supporting more meaningful participation in decision-making. This may include providing a quiet room, allowing sufficient time for discussion, repeating key information, and using visual or written aids.

Establishing a **non-punitive post-incident review process** could promote learning among practitioners and increase their confidence in implementing a dignity of risk approach. In addition, when disagreements arise with or between care partners and the individual, a structured mediation or conflict-resolution process could provide practitioners with greater support and reassurance.

While participants agreed on the importance of supporting individuals' involvement in decision-making, it may also be valuable to create advisory committees or organize **co-development sessions** with individuals and their care partners to design communication tools and decision-support resources that better reflect their needs and experiences.

Another promising strategy for fostering cultural change would be to develop **performance indicators related to autonomy and participation**. For example, organizations could monitor and report the number of decisions made with the active participation of the individual living with cognitive impairments, thereby reinforcing the importance of person-centered decision-making and accountability for meaningful engagement.

Key Takeaway

Participants implicitly called for a **paradigm shift** in the way decision-making capacity and participation are approached. **Rather than focusing on whether an individual can participate in decisions, they emphasized the importance of creating the conditions necessary to explore beneficial risk-taking and in doing so, support participation in decision-making despite the presence of cognitive impairments.**

7. Conclusion – Barrier 2

The results from the participants highlight the importance of strengthening support for the relational and communication dimensions when adopting the dignity of risk principles into practice. Such an approach appears essential to promote a shared understanding of the complex issues surrounding decision-making autonomy. However, these concepts are often interpreted differently by the individual, their care partners and the practitioners, which can lead to misunderstandings, tensions and divergences as to the decisions to be made and the interventions to be prioritised.

In this context, it seems relevant to develop communication guides, visual aids and discussion scenarios, to support exchanges between the individual, their care partners, and the practitioners as these clinical situations are often emotionally and organizationally taxing. These tools could help clarify what to say, how to express it, when to ensure that the information has been understood, who to consult, and in what order.

These tools should also help to present the different options by facilitating the exploration of all the possible consequences, while first highlighting the potential benefits associated with thoughtful risk-taking. Such tools could also promote a better understanding of the expressed concerns by distinguishing between what is related to the values, preferences and aspirations of the individual and what is more reflective of the concerns or reassurance needs of those supporting them. This reflection invites the care partners and practitioners to question the origin of their concerns: do they respond to a need to reassure oneself, to what one would like for oneself in a similar situation, or to what one considers desirable for this person in light of his or her values, history and preferences?

Furthermore, presenting the individual with a range of progressive scenarios could encourage a gradual approach based on identifying acceptable compromises and exploring options incrementally. Such a process would help introduce change through familiar and reassuring reference points, while preserving the person's emotional sense of safety. This stepwise approach is likely to enhance the acceptability of the proposed interventions and foster greater openness to new perspectives.

Finally, the use of visual aids that concretely illustrate the different options and their potential consequences could make them more predictable and less threatening. Decision trees, risk scales or illustrated scenarios would help to better understand the issues, distinguish the probability of risks from the severity of their consequences, and support meaningful choices for the individual. Indeed, a decision is more likely to be accepted when it "comes from them", i.e. when it gives them a sense of control, is in line with their values and allows them to anticipate, in a realistic and non-alarmist way, the situations they wish to avoid. Such an approach can thus promote more informed, shared decision-making that respects self-determination.

Results from the participants also highlights the value of developing concrete best practice examples of micro-decisions, communication strategies and approaches that have proven to be useful in complex situations. The sharing of these experiences could contribute to the development of common knowledge and greater coherence of practices.

Finally, the results remind us of the importance of recognizing and supporting the moral distress that practitioners may experience when they are confronted with tensions between what they feel they should do, what they can do and what they would like to do. The establishment, or better visibility, of formal bodies for support, ethical reflection, mediation or consultation appears to be an essential avenue to support practices, strengthen trust and promote decisions that respect the values, preferences and reality of the individual.

OVERARCHING CONCLUSIONS

Participants' responses highlight that decisions about risk are never based solely on objective assessments of probability or severity. Every decision involves balancing competing values, weighing potential benefits and harms, and making judgments about what outcomes are most important. Differences between individuals, care partners, practitioners and organizations often reflect differences in the values each party prioritizes rather than disagreement about the facts themselves. Supporting dignity of risk therefore requires decision-making processes that explicitly explore and respect the individual's own values, preferences and priorities, while transparently considering the perspectives of others. Dignity of risk is therefore about making transparent, value-informed decisions under conditions of uncertainty. A well-supported decision is not one that eliminates the possibility of harm, but those that transparently balance the potential benefits and harms of different options in light of what matters most to the individual. The challenge is therefore not simply to assess risk more accurately, but to create decision-making processes and health systems that consistently respect what matters most to the individual while supporting practitioners, teams and organizations to share responsibility for those decisions.

What does implementation of a dignity of risk approach require?

The findings from both barriers suggest that adopting dignity of risk into practice requires coordinated action at multiple levels of the health system and is not simply about changing practitioner behaviour. At the **micro level**, practitioners need practical skills, confidence and tools to facilitate value-informed conversations and support shared decision-making under uncertainty. At the **meso level**, teams need collaborative processes, consistent approaches and shared accountability that include individuals and care partners as partners in decision-making. At the **macro level**, organizations and health systems need leadership, policies, education and accountability frameworks that foster learning, normalize balanced discussions of the potential benefits and harms of different options and recognize both the visible harms of adverse events and the hidden harms of unnecessary restriction. Ultimately, participants emphasized that good decisions are not those that eliminate risk, but those that transparently balance competing values and align decisions with the older person's informed preferences, priorities and goals.

Table: Summary of implementation priorities identified by participants

Level	Barrier 1	Barrier 2
Individual Practitioner (micro)	Confidence to make defensible decisions; skills to navigate uncertainty; communication and documentation tools	Skills in supported decision-making, balanced risk assessment, adapting communication and eliciting values and preferences
Teams and Programs (meso)	Shared accountability, interdisciplinary collaboration, consistent approaches, ethics support	Family partnerships, interdisciplinary care planning, shared understanding of acceptable risk
Organizations & Systems (macro)	Leadership and organizational policies that foster a learning culture; accountability mechanisms that promote clinical judgment rather than blame.	Transformation of organizational culture and policies through performance indicators that emphasize participation rather than restriction; adoption of frameworks that support the dignity of risk.

We invite you to consult the tools/resources presented at the symposium, which will be available on the Living with Risk website starting in September 2026.

Dignity of Risk Symposium

Synthesis of What participants Told Us

Risk is the possibility of both positive and negative consequences.

Decisions should therefore begin by understanding what the individual hopes to gain, before balancing the potential benefits and harms of different options.

518 participants

TRADITIONAL THINKING

- Focus on risk of physical harms
- ↓
- Prevent meaningful activity or choice
- ↓
- Reduce the possibility of harm
- ↓
- May unintentionally reduce autonomy and quality of life

DIGNITY OF RISK APPROACH

What does this person hope this decision will support them to do, be or experience?

POTENTIAL BENEFITS
What positive outcomes are possible?

POTENTIAL HARMS
What negative outcomes are possible?

↓

SHARED DECISION-MAKING UNDER UNCERTAINTY
Informed • Transparent • Collaborative

↓

CO-CREATE VALUE-INFORMED STRATEGIES
to optimize potential benefits and mitigate potential harms while aligning what matters most to the individual

↓

DECISION AND ACTION
Plan reviewed and adapted as needed

Good decisions are not those that eliminate the possibility of harm, but those that *transparently* balance the potential benefits of harms in light of ***what matters most to the individual***.

TWO KEY BARRIERS IDENTIFIED BY PARTICIPANTS

BARRIER 1: FEAR OF ACCOUNTABILITY/REPRISALS

- Fear of blame and having to defend reasonable decisions after a negative outcome
- Lack of organizational support and fear of retrospective judgment
- Focus on visible harms of risk while ignoring the hidden harms of unnecessary restriction
- Organizational culture that makes restriction easier and safer to defend than autonomy

BARRIER 2: CHALLENGES IN ENGAGING PEOPLE LIVING WITH COGNITIVE IMPAIRMENT

- Managing care partner expectations
- Uncertainty about decision-making capacity and how to support participation
- Difficulty finding middle-ground solutions
- Need for time, skills, communication and organizational support

IMPLEMENTATION REQUIRES COORDINATED ACTION AT EVERY LEVEL

MICRO (INDIVIDUAL CLINICIAN)

- Recognizing both potential benefits and harms
- Eliciting what matters most to the person
- Communication skills
- Practical tools and documentation to support decisions
- Confidence to support informed decision-making

MESO (TEAM / PROGRAM)

- Consistent approaches and shared language about risk
- Shared accountability and collective decision-making
- Interdisciplinary collaboration
- Partnerships with individuals and care partners
- Ethics consultation and conflict resolution support

MACRO (ORGANIZATION / SYSTEM)

- Policies, frameworks and guidelines that enable reasonable risk-taking
- Leadership that supports autonomy and stands behind staff
- Education and capacity building
- Adequate resources and time to do this work
- Learning culture with non-punitive accountability

FOUNDATIONAL PRINCIPLES EMPHASIZED BY PARTICIPANTS

- Person's values guide decisions
- Begin with hopes and goals
- Balance benefits and harms
- Optimize benefits and mitigate harms
- Support informed decision-making
- Share responsibility
- Learn and continuously improve

OUR SHARED GOAL

Focus on participation, autonomy and quality of life by supporting people to be as safe as necessary, not as safe as possible.

Source: This infographic is a visual representation of the *Dignity of Risk Symposium: Synthesis of the Workshop Participants' Comments* document. Please cite as: Provencher, V., & MacLeod, H. (2026). *Dignity of Risk Symposium: Synthesis of the Workshop Participants' Comments* [Infographic].