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Methodological letter

Shared decision making. Patient-centered evidence[☆]



La decisión compartida. La evidencia centrada en el paciente

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Shared decision-making (SDM) is a process that aims to build a relationship of trust between patients and surgeons, while the latter must recognize and respect the autonomy of the former. Therefore, patients must have reasonable knowledge of the potential problems associated with their surgical treatment as well as the therapeutic options available (including no intervention), along with their associated risks and benefits¹⁻³. General surgery is a specialty in which the surgeon has a wide variety of treatment options, all with potentially different perioperative and long-term results. The need for patient/surgeon SDM during the surgical consultation is underscored by the variation between 'cancerous' and 'non-cancerous', the potential complexity associated with each case, the breadth of decision-making by the surgeon, the impact this has on the results, and the variety of patient-specific risk factors and baseline disease⁴.

SDM involves a 2-way communication process between surgeon and patient. The surgeon provides information about the general condition of the patient, treatment options with their respective disadvantages and benefits, as well as a truthful explanation of the uncertainties of the available evidence regarding the different treatment options. On the other hand, patients must provide information about their values and preferences among the different therapeutic options. The objective is to let the patients (with the surgeon) evaluate and eventually have the option to decide on the surgical treatment that they will undergo. You often hear in

hospital corridors or at surgical conferences that treatments are offered that are based on the best available evidence. Well, we must also remember that the very definition of evidence-based medicine (EBM) clearly implies the concept of SDM:

"The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By 'individual clinical expertise', we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care"⁵.

Arguments against SDM in surgery

Various arguments have been posed against SDM in surgery⁴. First is the conceptual asymmetry of 'knowledge' and 'social authority', since surgeon and patients do not necessarily have to have the same degree of information. In addition, if patients consult rapidly accessible information media (eg, the internet) before the first office visit, their preferences, concerns, and expectations (eg, patient values) may sometimes be focused on other objectives than those of the surgeon, potentially

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contributing to biased or unrealistic perceptions of their pathology. Second is the lack of awareness and/or the 'attitude' of the surgeon towards SDM, due to limitations of time and resources during the consultation or simply a lack of applicability because of the characteristics of the patient and/or the clinical situation^{6,7}. Moreover, in our country, the remnants of a 'paternalistic' medical culture still continue to exist, which can make shared decision-making difficult⁸.

Some surgeons may argue that they apply SDM because the patient signs the informed consent form after an explanation of the process of their treatment and their options^{9,10}. However, informed consent is a unidirectional surgeon-to-patient communication, where the patient does not participate in any decision about their treatment⁹.

Arguments in favor of SDM in surgery

One of the main arguments in favor of SDM is to avoid the so-called 'preference error'¹¹. For example, let us imagine the case of an elderly, frail patient with an umbilical hernia measuring 2 cm in diameter plus diastasis recti. The hernia is highly symptomatic and completely alters the patient's quality of life. The surgeon may think that the laparoscopic or robot-assisted approach may be most appropriate, since a mesh could be placed in the 'best possible position' with minimally invasive surgery, which would also enable us to resolve the hernia and diastasis at the same time. However, the patient may want or prefer the fastest possible procedure, perhaps under local or regional anesthesia and without mesh placement. This 'preference error' can lead to inappropriate treatment or overtreatment. SDM facilitates aligning the treatment choice with the patient's preferences, since SDM provides a framework to improve the surgeon's communication in surgical decisions by explaining the 'best case scenario/worst case scenario' relationship¹². Many surgeons may think that, in the previous example, the 'preference error' would be unlikely since the 'less aggressive' option would be proposed in a patient with these characteristics, without the need for an SDM process. However, this is not always the case because, specifically, the words that surgeons use in daily conversations frame the concepts behind the advice or recommendations that we give to patients. Sometimes, this even arises at the request of patients, when they ask: "Doctor, if it were you or someone in your family, what would you recommend?"

Our language should reflect our professional values, but the patient's own goals should be our focus, and our task is to foster self-efficacy/self-care for each patient. Mistakes in language, even when unintentional, make it difficult to bring these values to life and can 'disfigure' the advice we provide¹³. In addition, biases in decision making (many of them unconscious and not intentional by the surgeon) can definitively influence our decision approach¹⁴.

Likewise, we surgeons have a tendency to focus more on the benefits than on the drawbacks of our interventions and treatments. The benefit of a procedure from the surgeon's perspective may not 'compensate' for the detrimental effects and patient expectations, even when patient-reported outcomes are provided. A typical example of the latter is the preference for quality of life over quantity of life when

palliative chemotherapy treatment is proposed in disseminated cancer¹⁵.

Lastly, data from observational studies seem to indicate that SDM for good quality shared decision making might offer some level of medicolegal protection, although more empirical data is needed to determine the impact of SDM on avoidable litigation¹⁶. Even so, in the context of an adverse outcome, the use of SDM can influence the patient's perception of guilt and/or responsibility¹⁷.

Summary

In our opinion, SDM should be considered a mandatory process to be implemented in all surgical procedures applied to each individual patient. It should be a practice independent of the level of evidence available on the benefits and/or drawbacks of treatment options, and independent of uncertainty among the expert surgical community as to whether a treatment will be of benefit. SDM requires training, pedagogy and a change in attitude for many surgeons and patients. In our opinion, its concept and teaching should be an essential and compulsory part of not only medicine and surgery degree studies, but also of all university degrees that are related to decision-making in healthcare.

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Conflict of interests

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