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EDITORIAL

Shared decision making in surgery, why is it important?

Toma de decisiones compartida en cirugía ¿por qué es importante?

M. Maes-Carballo[a,b,c]

[a] *Servicio de Cirugía General y Aparato Digestivo del Hospital Público de Verín, Ourense, Spain*
[b] *Vocal del Comité de Ética Asistencial del Área Sanitaria de Ourense, Spain*
[c] *Vocal del Comité Deontológico del Colegio de Médicos de Ourense, Spain*

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The therapeutic complexity of cancer demands improving quality of care for the diagnosis, treatment and follow-up with the input of the sufferer. Information systems for self-evaluation and the detection of improvement opportunities ought to be incorporated to maximise patient outcomes. There is no consensus on how best involve patients and practice varies, so several initiatives have put forward specific integrated cancer care pathways with their own quality indicators for monitoring progress.[1] Patient-centred care, including shared decision-making (SDM), has been postulated as the best model of clinical practice involving patient preferences and values. The main pillars that sustains this practice are the quality of care, doctor–patient bidirectional communication and collaboration, and the search for patient well-being.[2]

Patient-centred care has been defined as ''providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions''.[3] Under a patient-centred model, healthcare teams operate to understand and deliver care to the entire patient, assembling exhaustive and individualised care plans in which social necessities and mental health receive attention comparable to conventional medical therapy. In this context, SDM is ''an approach in which the doctor and the patient share the best available evidence and where the patient is supported to consider options and reach decisions about the process according to their preferences and values'',[4] and it has recently gained greater importance. Consequently, patient-centred care plans prompt health systems to rethink their approach to healthcare delivery, bringing new attention to active collaboration in SDM with patients.

In a world where healthcare resources are limited, SDM has shown to be an excellent tool for enriching the efficiency of the healthcare process.[4] In surgery, a recent meta-analysis[5] has revealed that SDM is a leading alternative to enhance patient understanding of their disease and the appropriate surgical procedures, increasing their satisfaction, adherence to treatment and perception of risk.[4] It has also been shown to decrease regret, stress and conflict in choosing a surgical procedure.[5] SDM is particularly relevant when there are various treatment options with similar outcome potential overall but with very different individual results according to the patient's preferences and values.[4] Several studies have exhibited that SDM is the way forward as a more compassionate medical practice following ethical paradigms.[5] Modern healthcare need not be paternal, as it used to be. SDM should be obligatorily included in the

E-mail address: marta.maes.md@gmail.com

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informed consent form respecting patient preferences and values.

Although all these different benefits of SDM, it is perceived that its implementation still needs to be improved due to the lack of knowledge. SDM requires a series of educational elements that are not usually taught in medical schools and surgical training programmes and this background is a known barrier to its implementation.[5] Surgeons must design communication skills training that emphasises the exchange of information (personal and medical) with the patient, allowing the patient to articulate their values and preferences.[5] There is also a need of deliberating between the different options, preserving the principle of autonomy of the patient.[4] The lack of professional communication training on the part of surgeons can reduce patients' desire to participate actively in SDM.[5] Recent systematic reviews by our team show that SDM is poorly addressed in clinical practice and consensus guidelines.[6] Other barriers reported for the correct use of SDM are the lack of means and resources.[7] Although there is no evidence that SDM is more time-consuming, it should be prioritised for decisions highly dependent on the patient's preferences and values and where clinical outcomes are uncertain.[4] It is unclear whether patients choose surgery less often when using SDM in surgical procedures. The observed benefits of SDM are only beneficial if the risks and possible benefits of not having surgery are outweighed by a patient's understanding and acceptance of their current and future condition, e.g. in cases of highly complicated surgical procedure with a high chance of failure.[5]

For better implementation of SDM, it has been demonstrated that it is necessary to promote the use of decision-making tools, i.e. ''interventions that support patients in making decisions, providing information on options and benefits/associated harm, and helping to clarify the congruence between decisions and personal values and preferences''.[8] Studies show that doctors' explanations of benefits and risks are often inadequate. However, increasing the availability and routine use of decision-making aids helps patients participate more and SDM is better delivered this way.[8]

Considerable studies have offered different approaches for SDM practice. One of the presented models established three steps: announcing that there are various options available, delivering more detailed information about them, and finally, examining the patient's preferences to encourage them to designate their own objectives.[9] Another proposition stands to establish objectives following the patient's choices, decoding them into therapy plans.[10] Utterly, the promotion of SDM as a quality indicator has been demonstrated as one sustainable strategy suggested to improve outcomes.[1]

In conclusion, the main goal of the SDM is to help in patient autonomy, providing quality care congruent with the patient's values and preferences. SDM process implies the development of multidisciplinary teams with a high scientific-technical level and excellent coordination. These teams need to be trained in the implementation of a bidirectional doctor–patient communication and the permanent review of the results inside a continuous improvement programme. Even if some patients do not want or do not know how to participate very actively in the decision-making process, it does not exempt us from the duty to propose it. Developing a health system that offers SDM is an ethical and moral duty. The implementation of SDM in cancer care is a demanding challenge. It requires training and resources. Above all, it requires a team that is committed and oriented to patient satisfaction. The practice of SDM in surgery has been proposed as a crucial element in changing the health system's course towards excellence and sustainability.

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