Putting Yourself in Your Patient's Place

Medical decision making isn't always easy

Identifying a patient's values to appropriately address them during treatment is an important part of medical decision making. In the August issue of *AAOS Now,* members of the Patient Safety Committee began a discussion focused on identifying and responding to patient preferences in treatment. That conversation continues with participating committee members **David Ring, MD, PhD; Dwight Burney, MD; Michael Pinzur, MD; Alan Reznik, MD; Andrew Grose, MD; Chris Gaunder, MD; Ramon Jimenez, MD;** and **Michael Marks, MD.**

Dr. Jimenez: I have many Hispanic patients who are recent immigrants and are often accustomed to receiving relatively paternalistic medicine, based on their experiences in their home countries.

Dr. Ring: Some evidence indicates that with a paternalistic approach it comes down to trust. If patients don't trust you, they may not adhere to your plan.

Dr. Reznik: I had an elderly Japanese patient once and learned that in his traditional family, it could be considered an insult to talk to him as the father. For some families in certain cultures, it's the elder's right to be taken care of by the adult children. It's the children's responsibility to direct care. However, in other cultures, the exact opposite may be true. We should be aware of these differences and be prepared to adjust to them.

Dr. Ring: You can always ask permission. Asking permission is a powerful sign of respect. You might ask, "Would you like to hear about X?" The family might say, "Can we talk about that in a family meeting without our father there?" Then you can ask the patient, "Is that your preference?"

Dr. Reznik: Another useful communication tool is silence. Silence gives people space to fill the void with the issues that are on their minds.

We might also be aware of our role as the shaman. Even 10,000 years ago, every culture had a healer. Even when they could not do much about the pathophysiology, the healer could at least relieve the patient and family of the responsibility for things beyond their control.

Editor's Note: This is the second of a two-part roundtable among members of the AAOS Patient Safety Committee on identifying and addressing patient preferences. The first article, "Addressing Patient Preferences Appropriately," was published in the August issue.

Healing rituals have the power to give the patient and the family the peace of mind that they have done what they should do. They have gotten the best possible care for something they can't control. It's important to be sure that shared decision making does not undermine this role that we play: The ability of the doctor to alleviate the terrible burden that grandma's going to die. It allows people to say, "I can't handle that, and I need to rely on an expert."

Another consideration is the fact that evidence-based medicine (EBM) might be seen as at odds with shared decision making in some ways. The idea behind EBM may be interpreted as "we're going to study the data and we're going to tell you the best way to go."

Dr. Ring: It seems to me that even really good evidence would probably leave the patient with a choice. Clavicle fracture and Achilles tendon rupture are two good examples. And the role of the shaman might be more about providing support and companionship than it is about taking charge. Having options can give patients and their families a much-needed sense of control.

Dr. Pinzur: Another consideration when discussing accurate diagnosis of patient preferences is the gap between what surgeons would do for themselves and what they tend to recommend to patients.

Dr. Burney: We asked a group of foot and ankle specialists from all over the country, "If you ruptured your Achilles tendon, how would you want it treated?" All of them said nonsurgically. But when we asked, "What would be your recommendation to the patient who has an Achilles rupture?" most said they would recommend surgery.

Dr. Ring: The Science of Variation Group, an international collaboration of surgeons, also did a study on this. Surgeons were shown problems that could be treated with or without surgery and were randomized to consider what they would do for this problem for themselves as the patient or for a patient near their age and their same sex. They were significantly more likely to recommend surgery to others than they were to choose it for themselves. This is sometimes referred to as the surgical double standard.

Dr. Gaunder: Cultural or sociological factors may also influence patient preferences and variation. In my experience of the shared–decision-making process in the military, I've noticed that when individuals on active duty have surgery, they get 30 days of leave and more benefits, and have an easier time getting work releases.

Sometimes patients ask: "What would you choose?"

Dr. Pinzur: Our answer should emphasize that the important thing is their preference based on their values. There isn't usually a correct answer. We could say, "You have different wants, needs, and desires than I do. I can't make this decision for you."

Dr. Grose: It can be problematic that we emphasize the things we've been trained to do, because what we've been trained to do is perform surgical procedures. I believe that just sitting in the room and spending time with the patient is valuable. There's an amazing boost to resiliency (the placebo effect) when a person feels cared for. Whatever that effect is, it's the interaction with the physician that patients want. It may explain, in part, the appeal of chiropractors, reiki therapists, and other alternative medical providers; maybe patients are not getting enough compassion and empathy from physicians and surgeons.

Dr. Burney: That underscores the importance of therapeutic touch and empathic communication.

Dr. Jimenez: When I am asked, "What would you do, doctor?" I say, "What I would recommend to you is what I would recommend to a younger patient, or to my daughter, another member of my family, or one of my friends."

Dr. Marks: I want to return to the importance of identifying a patient's goals. The stories reported in the media can create some chaos for us.

One of my patients had been told by his internist that he had an arthritic hip and that he could have a hip replacement. I asked, "What do you want to do?" He said, "I think I've got one or two more marathons in me." That prompted a discussion on how demanding physical activity is not good for patients with hip or knee arthroplasties.

The patient said, "Bo Jackson had his hip replaced and went back to playing baseball." So I explained, "Yeah, but Bo Jackson had two more procedures after that because he really shouldn't have returned to play." He decided to put off his hip replacement for a few years while he continued his long-distance running. He was happy to be able to run two more marathons and then he changed his lifestyle. Nobody had ever asked him, "What do you want to do?"

Dr. Reznik: What about when a patient asks, "How many of these have you done?" It's important to consider why that person is asking that question. The patient may be thinking, "My uncle had this procedure, and it was a disaster."

Dr. Marks: When I teach the communications course, I tell the story of a woman who came to see me complaining of back pain after shoveling 18 inches of snow. In the old days, I would have thought, "Great, this is going to be a 30-second visit. It's a lumbar sprain. Anti-inflammatory medication, some ice, physical therapy and we're done."

But instead I asked, "What do you think is going on?" She said, "I think I've got cancer on my back." I said, "Why do you think you've got cancer on your back?" She answered, "My neighbor started having back pain after shoveling snow last winter and it took 6 months for doctors to find out that she had metastatic breast cancer. She died 3 months after the diagnosis." It's important to make sure people can express their concerns.

Dr. Reznik: Did you order a radiograph on that patient?

Dr. Marks: I asked her what she thought she needed to have done

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With that said, every patient should be treated with universal precautions. I do not believe that preoperative screening would allow potential for complacency, because each patient would still be treated the same with regard to contact with bodily fluid. Preoperative screening, however, may allow the surgeon to take extra measures such as reinforced surgical gloves as an added element of protection in case an accidental breach in universal precautions occurs.

AAOS Now: What are the main considerations that arise in orthopaedic management of patients with HIV and antiviral therapies? Are they all warranted? The article mentions that surgeons may be hesitant to employ internal fixation on patients with HIV infection.

Dr. Pilato: Overall, the considerations that arise are ultimately patient outcomes in the areas of fracture healing, wound healing, and risk of infections. Often patients with HIV who are not medically optimized with regard to their viral load and overall clinical health may have healing issues. This may be related to decreased immunity due to the disease itself or to sequalae of the disease such as malnutrition or anemia.

The goal is to take good care of our patients and successfully treat their musculoskeletal problems to allow them stable function and mobility, devoid of complications such as infection, wound breakdown, and fracture healing. Our hope is that the article provides a basic foundation of information and a framework from which to provide successful perioperative care in the setting of HIV, while minimizing potential complications.

The other authors of "HIV in Orthopaedic Surgery" are **Caroline Clark, MMS, PA-C,** and **J. Benjamin Jackson III, MD.** **J** *Am Acad Orthop Surg* 2017;25:569-576.

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and she said, "Nobody ever took an X-ray."

Dr. Ring: This gets back to appropriateness a bit. In that situation, the risk/benefit of a radiograph is pretty good, whereas an MRI might do more harm than good.

Dr. Jimenez: Before ordering a test, we need to consider what we'll do with the results. Another consideration might be cost. If you had to pay $1,000 for this test, would you have it done?

Dr. Ring: One response might be as simple as, "In this situation, that test is misleading as often as it is helpful."

Dr. Reznik: I sometimes say to patients, "I don't know if this is a good idea or not. I don't want you to have an operation you don't need. Because your symptoms might go away in 6 weeks, it might be better to wait." For many relatively benign complaints, observation and repeat examination in a reasonable time frame are frequently the best treatment.

Dr. Ring: I'd like to see us having these types of conversations day-to-day. An argument can be made that the nontechnical aspects of what we do for our patients are just as important as our technical skills.