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EDITORIAL

Shared decision, is there still a role for the surgeon?. Round table of the 121st congress of the French Association of Surgery (AFC - Association française de Chirurgie)



It is feared that the increasing prominence of patients' rights, together with the dissemination of practice guidelines from learned societies, could restrict the surgeon's ability to make decisions. The surgeon could thus become a simple service provider, for whom every degree of autonomy would jeopardize the appropriateness of care [1]. Truly appropriate care means a validated care pathway, with multiple caregivers and efficient communication; it implies an evaluation of organization of care, indications for surgery, follow-up and coordination between caregivers.

Although the patient remains the main assessor of the whole pathway, the commitment of all of us is necessary to meet the challenge of quality as opposed to quantity.

Value-based health care [2] is based on the analysis of results from the patient's point of view and of the cost of obtaining them. To have such data with transparency is important to initiate the cycle of care quality improvement, with self-auditing and continuous criticism of our daily practice.

Value depends on priority ranking and subjective appraisal. For example, trading off increased survival rate with the side effects of chemotherapy will not be viewed in the same way according to the values and preferences of patients. A further question is that of evaluating the cost of any given option for society. Relevance of care cannot be defended without considering the financial aspects of our care system, which attaches most value to the quantity of procedures it performs and neglects their quality.

To reward high quality could be a strong enabler to facilitate the paradigm shift from quantity to quality. But how can this be done in practice?

The Montaigne Institute has just completed a report on the evaluation of appropriateness of care. Focusing on the weakness of our system of care, this report makes ten recommendations (<https://www.institutmontaigne.org/publications/systeme-de-sante-soyez-consultes>). These include launching a multi-disciplinary task force to define the quality of care indicators based on international experience using standardized questionnaires with clinical and quality-of-life criteria. Once validated, this documentation should be routinely used by both caregivers and patients, with public, transparent, easily accessible indicators. The next stage should involve the integration of a relation between payment and quality. Surgery should not be absent from this evolution.

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This organizational innovation project has been put into action at Institute of Image-Guided Surgery of Strasbourg to implement a pathway of care re-defined and co-built with patients. According to the health disorder, several enablers have been defined: accelerated diagnostic procedures (one-day explorations and preparation for surgery) [3]; digital means to inform, prepare and assist the patients during the perioperative phases; encouraged ambulatory care with a straight collaboration between the hospital and private exercise using connected devices supervised by a pathway coordinator to enhance the human relationship.

These new approaches are to be evaluated with respect to health values, aiming to propose efficient and reproducible models and to share with others the best practices for the good of patients and the system of care.

Besides Clinical Reported Outcomes Measurement (CROM), the participating patients are also asked about their long-term quality of life, for Patient-Reported Outcomes Measurement (PROM).

For the first time in France, standardized questionnaires on the care of patients with cancers of the pancreas or the liver have been built. Using the same methodology as that of the International Consortium for Health Outcomes Measurement (ICHOM) (literature search and analyses, indicator selection, working groups (multidisciplinary practitioners, patients & associations, international experts), the work on cancer of the pancreas was selected among the TOP oral presentations in the last Congress of the French Association of Surgery [4], suggesting that such an approach is feasible and can be developed and extended to other diseases.

All these data, when analysed in real time, are a good support during the visit, and allow the analysis of the longitudinal evolution of parameters and the comparison (after stratification) with those of other patients in the database. These data shared with others are a strong means for evaluating and improving care. The objective being not to stigmatize or oppose the Care Centres or the practitioners but to offer a tool to impel the virtuous circle of quality of care. The objective is not to promote a patient-led selection with two-tier medicine, where to obtain favourable results we can select the best candidates (least ill) for a given pathway. Obviously, there are methods of stratification to make the results truly comparable.

In addition to "care" we should consider "taking care", aiming to integrate the technical or organizational innovation for the good of patients.

Tremendous potential in France favors a revolution in the methods of evaluating innovations. This approach makes a continuous evaluation possible, taking into account some indicators that are important for the patients and fully recognized by the caregivers.

There may be some reluctance. The first barrier is the added administrative workload for the practitioners, hampering their close relationship with patients. But most of the data to be collected are present in the current information systems. It is, however, of paramount importance to develop the interoperability of these systems and dedicated tools for data collection, follow-up, and transmission of information.

Because these new pathway coordination provisions have been designed prospectively, they will impact positively on the payment of actors and a real value chain.

It is for caregivers and patients to endorse this patient-centered innovation.

Disclosure of interest

The authors declare that they have no competing interest.

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