Opening Address by Dr Chee Yam Cheng, Master, Academy of Medicine, Singapore at the 33rd Annual Combined Surgical Meeting on 4 November 1999 at the COMB Auditorium

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Medical Decisions

Colleagues and Friends,

It is a pleasure to be present with you all at your 33rd Annual Combined Surgical Meeting for 1999 with less than 60 days to go into the new millennium. I applaud your organising committee under Dr Sarbjit Singh for a comprehensive and exciting programme which I trust you will enjoy and find useful and relevant to your practice.

We are happy that the College of Surgeons of Malaysia and Indonesia have joined us. A warm and hearty welcome to their Presidents and members.

The theme is Recent Advances in Surgery. I would like to recollect the first organised treatise on the practice of Surgery ever to be written. It is the pioneering work of the ancient Indian Surgeon Susrutha. Susrutha (about 6th Century BC) described and practised an astonishing variety of surgical operations and in the Susrutha Samhita, which is the original Sanskrit work describing his methods, philosophies and techniques, these operations are recorded in meticulous detail. The Samhita is thought to be the work of Susrutha and generations of his surgical students and disciples and is dated by historians as not later than the 6th century AD and possibly the 3rd century BC. Susrutha was the first to describe the resection and anastomosis of injured bowel by the ingenious technique of using the powerful jaws of ants as the anastomosing material; he described the use of hemp sutures and the splinting and setting of fractured bones. His technique of the seton treatment of difficult fistulas in ano has enjoyed a recent revival worldwide. And he is universally acknowledged as the originator of plastic flap advancement, from his description of the forehead flap for the repair of the nose.

Medicine and Surgery have since come a long way. The public and our patients are becoming better informed and often ask to be involved in medical and surgical decisions affecting their health. This is to be expected and encouraged. But do we as doctors know how to make good decisions and help our patients in this process?

Any important medical (and I include surgical) decision has two distinct components. The first component consists of technical judgements, which are the answers to such questions as "What is the diagnosis? What is the most effective treatment? What are the likely consequences of the treatment?" The second component consists of value judgements, which are the answers to such questions as "Do I want to know the diagnosis if the outcome will not change much? What is my tolerance for a false-positive result on this test? Will the quality of my life be better with a less effective treatment?"

Many bad decisions may result from a confusion of these two components and from not appreciating who is the best decision-maker for each. Technical judgements need to be made by experts, not by patients. Physicians (and I include surgeons) are trained to know how to establish a diagnosis; patients are not. Physicians abdicate their responsibility when they invite patients to make technical decisions. Yet some physicians believe that respect for patient autonomy requires them to share all aspects of decision making with their patients. Sharing responsibility for technical decisions results in bad decisions.

On the other hand, the value judgements that are so much a part of important medical decisions can be made only by patients. Physicians should limit their role in these judgements to advising. Sometimes patients' value judgements may seem eccentric or even wrong to their physicians. For example, some patients have refused to have a gangrenous limb amputated, preferring to risk death. In less dramatic instances, patients may refuse recommended procedures because they did not think the procedures were worth the discomfort or risks. As long as the risks and benefits have been clearly spelled out by physicians, patients should have the responsibility of weighing them against each other and deciding what to do. Only they can evaluate the likely effect on the quality of their lives. Bad decisions are probable when physicians attempt to usurp that aspect of the decision-making role from patients. I believe that such usurpation is more common than inappropriately sharing technical decisions with patients.

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When physicians and patients are explicit about which component of a medical decision they are considering, good decisions are far more likely. What is a good decision? It is one that achieves the optimum improvement in health and peace of mind for the patient. Physicians should feel that they have done the best job they could, and patients should feel that the decision was the best they could have made.

Many sources of information now available to patients, including videos, web sites, and pamphlets, can aid decision-making. However, these sources should not be a substitute for conversations with physicians. Physicians should take the time to review informational material with their patients and engage in a dialogue that can get to the heart of their patients' uncertainties and concerns. It would be a pity if the new decision-making tools served as an excuse for physicians to avoid a crucial part of their responsibilities. I do not believe that good decisions can be routinely made by patients sitting alone at their computers or videocassette recorders. Physicians need to take an active part in the process.

Making good decisions—thinking smart—remains a pillar of high-quality medical practice. In attempting to improve our clinical decision-making ability, we focus on standard guidelines for disease management, outcomes of alternate strategies of care, and occasionally the processes by which we interpret evidence and apply it to patient care. Although such evidence can be drawn from experience with groups of patients, it often needs to reflect the individual circumstances of the patient sitting before us. Over the past several decades, we have become increasingly respectful of patients' central role in making decisions about their care. Outstanding clinical decision making must reflect partnerships between clinicians and patients. Such partnerships must be based on trust, clear and open communication, and mutual respect.

The ultimate plan should integrate components and ideas from as many interested parties as is feasible. As physicians, we rarely can make good decisions for our patients—we must strive to make good decisions with our patients.

I ask again, "What is a good medical decision?" First, good decisions should be well informed. The uninformed selection of an option that has a good outcome is luck, not a good decision. For the typical patient, the task of becoming well informed about his or her medical choices is a formidable challenge. A broad spectrum of topics—the efficacy of a health maintenance strategy, the natural history of an untreated condition, the relative efficacy of competing treatment strategies, the comparative cost of alternative choices, and the risk-benefit ratio of the options—must be researched and mastered. The task of remaining well informed is also challenging for the health care professional because the pace of change, development, and discovery is rapid and accelerating. I am hopeful that enhanced access to timely and accurate medical information (such as is occurring on the Internet) will assist all parties. Nevertheless, physicians must retain a clear sense of responsibility for ensuring that individual patients are appropriately educated and fully informed about their choices.

Second, good decisions should be compatible with the values of the patient. Medically sound strategies that are not compatible with the patient's values are not acceptable options. Although physicians confront difficult value-sensitive medical decisions daily, patients usually have less experience with serious choices. To make a decision that is fully compatible with their own values, patients need help and time to assimilate the realities of the choice and to consider what their values are.

Finally, good decisions should be "workable" or "practical." Specific elements, such as affordability, efficacy, complexity, availability of appropriate support systems, geography, transportation, and many other factors, affect this aspect of the decision-making process. Of course, each of these elements must be considered in the context of the individual patient's special circumstances.

All that said, for any single decision, there is a chance that a bad outcome will result, regardless of the quality of the decision-making process. Medical decisions are different from other decisions in several important ways. Gaps in knowledge and authority between physician and patient can be profound. Although a given decision may appear trivial, the stakes can be high. The wisest decision may, against the odds, lead to death; a careless decision may have a wonderful outcome. The wisdom of a medical decision therefore cannot be judged by its outcome. It must be judged by the care and attention that preceded it—by the quality of the process used by the physician, the patient and others to negotiate their differences and reach a final decision. The patient, the physician and other affected parties must be satisfied with both the decision making process and the substance of the final decision.

It is now my distinct privilege and honour to declare your meeting open. May you experience a fruitful, stimulating and rewarding meeting.

Thank you.