

Shared decision-over a p value

Introduction

Since the 1980s there has been a discussion about the application of the person-centered clinical method, with several authors¹⁻³ commenting on the need to offer people the possibility of understanding their health issues. Both by listening to their stories and expectations, and by providing quality technical information, so that decisions taken together could impact on the quality and quantity of people's lives.

The evolution of the quality of evidence and more controlled studies seemed to be a sure path for these goals to be achieved, but unfortunately the distortions of the medical literature and the pressure of the media have caused great difficulty for these objectives to be achieved. It is necessary to review the levels of information and the quality of this information provided to patients so that it is possible to speak in a shared decision.

Conceptualizing

Life expectancies and health levels perceived by people differ from doctors' understanding and expectations of health. People have the desire to live their lives satisfactorily to their prospects. They want to experience the relationships and opportunities that life offers, without much concern or notion that harm to their health - or their family members - can happen. Often confronted with these risks, they deny or find excuses to justify their attitudes.⁴

It is a common and primary mistake to believe that concern for health and the consequences of habits and attitudes are part of people's daily concerns. Physicians are given the opportunity to reflect on the protocols for professional practice and the scientific evidence available - and for this there is no safe and secure environment. When Sacket et al.⁵ propagated the concept of evidence-based medicine, it was not possible to deal with the problem of fraudulent medical literature. Ioannides⁶ in his seminal article of 2005 presents the inconsistencies of the studies, and current references⁷⁻¹⁰ present different ways of obtaining results in scientific research and how this compromises the capacity for competent action and judicious view of the medical professional.

Why apart from the "p"

The concept of "p" or null probability that the hypothesis is correct is a statistical proposal to justify the actions of the physician. However, apart from the difficulties of understanding-whether by professionals or the community - statistical concepts, it is necessary to understand that statistics, lacking a nexus previously traced, allows different instruments to be used for the one that is most favorable to the research sponsors.

It has long been known that the perfect design of any research is to prove the nullity of a theory, but the criteria for doing so must be clear - the research protocol to spell out what will be studied and with which instruments will be evaluated. Out-of-the-range results in the study may be used only for indication of achievement of new studies centered on the quest to clarify whether true or false. In fact, there are at least three possibilities in any study - the hypothesis is ruled out, the hypothesis cannot be ruled out in the present study, or there are unplanned findings suggesting the need for further studies.^{8,11}

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The application of Bayesian probability concepts^{7,8} opens a new universe of possibilities, generating the possibility of considering the reproducibility of the study, the previous probability of veracity and finally the posterior probability of being true in a given situation the study and its applicability to the patient in focus.

Medicine is an inexact science, if you work with data that are not always accurate, and they are applied to people with genetics and completely different life histories, generating results that are often inadequate or unexpected.

Going beyond "p"

When talking about shared decision, the level of information that doctors and patients have is central. If on the one hand the scientific knowledge of medicine is part of the professional arsenal, on the other hand it is the patient who holds the knowledge and possibilities of his life. Without the understanding that each should share this knowledge of which they are dominant, it is impossible to speak of shared decision.

Within this concept, it is essential for the patient to be clear about how many people need to be investigated or treated in order to obtain adequate and favorable results - and how many people can be harmed by this (the concepts of NNT (number needed to treat) and NND necessary to dance) are fundamental in an enlightening dialogue. But it is not enough.

It is necessary to explain the expected impact of the therapeutic alternatives and how this will change the life and the personal possibilities. In a clear and transparent way this will have an impact on the decisions, which are considered life expectancy, lifestyle changes and associated costs. Sharing the uncertainties makes the dialogue more truthful and honest, giving people a chance for mature and truly co-responsible choices.

Conclusion

The search for shared decision is much broader than the knowledge regarding the statistical significance of an article goes much further. You should look at how this will impact people's lives and offer more quality and quantity of life.

In addition to the weaknesses inherent in the quality of publications, the economic interests that often permeate therapeutic suggestions, it is fundamental to know how reproducible the studies are presented, and how much they will make a difference in people's lives.

Shared decision means good clinical listening, ability to be transparent in the information given to patients, good ability to critically analyze the literature and finally respect the interests and desires of the people.

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Conflicts of interest

The authors declare there is no conflict of interest.

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