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Point of View: In the eye of the beholder: Preferences of patients, family physicians, and surgeons for lumbar spinal surgery

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Wennberg has described three broad categories of care: effective, preference sensitive, and supply sensitive, and highlight deficiencies in the current state of health care delivery for each (1). For effective and supply sensitive care, there is considerable evidence that we fail to do enough of the former (such as beta blockers for myocardial infarction) and deliver too much of the later (such as MRIs for acute back pain) (2,3). The current study addresses the domain of preference sensitive care. Since most spine care is elective, meaning it's provided to patients primarily to address pain and its functional limitations, most treatments for spine conditions fall into this preference sensitive category (2). Unlike effective care where the patient appropriately looks to the physician for guidance, preference sensitive care should go in the other direction – the physician should look to the patient for guidance. This is what shared decision making is intended to foster (4). The goal of shared decision making is to provide sufficient information to permit patients to use their preferences and values to define a treatment plan based upon what matters most to them. As defined, preferences make up only one, albeit important, aspect of shared decision making.

The current study highlights differences among patients and physicians, both general practitioners and surgeons, regarding preferences for surgery on the degenerative lumbar spine. Though not necessarily surprising - that the preferences of patients, family physicians and surgeons differ - these results are nevertheless important. The nature of the differences among these groups is also not necessarily surprising. Patients placed the most value on quality of life - the symptoms and their duration and impact that led them to consider surgery. Family physicians were similar to patients in rating severity and impact highly, but also were appropriately concerned about neurological findings – a key factor when considering who to refer for surgical evaluation. Finally surgeons, focused on the location of symptoms as a way to define which patients would be appropriate for surgical intervention. These differences in preferences reflect the values or goals each group places on the surgical intervention. Patients and family physicians want the surgery to help relieve their symptoms (and to prevent neurological compromise for family physicians) while surgeons emphasize the kind of conditions for which evidence most supports the benefits of surgery.

For this reason, I take some exception with the authors' proposal that “aligning opinions of patients and physicians would improve the shared decision making process itself...” I would argue that rather than getting everyone to agree, we recognize that differences exist and are quite reasonable. The best alignment of patients and physicians that make sense is around the knowledge a patient needs to make a well-informed decision about the benefits and risks of the various treatment options available. If there are patient knowledge deficits that result in unrealistic expectations about the benefits and risks of available therapeutic options, then a patient's preference will be driven by incorrect information. On the other hand, it may be a challenge to always seek to align patient's values and preferences with those of the clinician. Ultimately the severity and impact of spine disorders will lead patients with the same examination and imaging findings to select different treatments based upon their own beliefs. The challenge for physicians is not when the patient's preferences align with ours, but when

they do not. A patient with symptoms and findings that suggest surgery is likely to help may chose to give it more time, while a patient who is less likely to benefit from surgery may be willing to take a greater risk. The challenge is to align opinions sufficiently that the patient thinks there is agreement between his/her own beliefs and that of the physician since this may predict better outcomes (5). We need to design systems of care that incorporate shared decision making as a means to address these differences in preferences among patients and physicians rather than focus on forcing everyone to share the same goals (6).

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