

Beyond the evidence: the values for the patient

MUITO ALÉM DA EVIDÊNCIA: OS VALORES PARA O PACIENTE

The process of health care always starts at some source of evidence (tacit or explicit) that guides decision-making, and is extinguished at the result (immediate and/or delayed) obtained with the patient.

A lot of work, a lot of discussion, much thought, much time has been devoted by many to establish quality measures that can be applied at the different stages of this process, to ensure the highest level of quality in care.

There are measures related to evidences (scientific production and citation indexes, graduation strength and critical evaluation); teaching and medical activity (tests for assessing progress, knowledge and performance in undergraduate level, medical residence, graduation courses and accreditation); and the provision of health services (hospital and service accreditation, high-level standardization of care systems, and “big data”).

Despite these measures, are theoretically connected by the same goal, for various reasons, they are completely dissociated, and have led to a waste of time and resources, competition, difficulty in spreading, and finally, today, being an end in themselves have become larger and more important than their own goal: the patient.

Evidence-based medicine, by definition, should take into account the values and preferences of patients. Not to follow this principle, however, has been responsible for the creation of a futile and theoretical world that has conspired against its actual usefulness.

Thus, the scientific production is increasing, the teaching of obtaining critical evidence is strong, and guidelines have been increasingly used, but the outcomes that matter to patients, and the practice of shared decision are ignored, making patient-centered medicine utopian.

With minimal patient participation in making evidence-based decision, the outcomes that matter to the patient are rarely considered or exposed, as the health condition achieved or preserved (survival, function and symptoms); the recovery process (time emotions, complications, adverse effects); and the sustainability of health (maintenance, recovery, relapse, long-term impact).

When decision is shared with the patient, the doctor must understand their experiences and expectations; must present evidence, including benefits, damages and uncertainties of the various options available; must offer recommendations, establishing objectives and functions; and, last, check the patient’s understanding and agreement.

The lack of time and financial resources; ignorance; lack of skill; unbelief; the paternalistic idea that “patients do not want this,” or the arrogant “already done it” are barriers to the practice of shared decision to be overcome through education.

At best national scene to the detriment of the widespread inequality (which, in health, is expressed through great or terrible quality), emotion, adherence, individuality, and values of each patient, are far beyond the evidence, they determine the world of actual practice, in which there is no room for the superfluous produced by science, and even less for the insensitive patterns of a health system geared toward its own interests.

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