obligate us to provide a therapy we believe is unnecessary or irrational. Sometimes the wrong thing is not a little wrong, but simply wrong.

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Commentary: Making decisions with all the evidence: What does the patient really want?

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Modern health care practices have shifted away from the paternalistic model of “doctor knows best” to shared decision-making (SDM) between patients and physicians. In this model, best guideline practices derived from evidence-based medicine are now being applied within the individual context of a patient’s values and preferences.¹ SDM is desirable in all disciplines of medicine but especially in the context of coronary revascularization, where morbidity and mortality from one strategy (percutaneous coronary intervention [PCI]) is lower in the short term but the alternative (coronary artery bypass grafting [CABG]) may offer better long-term survival and freedom from adverse events.²

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CENTRAL MESSAGE

For patients requiring coronary revascularization, patient-centered care is paramount.

Rubens and colleagues³ navigate the challenges of arriving at the optimal decision for coronary revascularization using an illustrative case example of a patient who would clearly benefit from CABG but chooses ad hoc multivessel PCI. Several key issues are highlighted when balancing best guideline practices and patient-centered care, including cognitive biases, practical challenges to SDM, and specialty bias. The informed consent process can be influenced by the cognitive biases experienced by the patient, including the phenomenon of focusing effect aversion, availability heuristic, and forecasting error.⁴⁻⁶ In the context of effective communication, clinician framing and structural inequities each have the potential to prevent fair SDM. Furthermore, when presenting treatment recommendations, surgeons, interventionists, and clinicians may carry biases about which approach is most suitable.^{7,8} Addressing these patient and provider issues systematically results from a compassionate stance that prioritizes patient autonomy.

Originating from the SYNTAX (Synergy between Percutaneous Coronary Intervention with Taxus and Cardiac Surgery) trial,⁹ several studies since have demonstrated the success of the Heart Team to facilitate patient-centered SDM.¹⁰⁻¹² A clear comprehensive presentation of the harms and benefits of each treatment option, incorporating perspectives of the various health care providers, may avert the cognitive biases that influence a patient during the informed consent process. Similarly, this multidisciplinary setting offers an opportunity for clinicians to review and remove sources of biases they may present to the patient during their verbal and nonverbal discourse. This is especially true in the case of coronary revascularization, where patients most often see the interventional cardiologist first and do not receive the input of a cardiac surgeon, which may result in greater rates of ad hoc PCI.¹³

Importantly, Rubens and colleagues³ emphasize that all decisions should prioritize patient autonomy. When the competent patient decides against best practice guidelines, as in this case example, the authors remind us to consider our fiduciary responsibility. At the same time, it is the responsibility of a multidisciplinary team to ensure the patient receives optimal personalized information regarding their potential treatments, based on the best-available evidence, unique individual patient considerations, and local expertise. Finally, if the patient's decision is within reasonable limits, it is the duty of the physician to support the patient throughout the treatment process and beyond.

The authors also present an alternative example of a patient with operable breast cancer who chooses naturopathic treatment rather than surgery, a decision that carries a 6-fold increase in mortality. What is our fiduciary responsibility in this situation?¹⁴ As Rubens and colleagues explain, beyond beneficent persuasion, when the harms significantly outweigh the benefits, physicians should not proceed.^{3,15} However, the patient should be monitored such that life-saving and/or prolonging interventions can be administered in the future.

We congratulate Rubens and colleagues for illustrating the complexities associated with SDM in patients requiring

coronary revascularization. With increasing attention on long-term outcomes of PCI and CABG for multivessel disease, this is a timely reminder for clinicians to consider both the ethical considerations in the SDM process and the value of heart teams to improve patient-related care and outcomes.

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