

Not the Last Word: Informed Consent, Omakase Style

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The best meal I ever ordered at a restaurant was hardly ordered at all. The occasion: a birthday celebration of a good friend. The setting: Royal Sushi & Izakaya in Queen Village, Philadelphia, PA, USA. The meal was served *omakase* style, that is, “chef’s choice.” I was asked to state some general preferences—likes, dislikes, and allergies—but beyond that, the meal was going to be composed by the chef, using his experience, expertise, and best judgment. I was not disappointed.

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That restaurant visit made me wonder if there is a role for surgical informed consent, *omakase* style as well. In this model, patients can state some general preferences—a willingness to take some risk for a faster recovery, say, or a particular dislike of immobilization—but beyond that, the details of the care are left to the surgeon’s experience, expertise, and best judgment, just as they’d be used in an emergency setting [4].

I am not suggesting a return to the days of old, when some physicians did not even share the diagnosis with a patient [9]. Nonetheless, the pendulum might have swung too far in the direction of patient involvement, far beyond what patients want themselves.

A few years ago, I had a patient considering an ACL reconstruction. I presented him with three graft options: his own patellar tendon, his own hamstring, or an allograft Achilles tendon. I drew some Caves-of-Altamira sketches, recited the statistics, and reviewed the relative advantages and disadvantages of all three choices. I then asked him what he wanted. His reply: “Doc, give me the one that works.”

My patient’s glib response may reveal what patients intend when they consent to treatment. They are not so much consenting to treatment, they are

“consenting” to the cure, with the former merely tolerated as means to the latter. For some, making decisions is a cognitive and emotional burden they’d rather foist on others.

Furthermore, truly unbiased informed consent can be elusive, and maybe impossible. Surgeons inevitably will influence patients’ decision-making. That’s because the language used by the surgeon framing a decision [2] inherently affects how the choices are perceived and in turn which option is selected.

This framing effect was demonstrated by Tversky and Kahneman [11]. In a replication study I conducted with my colleagues Eli Kupperman, Ari Kandel, and Jaimo Ahn (the birthday boy, above), we confirmed that these phenomena permeate surgical informed consent as well [3]. We presented clinical scenarios to 131 volunteer respondents and asked them to make choices as if they were the patient described. We then repeated the presentation a month later, with identical facts but different wording, aiming to trigger some of the biases identified by Tversky and Kahneman.

In one example, we twice asked respondents to choose between surgery and physical therapy to address a post-fracture 40° flexion contracture of the knee. In the first presentation, they were told that therapy offered a certain gain of 10° of motion *relative to the current 40° contracted state*, whereas surgery offered a 25% chance of a 40° gain and a 75% chance of no gain at all. In the second presentation, the patients

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were told that therapy offered a guaranteed net loss of 30° of motion *relative to the preinjury normal state*, whereas surgery offered a 75% chance of a 40° loss, but a 25% chance of preventing all losses. Clearly, in both scenarios, the average expected effect of both options was a 10° gain, with therapy offering a certain 10° gain and surgery offering a 25% chance of 40° and 75% chance of 0°. The only difference was the framing. We found that when surgery was framed as means to a gain, only 49 patients (37%) opted for it, yet when the uncertainty of the treatment was presented as a means of avoiding losses, 80 patients (61%) opted for surgery [3]. As predicted by the Tversky and Kahneman theory, patients were more risk-seeking to avoid losses but more risk-averse when facing potential gains. This phenomenon has real-world relevance in orthopaedic practice [12]. That is, changing the language used, but nothing more, caused 31 patients to change their choice. And note that *some* choice of language must be made by the surgeon.

As such, if some patients don't want to make choices, and in other situations, complete free choice is not even possible, perhaps it would better (and certainly easier) if patients were to explicitly relinquish their decision-making power to surgeons, deferring to their experience, expertise, and best judgment: informed consent, omakase style.

Of course, the omakase analogy falls short. In the restaurant, no information was shared with me and very little was collected. I was assumed to have researched the place, to have a good enough idea about what I liked, and to be counted on to articulate my wants and needs. Also, and more to the point, the stakes were low. If I were to discover that I don't like hay-smoked salmon, I could unobtrusively slip it

into my napkin (at least I hope it was unobtrusive!). In a pre-op consultation, by contrast, the patient can be assumed to know nothing. The surgeon must strive to learn not only the patient's preferences but also to get a sense of the patient's level of understanding and his or her expectations, and to modulate both accordingly.

Still, the omakase model may be more appealing than what I will call the *Portlandia* model [13]. On the TV show of that name, the characters Fred and Carrie are at a restaurant, ordering a chicken dinner. They are told not only about how it is prepared, but that it was a Heritage Breed, woodland-raised chicken named Colin who, before slaughter, was fed a diet of sheep's milk, soy, and locally sourced hazelnuts. That's too much information, I would say.

These days, too many surgeons—including me, as my ACL story reveals—are opting for the *Portlandia* model. Of course, the ideal would be the Aristotelean golden mean, providing just exactly the right amount of information, in the right words, with a follow-up assessment of comprehension. In the meantime, a little omakase might be just what the patient ordered. Or didn't.

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Dr. Bernstein presents an interesting perspective on how surgeons' approach to informed consent should evolve. In his thought-provoking piece, he argues that in the process of consenting patients, surgeons are

giving them too much information, or what he terms the "*Portlandia* model." He then advocates for an alternative, what he calls an "omakase style" consent approach, in which "the details of the care are left to the surgeon's experience, expertise, and best judgment." While making his point, he highlights the work of Tversky and Kahneman [11], which underscores the importance of framing bias in affecting patient choice.

I commend Dr. Bernstein for writing about this important topic, as few have focused on a surgeon's style and its effect on the consent process [10]. However, I respectfully disagree with him regarding choice of style. There is growing evidence that clinicians are not very accurate in predicting outcomes—and orthopaedic surgeons are no different. In fact, in one study I published recently, my colleagues and I showed that orthopaedic surgeons' preoperative expectations were essentially like a flip of a coin in predicting improvement in pain and function after total joint replacement [6]. So, to defer to the surgeon "omakase style" would not be in the best interest of patients, in my opinion. Patients are becoming increasingly savvy and educated about their conditions, and evidence shows the importance of patients' preoperative expectations in predicting their outcomes [8].

Having said that, a *Portlandia* approach to consenting is not the way to go either. Informed consent is a complex process that involves the transfer of knowledge from surgeons to patients [5]. In a recent systematic review, Convie and colleagues [5] reported that patients "feeling" informed was more important to them than the amount of information provided. So, the process of transferring this information is critically important. Since each patient is different, perhaps the right way is a patient-centered

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approach to informed consent [1]. An effective patient-centered approach to consent emphasizes interactive, shared decision-making that considers many dimensions, including the different elements of patient comprehension, beyond risks of the procedure at hand [7].

Understanding the influence of framing bias on patient decisions is salient to effective transfer of knowledge to the patient and developing patient-centered approaches to informed consent. The excellent study that Dr. Bernstein and his colleagues published in 2016 showed that patient choice of orthopaedic surgery versus physical therapy was affected by how the gains and losses of each treatment option were framed or presented to patients [3]. This study not only highlights the importance of framing, but also implies that framing is potentially a modifiable preoperative factor that could affect patient decisions, and ultimately their outcomes. Therefore, helping surgeons understand their own biases in framing treatment plans, and providing them with the tools to augment these biases, may help surgeons tailor their consent style to each patient, and hopefully get us one step closer to delivering the right amount of consent information. Orthopaedic practices may assess the need for developing practice-based strategies (education modules) to address these biases.

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I come for the chef's expertise, skill, and creativity. The chef knows what's

fresh today and what he or she can do with it to make the best possible meal.

I bring respect and admiration. I also bring trust and flexible thinking. I'm the expert on me. But I expect the chef to know more about what's good for me than I may be aware of. I'm not at the table for my expertise. I'm here for the chef's expertise. I'm humble and curious. I'm expecting to learn and experience something new. I also bring an understanding that the meal has potential for harm in the form of parasites in raw fish or undiscovered allergies, but also financial harm and disappointment.

As Dr. Bernstein notes, when the chef makes me a meal, my preferences and circumstances are considered, but my expressed preferences are not determining the meal I will eat. The best chefs are masters of the science and art of gastronomy. The meal is based on sound principles of both food and ethics. The chef's aim is to provide me with the best possible experience. I'm almost certainly bringing some misconceptions about what flavors to put together to make something tasty, and I'm willing to put those aside. The best meals take me to a place I could not have anticipated.

As with gastronomic decisions, medical decisions also have a foundation. One of the baseline principles is that surgery is strategic harm. A choice for surgery means I start in deficit. I must derive a notable benefit from surgery for it to be an appropriate choice. The benefit derived must be more than can be achieved without an incision, anesthesia, medications, costs, and time out of cherished activities. It must be greater than my inherent human capacity for accommodation.

Medical decisions may also take me to a place I may not have anticipated. I don't regard the chef as deciding for me. We have decided together that I

want the chef's help making good decisions. I hope that patients feel the same about decisions we make together. It's my ethical responsibility as a surgeon to be as certain as possible that a person is aware of what matters most to them, and that their expressed preferences correspond with those values. What experts about the normal functioning of the human mind (such as Tversky and Kahneman [11]) showed us is that expressed preferences are often muddled by common misconceptions related to cognitive bias.

I don't think people shy away from the cognitive and emotional burden of decisions. They are ready for that burden. They just want a trusted companion to help them with it, more so if they are aware of cognitive bias. Awareness of cognitive bias and cognitive error can be considered a key aspect of health literacy.

Awareness of cognitive bias on the surgeon's part leads directly to a guiding rather than directing style of expertise transfer. I, the expert, have bias and misconceptions. The patient has bias and misconceptions. Together we are exploring the patient's values, the best current knowledge about the potential benefits and potential harms of various options, and any cognitive errors that may be interfering with decisions consistent with what matters most to them.

Informed consent in its current form may be reduced to a legal ritual. To improve, we are exploring interactive consents that help patients explore their values, become aware of common misconceptions, and repeatedly affirm that they are comfortable with the balance of potential harms and potential benefits until they arrive at a decision either for or against a course of action. It's not a decision made for them. It's a supported decision based

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on medical expertise and expertise about the normal functioning of the human mind.

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