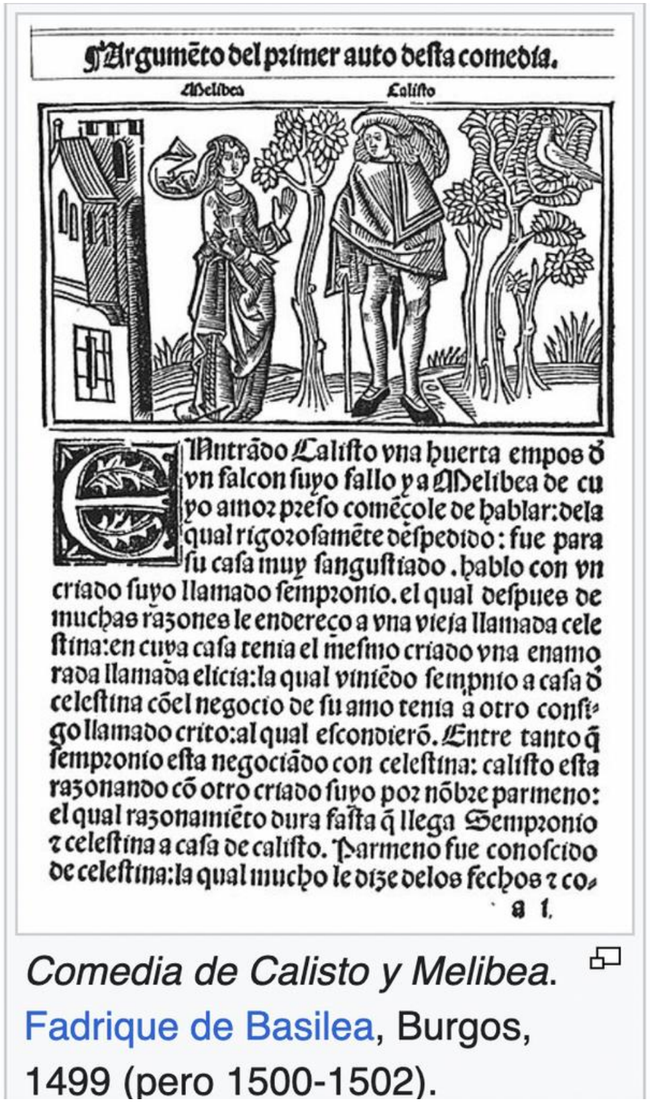
LA CELESTINA, FERNANDO DE ROJAS

Tragicomedia

de Calisto y Melibea nueuamẽte reui=
sta y emendada cõ addicion delos argu
mẽtos de cada vn auto en principio. la
qual cõtiene de mas de su agradable y
dulce estilo muchas sentẽcias filosofa=
les: y auisos muy necessarios pa mãce
bos: mostrãdo les los engaños q̃ estan
encerrados en sirueẽtes y alcahuetas.



El Argumẽto del primer auto desta comedia.

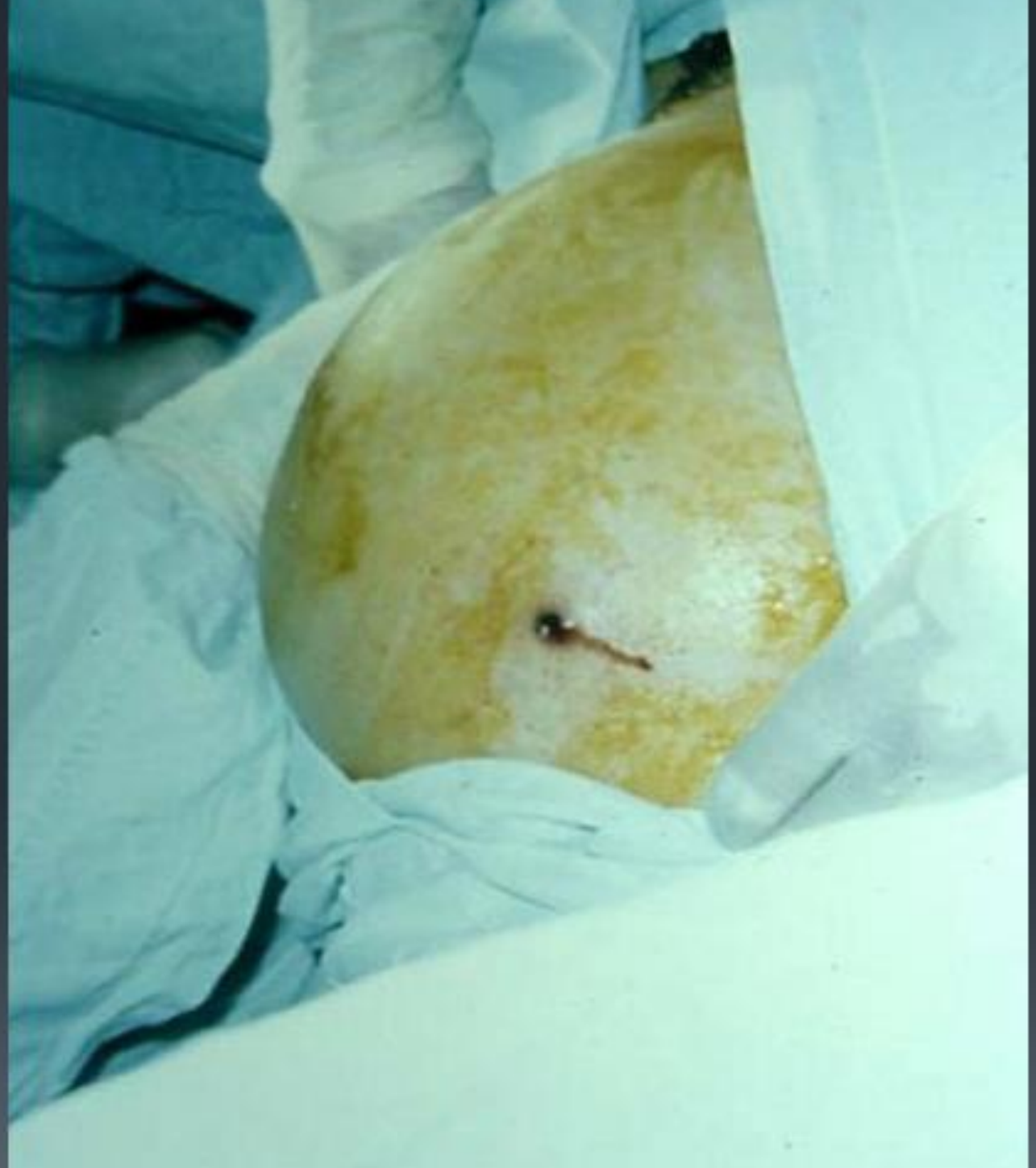
Melibea Calisto

Entrãdo Calisto vna huerta empos ỏ
vn falcon suyo fallo y a Melibea de cu
yo amor preso comẽçole de hablar: dela
qual rigorosamẽte despedido: fue para
su casa muy sanguſtiado. hablo con vn
criado suyo llamado sempronio. el qual despues de
muchas razones le endereço a vna vieja llamada cele
stina: en cuya casa tenia el mesmo criado vna enamo
rada llamada elicia: la qual viniẽdo sempnio a casa ỏ
celestina cõel negocio de su amo tenia a otro consi=
go llamado crito: al qual escondierõ. Entre tanto q̃
sempronio esta negociãdo con celestina: calisto esta
razonando cõ otro criado suyo por nõbre parmeno:
el qual razonamiẽto dura fasta q̃ llega Sempronio
y celestina a casa de calisto. Parmeno fue conoscido
de celestina: la qual mucho le dize delos fechos y co=

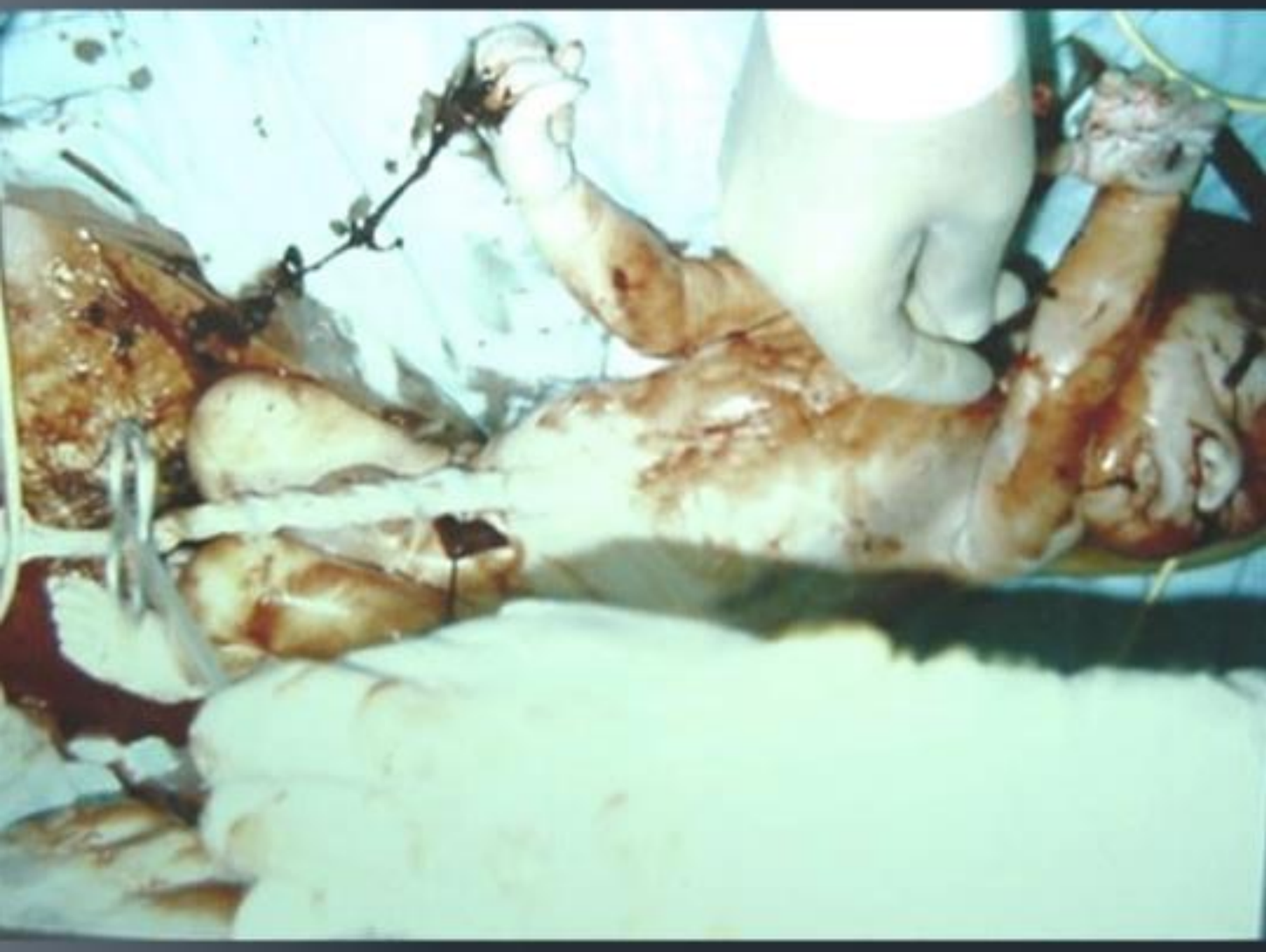
a 1.

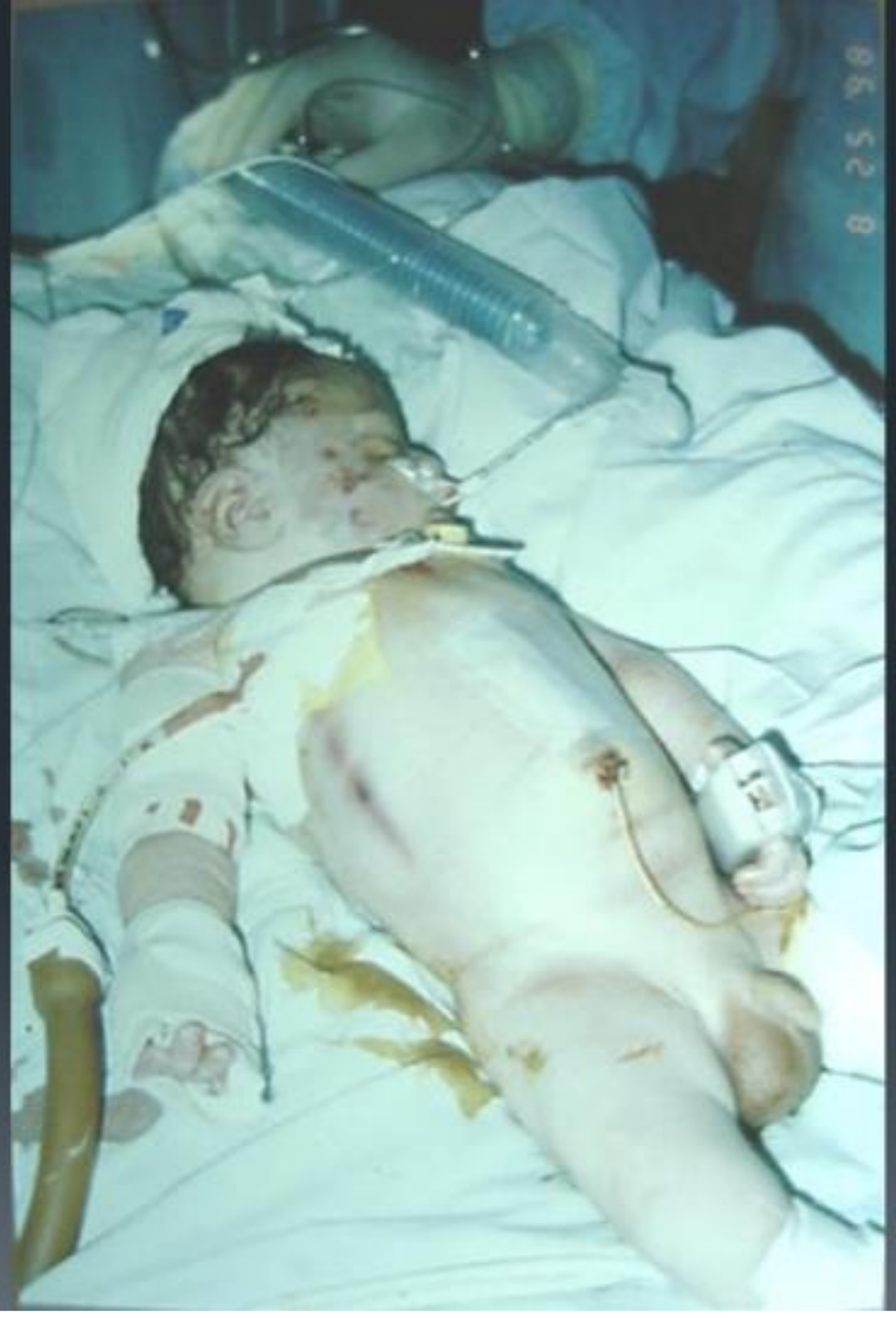
Comedia de Calisto y Melibea. Fadrique de Basilea, Burgos, 1499 (pero 1500-1502).

NADIE ESTA TAN VIEJO
QUE NO PUEDA VIVIR UN AÑO MAS
NI TAN JOVEN
QUE NO PUEDA MORIR MAÑANA.

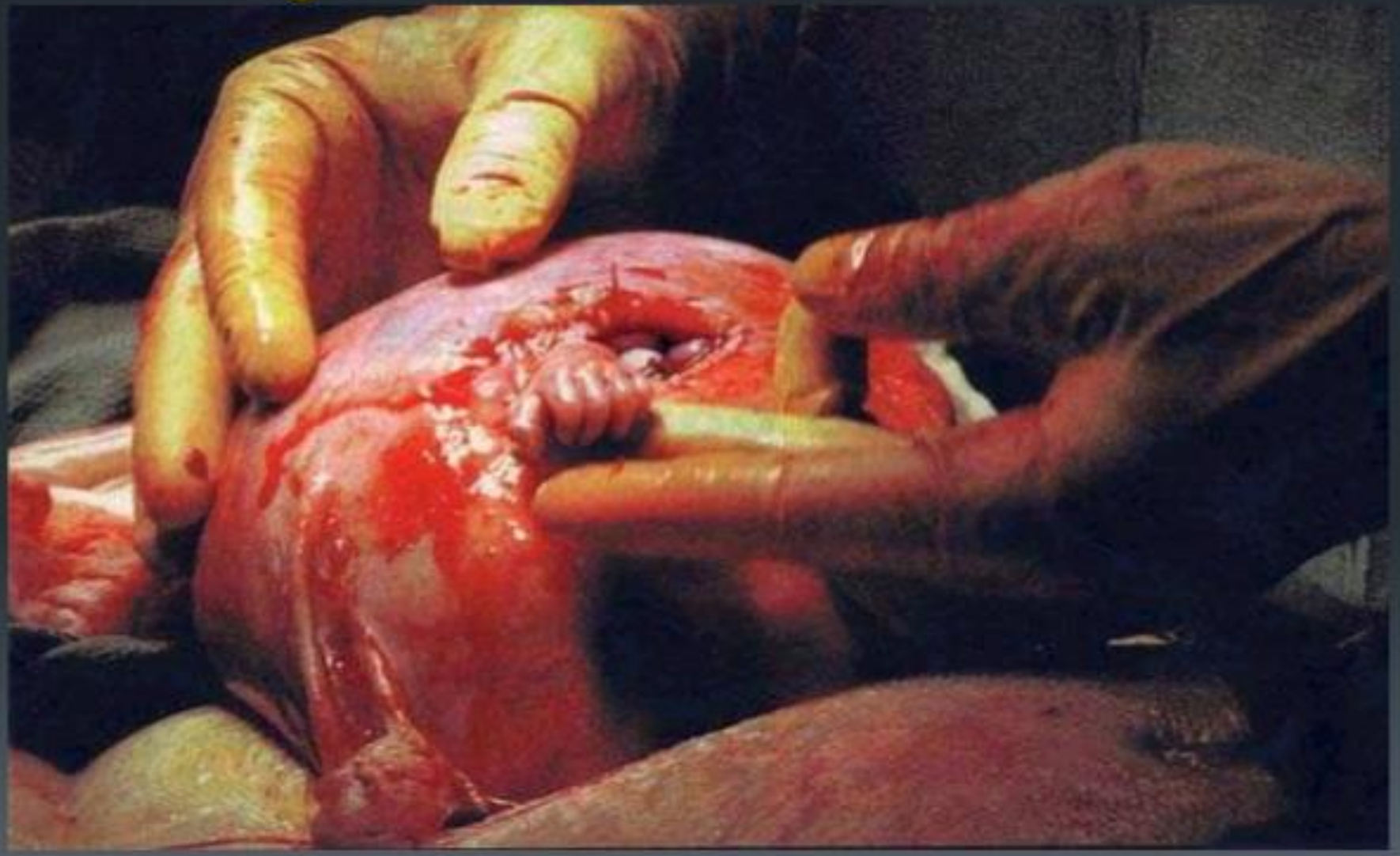



Reebok
mindray





El Milagro de la Vida




CÓMO NOS VEN

62 años de edad. Accidente de transito hace 20 años.
Lesiones en columna vertebral y pélvis.
Exposición cónica al asbesto. Tabaquismo. Apnea del sueño
ACV multi infarto

“Ya no soporto la vida. No soporto el dolor. Tengo derecho a morir dignamente.Ya tengo sentencia judicial que autoriza esto. Ayudenme a morir por favor”

6 años de edad. Encefalopatia epiléptica desde los dos meses de edad. Episodios convulsivos hasta treinta veces al día en los que su rostro evidencia mucho dolor. Ceguera y sordera desde las dos años como secuela.

Traqueostomizado. Conectado a ventilador en casa.

Gastrostomia permanente. Neumonias a repetición.

Excelente red de apoyo.

“Hemos hecho todo. Adoramos a Daniel. Su hermana duerme a su lado cada noche. Europa, Estados Unidos , Colombia, han unido su saber médico. No hay opción de recuperación. Ayudennos a que este sufrimiento termine”

PERSPECTIVE

Shared Decision Making: A Model for Clinical Practice

Glyn Elwyn, PhD[1,2], Dominick Frosch, PhD[3,4], Richard Thomson, MD[5], Natalie Joseph-Williams, MSc[1], Amy Lloyd, PhD[1], Paul Kinnersley, MD[1], Emma Cording, MB BCh[1], Dave Tomson, BM BCh[6], Carole Dodd, MSc[7], Stephen Rollnick, PhD[1], Adrian Edwards, PhD[1], and Michael Barry, MD[8,9]

[1]Cochrane Institute of Primary Care and Public Health, Neuadd Meirionydd, Cardiff University, Cardiff, UK; [2]The Dartmouth Center for Health Care Delivery Science, Dartmouth College, New Hampshire, NH, USA; [3]Department of Health Services Research, Palo Alto Medical Foundation Research Institute, Palo Alto, CA, USA; [4]Department of Medicine, University of California, Los Angeles, Los Angeles, CA, USA; [5]Institute of Health and Society, Newcastle University, Newcastle upon Tyne, UK; [6]Collingwood Health Group, New York Surgery, North Shields, UK; [7]Clinical Governance & Risk department, Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle upon Tyne, UK; [8]General Medicine Division, Massachusetts General Hospital, Boston, MA, USA; [9]Informed Medical Decisions Foundation, Boston, MA, USA.

emerged as two new *outcome* indicators of high-quality care.

Practice implications: This study provides a first qualitative fundament for understanding the components of "quality of care" from a triangulated frontline perspective. Future research needs to validate our findings with quantitative data to explore their usefulness for completing existing quality frameworks.

PERSPECTIVE

Shared Decision Making: A Model for Clinical Practice

Glyn Elwyn, PhD[1,2], Dominick Frosch, PhD[3,4], Richard Thomson, MD[5], Natalie Joseph-Williams, MSc[1], Amy Lloyd, PhD[1], Paul Kinnersley, MD[1], Emma Cording, MB BCh[1], Dave Tomson, BM BCh[6], Carole Dodd, MSc[7], Stephen Rollnick, PhD[1], Adrian Edwards, PhD[1], and Michael Barry, MD[8,9]

[1]Cochrane Institute of Primary Care and Public Health, Neuadd Meirionydd, Cardiff University, Cardiff, UK; [2]The Dartmouth Center for Health Care Delivery Science, Dartmouth College, New Hampshire, NH, USA; [3]Department of Health Services Research, Palo Alto Medical Foundation Research Institute, Palo Alto, CA, USA; [4]Department of Medicine, University of California, Los Angeles, Los Angeles, CA, USA; [5]Institute of Health and Society, Newcastle University, Newcastle upon Tyne, UK; [6]Collingwood Health Group, New York Surgery, North Shields, UK; [7]Clinical Governance & Risk department, Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle upon Tyne, UK; [8]General Medicine Division, Massachusetts General Hospital, Boston, MA, USA; [9]Informed Medical Decisions Foundation, Boston, MA, USA.

The principles of shared decision making are well documented but there is a lack of guidance about how to accomplish the approach in routine clinical practice. Our aim here is to translate existing conceptual descriptions into a three-step model that is practical, easy to remember, and can act as a guide to skill development. Achieving shared decision making depends on building a good relationship in the clinical encounter so that information is shared and patients

(SDM) has been defined as: 'an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences".[2]

The principles of SDM are well documented and the common elements have been summarized.[5] The earliest mention was in 1982,[6] but the idea draws on and deepens

La toma de Decisiones compartidas ha sido definida como un abordaje en el cual, clínicos y pacientes comparten la mejor evidencia disponible cuando se enfrentan a la tarea de tomar decisiones y durante el cual los pacientes son acompañados para alcanzar preferencias informadas.

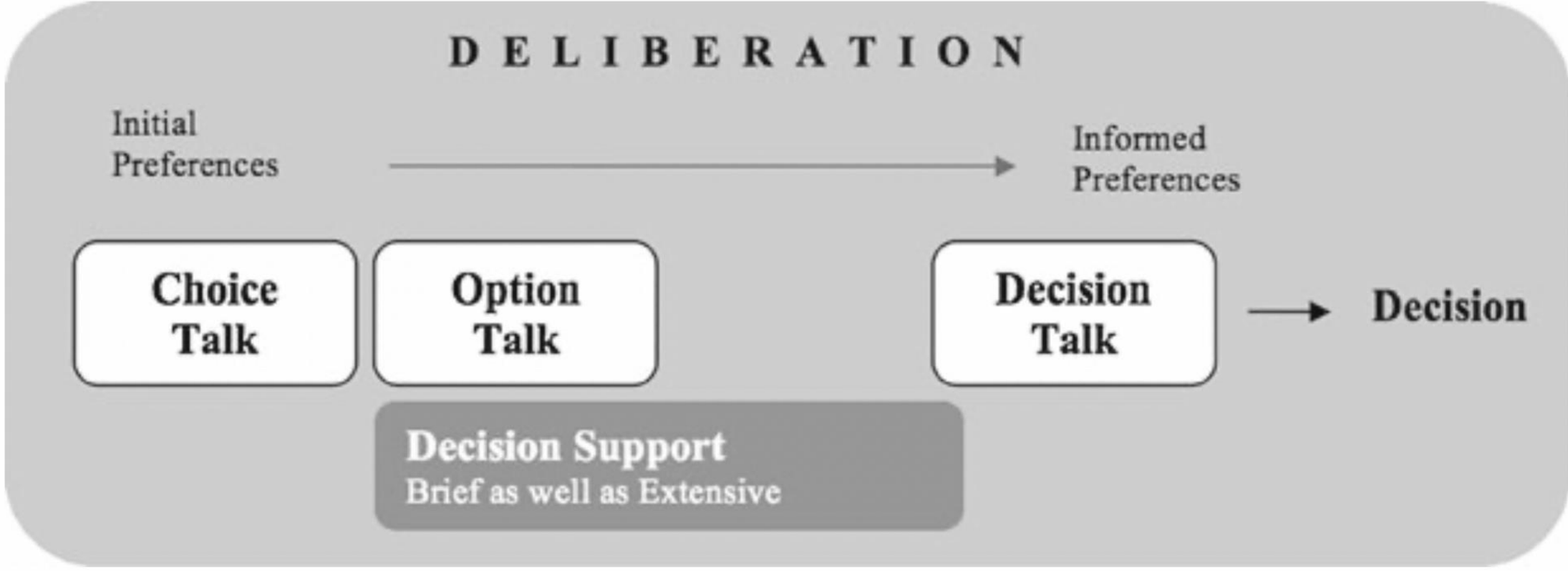
Los principios de las decisiones compartidas están bien documentados y su más temprana mención data de 1982 pero la idea se basa y profundiza los principios de atención centrada en la persona. A pesar de la claridad en su concepto pocas instituciones en el mundo la han llevado a un plano de prioridad y pocas saben como implementarlo

En su concepto medular las decisiones compartidas se basan en la aceptación de la autodeterminación de las personas y en la necesidad de que los clinicos den soporte al paciente para que se logre el objetivo siempre que sea posible. En el contexto de esta filosofía la autodetrminación no implica que el individuo sea abandonado

Muchos profesionales de la salud expresan dudas y manifiestan que los pacientes no desean ser involucrados en las decisiones; que los pacientes no tienen la habilidad o la capacidad de tomarlas y que por tanto van a tomar malas decisiones. Otros manifiestan que eso no es práctico dadas las presiones del manejo del tiempo. Otros manifiestan que “ya lo están haciendo” pero los datos revelan otra cosa. Por ello un primer paso en el proceso implica que los clínicos entiendan la trascendencia del asunto

Por qué las decisiones compartidas: mas allá del imperativo ético

El concepto y la práctica están soportados por mas de 86 pruebas ramdomizadas mostrando el conocimiento ganado por los paciente mayor confianza en las decisiones, involucramiento más activo y , en muchas situaciones, los pacientes más informados escogen la opción más conservadora del tratamiento.


DELIBERATION
Initial Preferences
Informed Preferences
Choice Talk
Option Talk
Decision Talk
Decision
Decision Support
Brief as well as Extensive

Special Article

Psychotherapy and Psychosomatics

Psychother Psychosom 2008;77:219–226
DOI: 10.1159/000126073

Published online: April 16, 2008

Systematic Review of the Effects of Shared Decision-Making on Patient Satisfaction, Treatment Adherence and Health Status

E.A.G. Joosten[a, b] L. DeFuentes-Merillas[a, b] G.H. de Weert[c] T. Sensky[e]
C.P.F. van der Staak[d] C.A.J. de Jong[a, b]

[a]Novadic-Kentron, Network for Addiction Treatment Services, St-Oedenrode, [b]Nijmegen Institute for Scientist-Practitioners in Addiction (NISPA), Nijmegen, [c]Julius Center for Health Sciences and Primary Health Care, UMC Utrecht, and [d]Academic Centre for Social Sciences, Radboud University Nijmegen, Nijmegen, The Netherlands; [e]Department of Psychological Medicine, Imperial College London, London, UK

Table 1. Models of shared decision-making about treatment [2, 42]

	Paternalistic model ('traditional medical model')	Shared decision-making	'Informed medical model'
Role of the clinician	*Active:* Reports only selected information to the patient, chooses the therapy he considers best for the patient.	*Active:* Reports all information and treatment possibilities to the patient. Can recommend an option. Decides on the therapy together with the patient.	*Passive:* Reports all information and treatment possibilities to the patient. Withholds his recommendations. Makes no decision.
Role of the patient	*Passive:* Accepts the proposal of the clinician. Is obliged to cooperate in his recovery.	*Active:* Receives all information. Forms his own judgement on harms and benefits of treatment options. Discusses his preferences with the clinician. Decides on the therapy together with the clinician.	*Active:* Receives all information. Forms his own judgement. Is free to choose between all options unbiased by his clinicians' own option. Decides on the therapy alone.
Information	*One way (largely):* Clinician → patient	*Two way:* Patient ↔ clinician	*One way (largely):* Clinician → patient
Deliberation	Clinician alone or with other clinicians	Clinician and patient (plus potential others)	Patient (plus potential others)
Who decides?	Clinician	Clinician and patient	Patient

LIFE IN VIEW/SPL

Implementing shared decision making in the NHS

Creation of a platform of tools to provide information to doctors and patients should be the first step in giving patients choice about their treatment, say **Glyn Elwyn and colleagues**

patient engagement.

Despite considerable interest in shared decision making, implementation has proved difficult and slow.[7] At least three conditions must be in place for shared decision making to become part of mainstream clinical practice: ready access to evidence based information about treatment options; guidance on how to weigh up the pros and cons of different options; and a supportive clinical culture that facilitates patient engagement. This article outlines some options for creating a sustainable decision support platform for patients that may facilitate a wider adoption of shared decision making in clinical practice.

Evidence of benefit

A large number of decision aids are now available, most of which were developed in North America. The latest iteration of the Cochrane systematic review includes 55 trials[6] and provides evidence that patients who have used these tools are better informed (mean difference 15.2/100 95% confidence interval 11.7 to 18.7) and less passive in decision making (relative risk 0.6, 0.5 to 0.8). There is some evidence that when patients have made well informed decisions, they also adhere better to treatment regimens[11] and that when informed patients face discretionary surgery, they make more conservative decisions, often deferring or declining interventions (relative risk 0.8, 0.6 to 0.9).[6] These effects seem to be strengthened when patients are given decision coaching (a brief discussion with a trained facilitator) to help them with the process of deliberation.[12 13]

In short, there is consistent evidence that decision support interventions designed for patients ensure that the ethical imperative of informed patient choice and consent is met, with a range of benefits for patients. In some examples, especially where there are choices between more and less invasive options, these may lead to cost reductions; the Cochrane review of decision aids found that, in some contexts, they could reduce rates of elective surgery by 25%. This means that the NHS might be able to save considerable amounts if shared decision making, supported by decision support, could be achieved before common elective surgical procedures. Shared decision making might also reduce the likelihood and cost of litigation, although there is no formal evidence for this yet.

Organisational culture

Although it is clear that patients desire and value information about treatment choices,[18 19] it is difficult to embed the attitudes, skills, and interventions into routine practice.[7] Many barriers are cited, including concerns about insufficient time and lack of fit into organisational routines. Professionals often claim that there is no need for this approach because shared decision making already occurs,[7] but the available evidence contradicts this assertion.[20 21] The latest results from the Care Quality Commission's national patient surveys show that 48% of inpatients and 30% of primary care patients would have liked more involvement in decisions about their care.[19]

Do patients want a choice and does it work?

The government in England wants to give patients more choice about their healthcare. But **Angela Coulter** argues that treatment choice is more popular with patients than provider choice, with much greater evidence of benefit

"Nothing about me without me" was the guiding principle adopted by 64 participants from 29 countries at a 1998 Salzburg global seminar convened to develop ideas for improving the quality of health care by involving patients.[1] The catchphrase

on the basis of their expectations of its effects, but research evidence to confirm or refute these assumptions is only now beginning to emerge.

In contrast, evidence about the effects of engaging patients in treatment choices has accumulated

Patients could choose where they were referred to, rather than an individual specialist, and a website, NHS Choices (www.nhs.uk), was set up to publish information on quality indicators to inform people's choices. In 2008 the available

Hablamos un lenguaje diferente. No nos entienden.

Las mamás tiene que aprender nuestro lenguage para entendernos.

Se nos olvida el español.

Lenguaje en Rayos X.

Olvidamos que no somos dueños de los pacientes

Todo cuanto proviene de lo incierto
queda a merced de fantasías y
conjeturas
del alma atemorizada

Toma de decisiones compartidas

De la Teoría a la Práctica

Pablo Lemos. IECS. Planetree América Latina Sur.
HPUC.

El paciente “mirando desde afuera”

Modelo médico hegemónico

Toma de decisiones compartidas

Objetivos:

- Definir el concepto de toma de decisiones compartidas.
- Porqué: Toma de decisiones compartida
- Qué: Conversaciones elegir
- Cómo: Tener la conversación con el paciente
- Cuánto: El costo de las decisiones
- Herramientas para la toma de decisión
- Barreras, dificultades y desafíos.
- Cómo educar en TDC

Definición de TDC:

“un enfoque donde los médicos y los pacientes comparten la mejor evidencia disponible cuando se enfrentan con la tarea de tomar decisiones, y dónde los pacientes se sienten apoyados para considerar opciones, para lograr información acorde a sus preferencias y valores "

Elwyn G, Coulter A, Laitner S, Walker E, Watson P, Thomson R. Implementing shared decision making in the NHS. BMJ. 2010;341: c5146

Toma de decisiones compartidas

Planetree International

Manual de Certificación Programa Atención Centrada en la Persona 2024

4.2 Toma de Decisiones Compartida

Directriz: Los pacientes/residentes y sus familias reciben la información y el apoyo que necesitan para tomar decisiones de tratamiento basadas en la evidencia y que se alineen con sus objetivos y valores personales. Cuando existe más de una opción de tratamiento clínicamente apropiada, la información proporcionada incluye una revisión de los riesgos, beneficios y evidencia de efectividad de cada opción.

Requerimientos relacionados: 4.3.1. 3... 3.3.3.

Declaración de intención: Los pacientes/residentes están plenamente informados sobre su condición médica y las opciones disponibles para ellos. La toma de decisiones se realiza de manera colaborativa para considerar tanto el conocimiento clínico especializado del equipo de tratamiento y el conocimiento del paciente/residente sobre sus preferencias, valores y estilo de vida. Los pacientes/residentes saben que pueden participar en las decisiones relacionadas con su atención y que sus decisiones serán respetadas.

Oro	4.2.1. En los últimos tres años se ha puesto a disposición de los médicos, formación basada en habilidades para la toma de decisiones compartida.
Oro	4.2.2. Se utilizan herramientas o procesos de toma de decisiones compartida para ayudar a las personas a diferenciar entre las opciones disponibles y para aclarar cómo las diferentes opciones se alinean con sus prioridades y valores personales.
Ejemplos de evidencia:	
Documentación de cualquier capacitación basada en competencias sobre la toma de decisiones compartida ofrecida en los últimos 12 meses, incluyendo objetivos de aprendizaje.	
Ejemplos de herramientas y/o procesos de toma de decisiones compartidas utilizados con pacientes/residentes.	

Toma de decisiones compartidas

¿Por qué?

A menudo estamos equivocados sobre las preferencias de los pacientes

A menudo estamos equivocados sobre las preferencias de los pacientes

	Mujer	Medico
Mantener la mama	7%	71%
Vive tanto tiempo como sea posible	59%	96%
Aspecto natural sin ropa	33%	80%
Evitar la prótesis	33%	0%

No podemos brindar atención de calidad, sin conocer las preferencias de los pacientes.

Fuente: Karen Sepucha, MD, Massachusetts General Hospital

Proporcionar información o la evidencia por sí sola no son suficientes para ayudar a los pacientes para que tomen una decisión.

Se necesitan conversaciones significativas.

April 2016 35:4 Health Affairs

Proporcionar información o la evidencia por sí sola no son suficientes para ayudar a los pacientes para que tomen una decisión.

33° Foro Internacional OES
en alianza con la Fundación Santa Fe de Bogotá
y Planetree Internacional

ENGAGING PATIENTS IN CLINICAL CARE

By Ian Hargraves, Annie LeBlanc, Nilay D. Shah, and Victor M. Montori

DOI: 10.1377/hlthaff.2015.1354
HEALTH AFFAIRS 35,
NO. 4 (2016): 627–629

VIEWPOINT

Shared Decision Making: The Need For Patient-Clinician Conversation, Not Just Information

ABSTRACT The growth of shared decision making has been driven largely by the understanding that patients need information and choices regarding their health care. But while these are important elements for patients who make decisions in partnership with their clinicians, our experience suggests that they are not enough to address the larger issue: the need for the patient and clinician to jointly create a course of action that is best for the individual patient and his or her family. The larger need in evidence-informed shared decision making is for a patient-clinician interaction that offers conversation, not just information, and care, not just choice.

Ian Hargraves is a service designer in the Knowledge and Evaluation Research Unit at Mayo Clinic, in Rochester, Minnesota.

Annie LeBlanc is an assistant professor of health services research and an investigator in the Knowledge and Evaluation Research Unit at Mayo Clinic.

Nilay D. Shah is an associate professor of health care policy and research at Mayo Clinic.

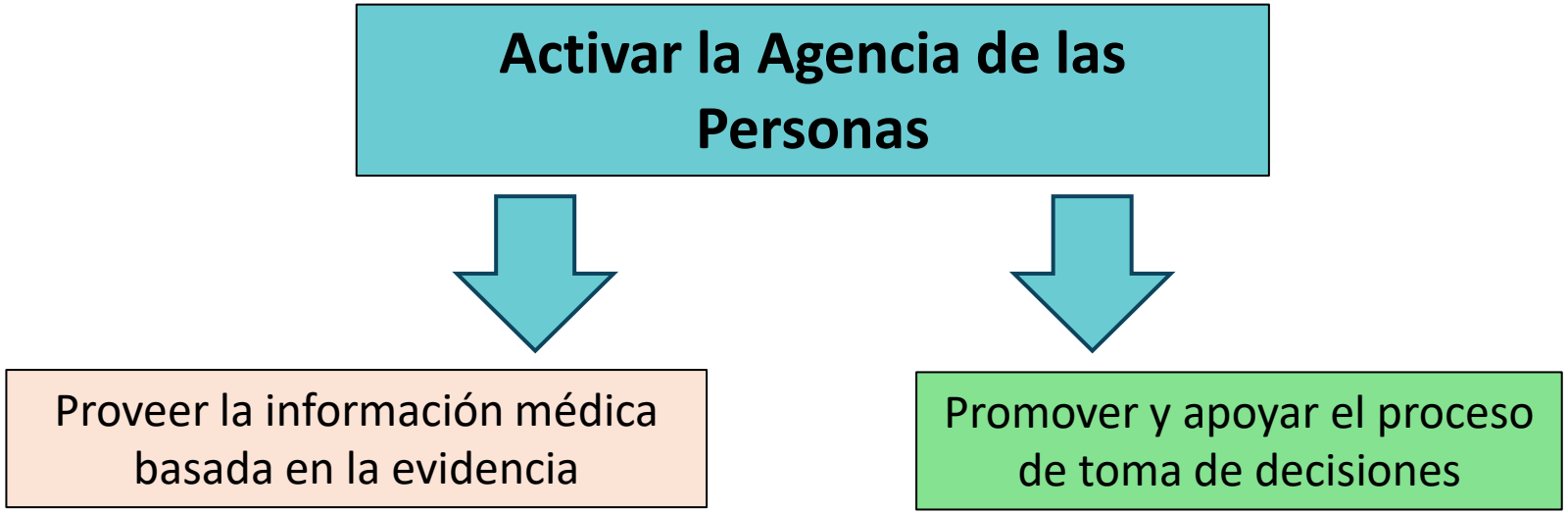
Victor M. Montori (montori

“Ofrecer cuidado, no solo elecciones”.

April 2016 35:4 Health Affairs

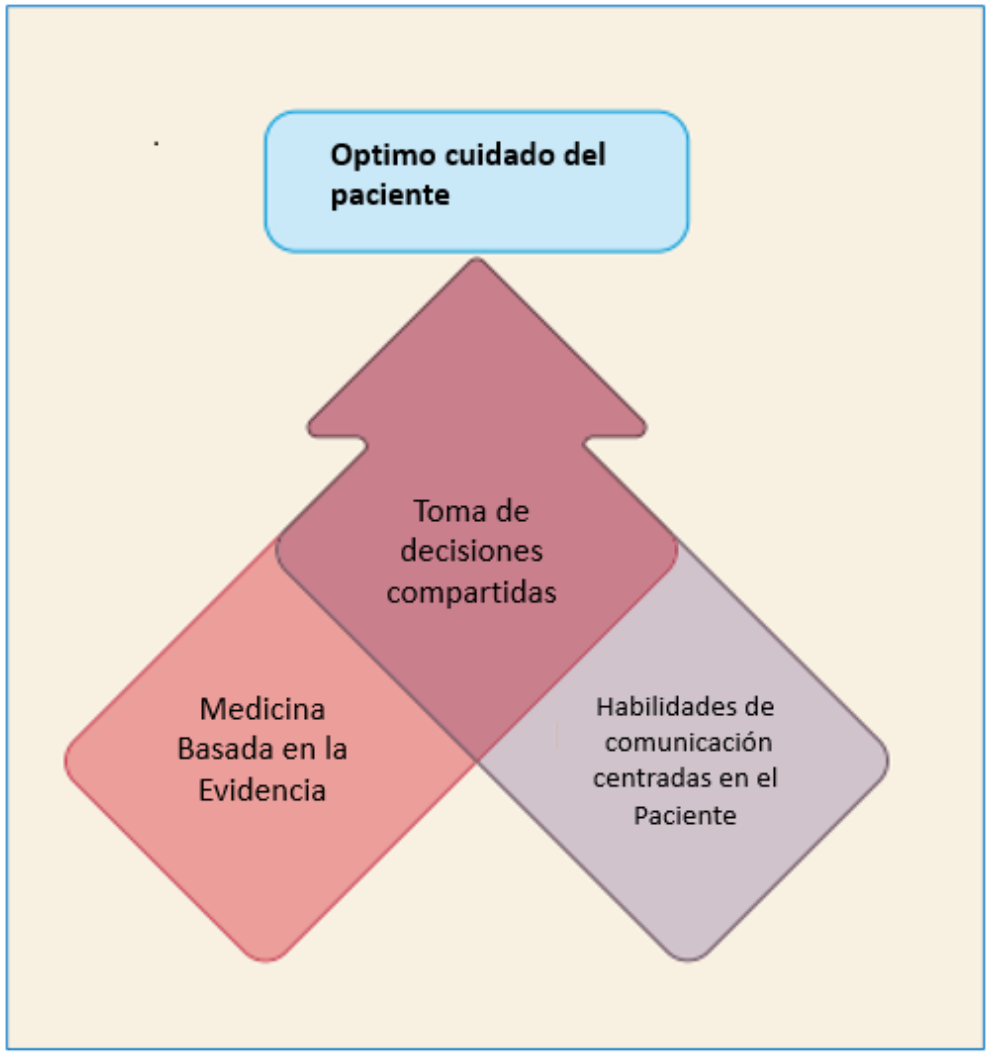
Toma de decisiones compartidas

Lograr la TDC depende de ayudar a **conferir agencia**, donde agencia se refiere a la capacidad de individuos para actuar independientemente, para hacer sus propias elecciones libres.



Elwyn et al.JGIM 2010;27(10):1361-7

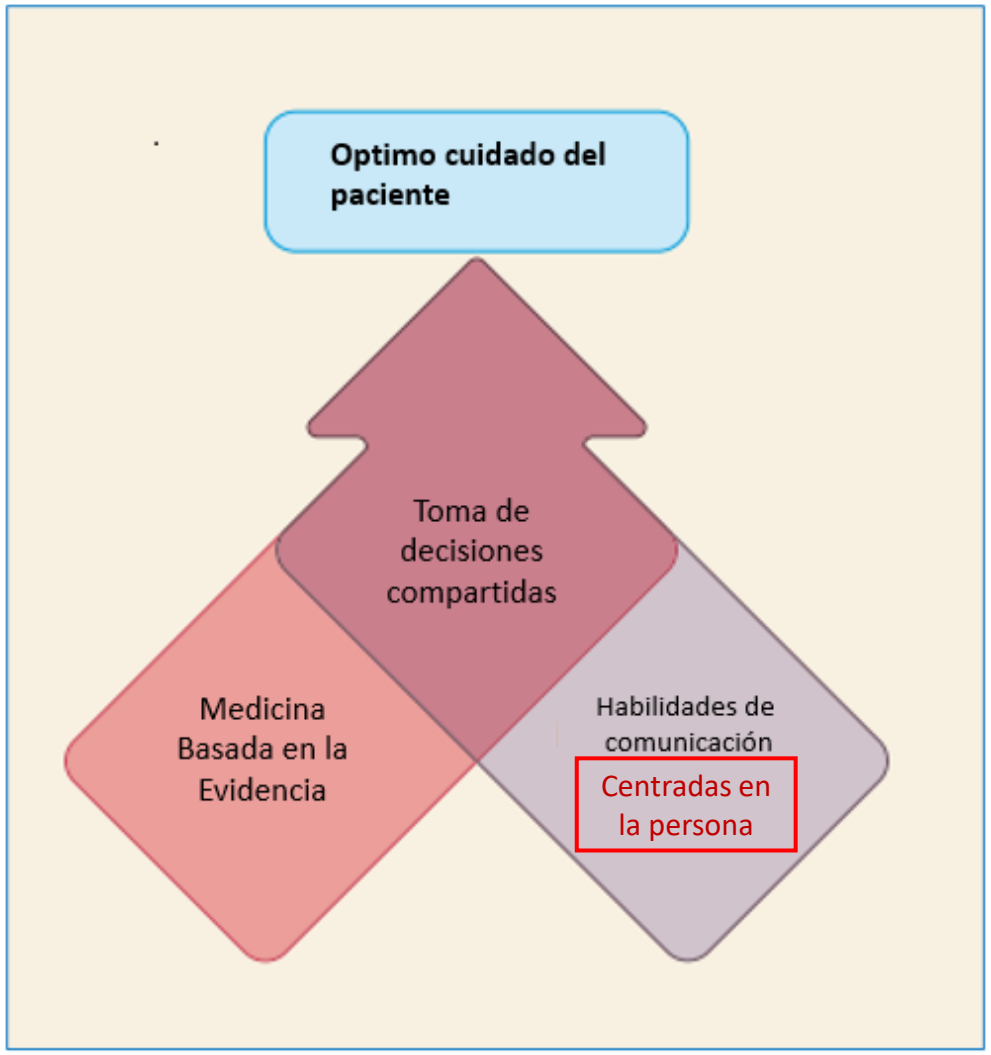
Toma de decisiones compartidas



Interdependencia de la medicina basada en la evidencia y la toma de decisiones compartida y la necesidad de ambos como parte de la atención óptima

JAMA October 1, 2014. Volume 312, Number 13

Toma de decisiones compartidas



Interdependencia de la medicina basada en la evidencia y la toma de decisiones compartida y la necesidad de ambos como parte de la atención óptima

JAMA October 1, 2014. Volume 312, Number 13

Toma de decisiones compartidas

¿Qué?

Toma de decisiones compartidas

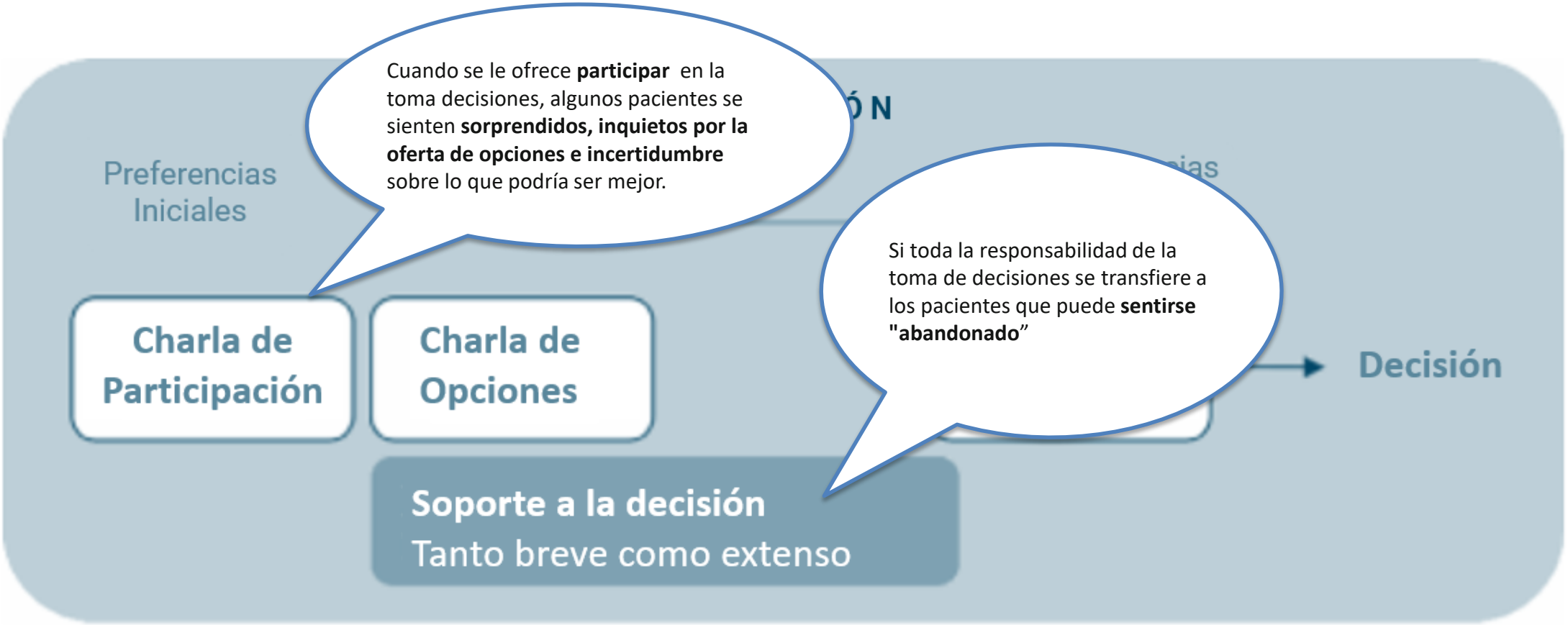
Ejemplos de condiciones sensibles para TDC:

- **Screening Cáncer:** mama, próstata, colon
- **Vacunas:** COVID, HVZ, Dengue etc.
- **Enfermedad Coronaria** (medicamentos, angioplastia/colocación de stents, CABG)
- **Cáncer de próstata** (vigilancia activa, radiación, cirugía)
- **Osteoartritis** (medicamentos, cirugía)
- **Cuidados al final de la vida** (curativos, paliativos, hospicio, etc.)
- **Estenosis espinal** (medicamentos, PT, cirugía)
- **Hernia de disco** (medicamentos, PT, cirugía)
- **Cáncer de mama en estadio temprano** (tumorectomía/radiación, mastectomía +/- reconstrucción)
- **Afecciones uterinas benignas** (medicamentos, histerectomía)
- **Obesidad** (cambio de comportamiento, medicamentos, cirugía bariátrica)

Toma de decisiones compartidas

¿Cómo?

Toma de decisiones compartidas



Elwyn et al.JGIM 2010;27(10):1361-7

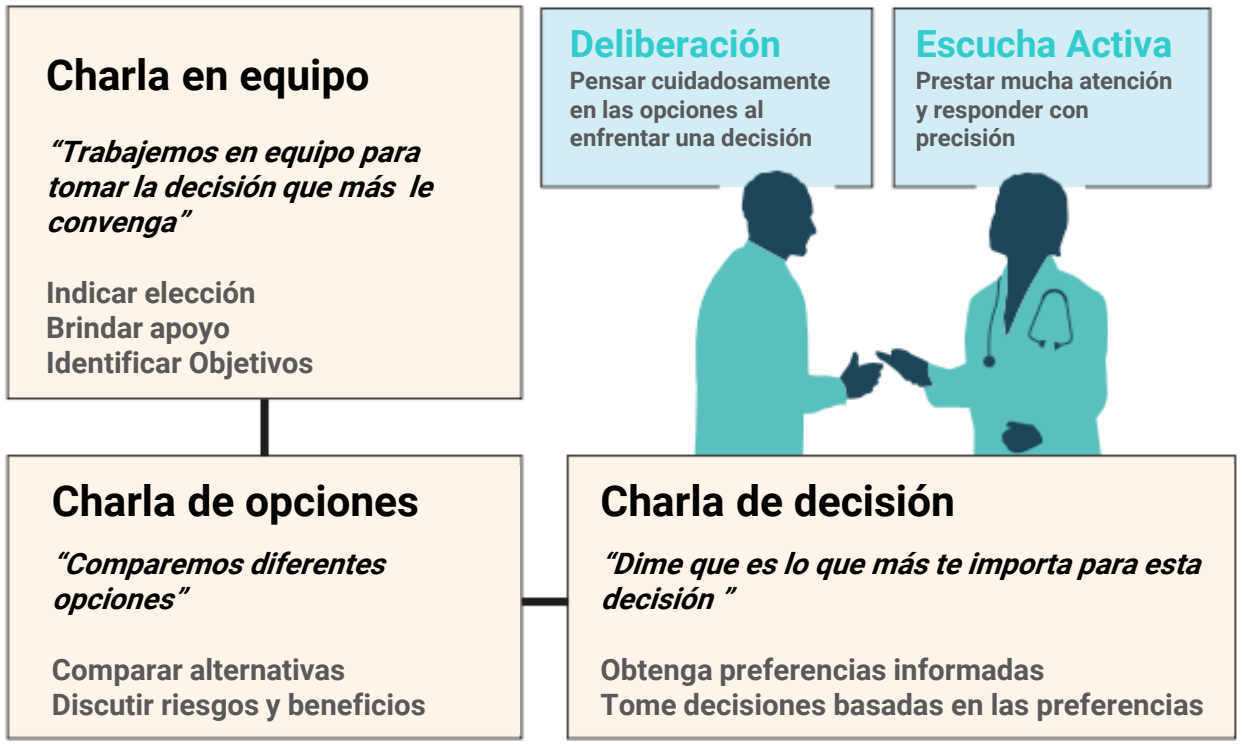


Fig. 1 *El modelo de las tres conversaciones de la toma de decisiones compartida.*

Journal of Internal Medicine, 2022, 291; 408–425

Toma de decisiones compartidas

Ayudando al paciente a decidir:

a) Centrarse en las preferencias.

Guíe al paciente para que forme preferencias. Frases sugeridas: "¿Qué es lo que, desde su punto de vista, le importa más?"

b) Obtener una preferencia.

Prepárese con un plan de respaldo ofreciendo más tiempo o estando dispuestos a guiar al paciente, si indica que este es su deseo.

c) Pasar a una decisión.

Intente verificar la necesidad de aplazar o tomar una decisión: Frases sugeridas: "¿Estás listo para decidir?" o "¿Quieres más tiempo? ¿Tienes más preguntas?" "¿Hay más cosas que deberíamos hacer? discutir?"

d) Revisión de la oferta.

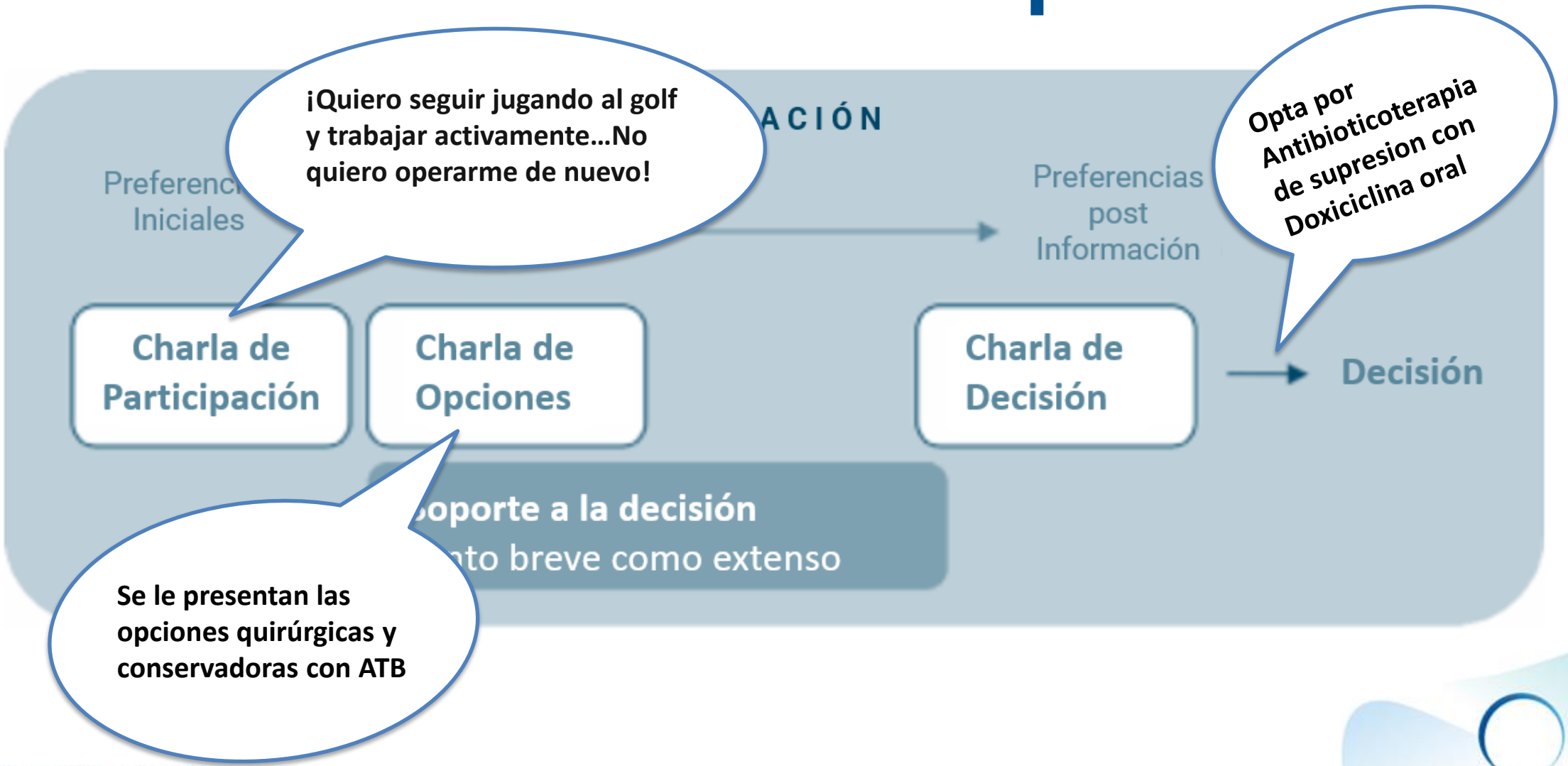
Recordar al paciente, cuando sea factible, que las decisiones pueden ser revisadas es una buena manera de llegar al cierre.

Toma de decisiones compartidas

El caso Raúl:

- Varón de 67 años en 2016
- Historia de CI con Stent en 2001 y 2007
- Operado de cadera derecha en 2009
- Infección de RTC izquierda en 2016 se re-opera para toilette y se aísla propionibacterium acnes.
- Cumple 40 días de vancomicina EV en atención domiciliaria
- Infectología y traumatología le proponen retirar la prótesis…

Toma de decisiones compartidas



Elwyn et al.JGIM 2010;27(10):1361-7

Toma de decisiones compartidas

El caso Raúl:

Datos del Evento: Turno del jueves, 22 de septiembre de 2016

Médico: LEMOS, PABLO ALEJANDRO
Evolución: Sin fiebre, sin dolor
PCR 0.08
Bajo tratamiento supresivo ATB con Doxiciclina 100+100 desde 1 de junio de 2016.-

Rp
Valsartán
Carvedilol
Atorvastatina 20
AAS 100
Doxicilcina

Asma estable
Neumoterol ...

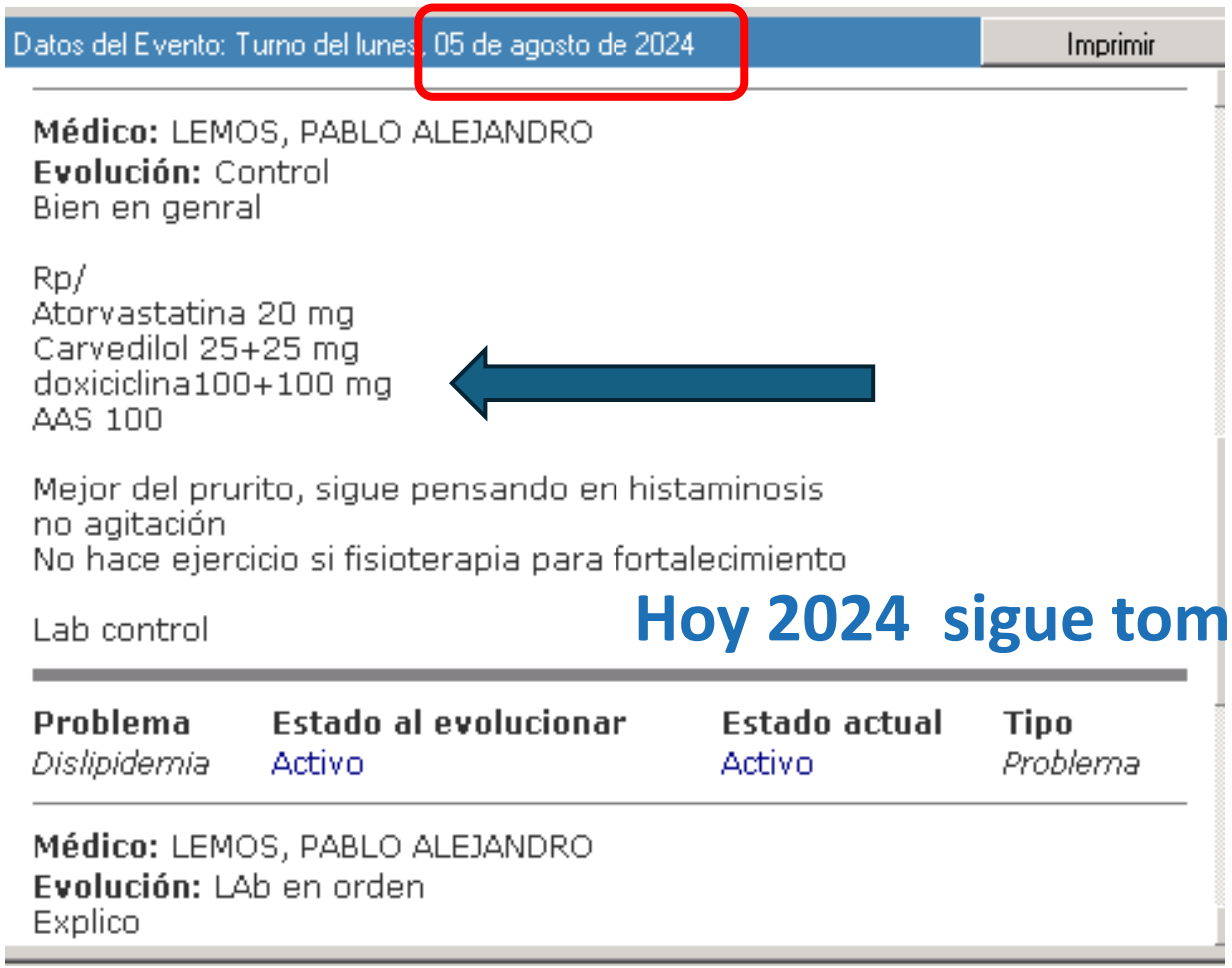
Examen:

Llamativamente Bien
PA 120/80
Ruidos normales
regular
pulmones limpios
Abdomen nada palpable

plan Lab ver lo metabólico

Toma de decisiones compartidas

El caso Raúl:



Datos del Evento: Turno del lunes, 05 de agosto de 2024 | Imprimir

Médico: LEMOS, PABLO ALEJANDRO
Evolución: Control
Bien en genral

Rp/
Atorvastatina 20 mg
Carvedilol 25+25 mg
doxiciclina100+100 mg
AAS 100

Mejor del prurito, sigue pensando en histaminosis
no agitación
No hace ejercicio si fisioterapia para fortalecimiento

Lab control

Problema	Estado al evolucionar	Estado actual	Tipo
Dislipidemia	Activo	Activo	*Problema*

Médico: LEMOS, PABLO ALEJANDRO
Evolución: LAb en orden
Explico

Hoy 2024 sigue tomando antibióticos…

Toma de decisiones compartidas

¿Cuánto?

Toma de decisiones compartidas

OPINION

Check for updates

1 Harvard Medical School, Massachusetts, USA

2 Department of Global Health and Population, Harvard T.H. Chan School of Public Health, Massachusetts, USA

3 Department of Computer Science, Jacobs Technion-Cornell Institute at Cornell Tech, Cornell University and the Technion-Israel Institute of Technology

4 Department of Population Health Sciences, Weill Cornell Medical College, New York, USA

@leah_pierson

@2plus2make5

Cite this as: *BMJ* 2022;378:o1747

http://dx.doi.org/10.1136/bmj.o1747

Published: 15 July 2022

Patients cannot consent to care unless they know how much it costs

Given the impact that medical expenses have, disclosing them should be a part of the informed consent process, argue Leah Pierson and Emma Pierson

Leah Pierson,[1,2] Emma Pierson[3,4]

Americans rarely know how much their medical care will cost and most have received a medical bill that they did not expect.[1] The lack of transparency around medical costs leads people to avoid seeking necessary care, fosters distrust in the US healthcare system, and has implications for informed consent.[2] If patients do not know how much their care will cost—and the financial risk they may face as a result—can they really consent to it?

What information must be disclosed to patients in the process of acquiring consent has often been the subject of ethical debates. A widely accepted principle is the reasonable person standard, which requires divulging the details a reasonable patient would want to know about a procedure, including its risks, its benefits, and alternative treatment options.

How you decide which risks should be disclosed is

Readers might raise two objections to this view. Firstly, some might argue that the financial hardships associated with care are distinct from the medical risks inherent to it. Perhaps, following this line of thought, informed consent only requires that patients understand the medical risks of treatment.

However, it is arbitrary to limit the risks clinicians must disclose to only risks of bodily harm, as financial harms can adversely affect patients' lives more than physical ones. Furthermore, financial risks and medical risks are intertwined. The anxiety and depression medical debt can inflict constitute side effects that, in other medical contexts, it would be obligatory to disclose. Weighty financial burdens can also compound existing medical risks, preventing or dissuading people from accessing care as they otherwise would. As one patient noted, "Charges for my insulin exceeded $1200 a month . . . I had to

Toma de decisiones compartidas

OPINION

Check for updates

1 Harvard Medical School, Massachusetts, USA

2 Department of Global Health and Population, Harvard T.H. Chan School of Public Health, Massachusetts, USA

3 Department (Jacobs Techn Cornell Tech, the Technion Technology

4 Department (Sciences, We College, New

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@2plus2make5

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http://dx.doi.org

Published: 15 Jul

Patients cannot consent to care unless they know how much it costs

Given the impact that medical expenses have, disclosing them should be a part of the informed consent process, argue Leah Pierson and Emma Pierson

Sin embargo, es arbitrario limitar los riesgos que los médicos deben revelar solo a los riesgos de daño corporal, ya que los daños financieros pueden afectar negativamente la vida de los pacientes más que los físicos. Además, los riesgos financieros y los riesgos médicos están entrelazados. La ansiedad y la depresión que la deuda médica puede infligir constituyen efectos secundarios que, en otros contextos médicos, sería obligatorio revelar…

subject of ethical debates. A widely accepted principle is the reasonable person standard, which requires divulging the details a reasonable patient would want to know about a procedure, including its risks, its benefits, and alternative treatment options.

How you decide which risks should be disclosed is

depression medical debt can inflict constitute side effects that, in other medical contexts, it would be obligatory to disclose. Weighty financial burdens can also compound existing medical risks, preventing or dissuading people from accessing care as they otherwise would. As one patient noted, "Charges for my insulin exceeded $1200 a month . . . I had to

Toma de decisiones compartidas

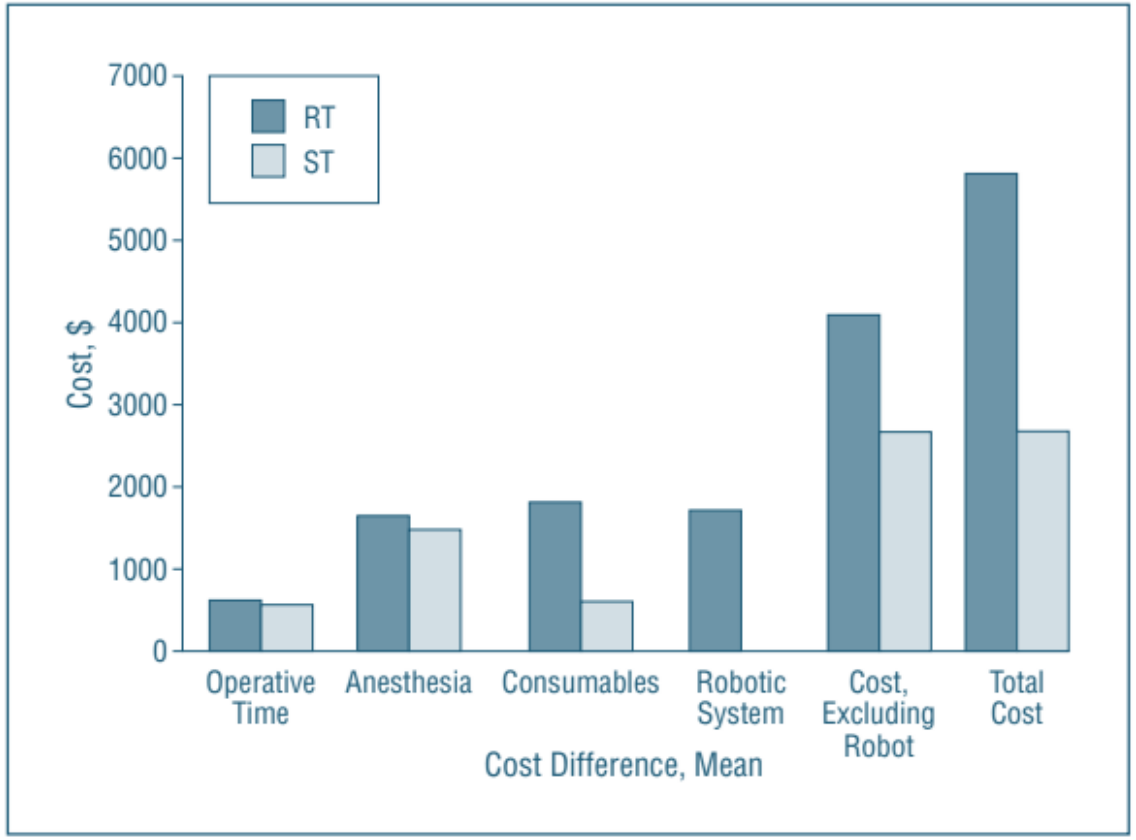


Figura. Diferencias de costos medios entre la tiroidectomía robótica (RT) y la tiroidectomía abierta (ST) estándar por los principales contribuyentes a los costos de los procedimientos. Los valores medios representan una combinación de los costes relativos de los casos cortos y largos.

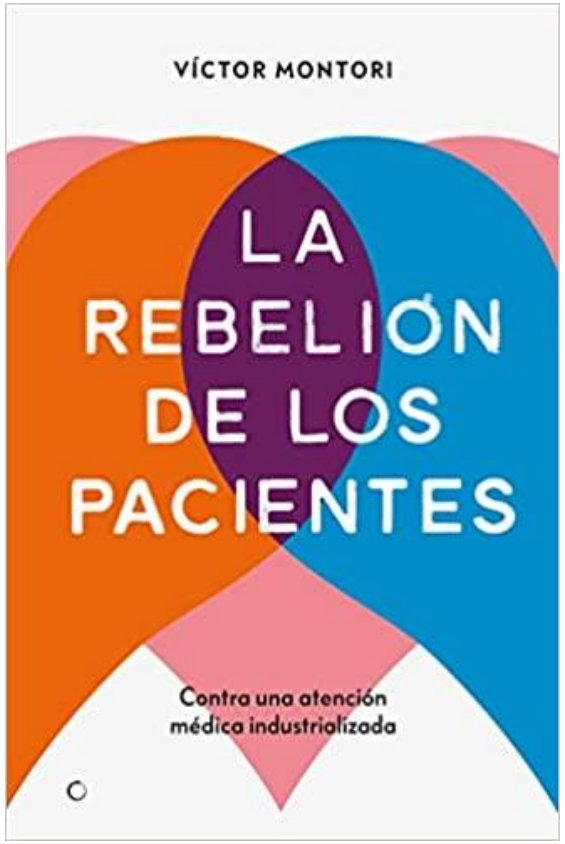
Arch Surg. 2012;147(12):1102-1106.

“La medicina industrializada”:

Estandariza prácticas para *pacientes como este*,

en vez de cuidar a *este paciente*.

Víctor Montori

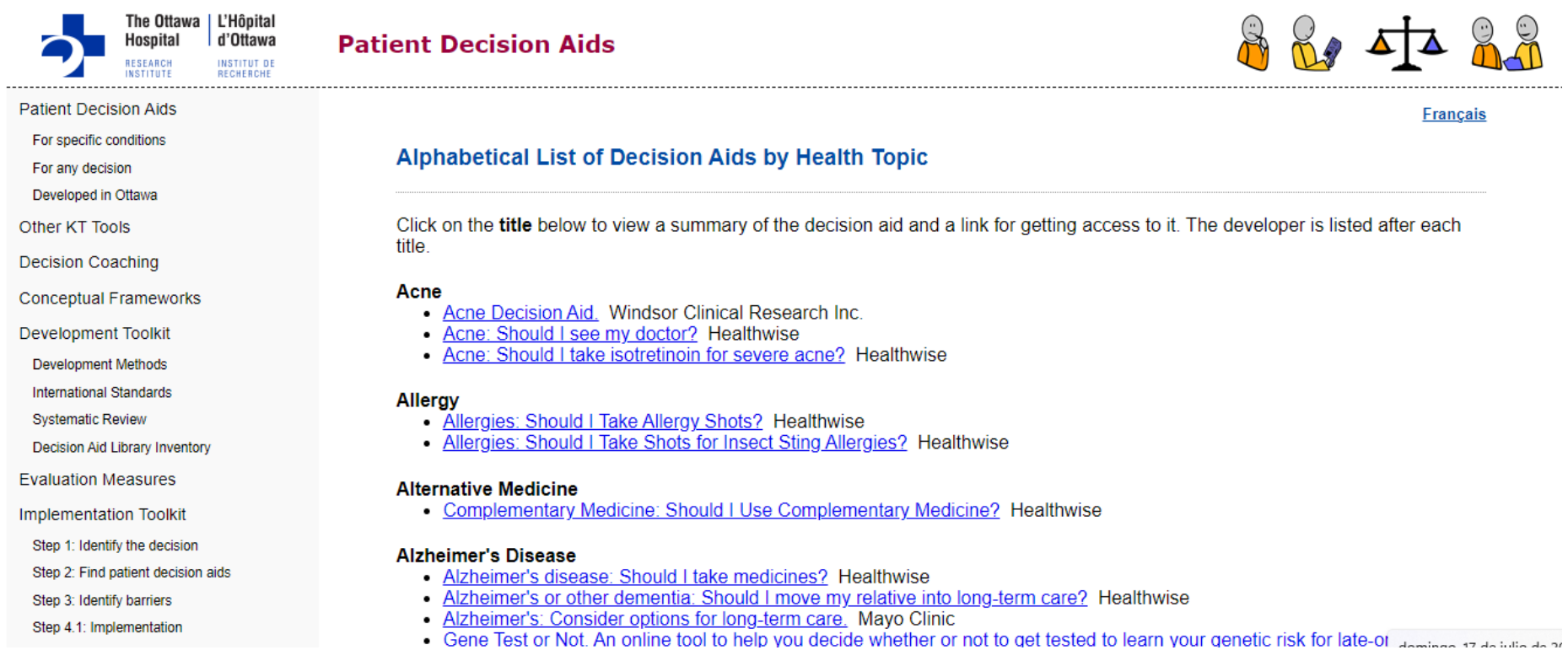


Toma de decisiones compartidas

Herramientas

Toma de decisiones compartidas

Ejemplos de herramientas:



The Ottawa Hospital | L'Hôpital d'Ottawa
RESEARCH INSTITUTE | INSTITUT DE RECHERCHE

Patient Decision Aids

- Patient Decision Aids
  - For specific conditions
  - For any decision
  - Developed in Ottawa
- Other KT Tools
- Decision Coaching
- Conceptual Frameworks
- Development Toolkit
  - Development Methods
  - International Standards
  - Systematic Review
  - Decision Aid Library Inventory
- Evaluation Measures
- Implementation Toolkit
  - Step 1: Identify the decision
  - Step 2: Find patient decision aids
  - Step 3: Identify barriers
  - Step 4.1: Implementation

Français

Alphabetical List of Decision Aids by Health Topic

Click on the **title** below to view a summary of the decision aid and a link for getting access to it. The developer is listed after each title.

Acne
- Acne Decision Aid. Windsor Clinical Research Inc.
- Acne: Should I see my doctor? Healthwise
- Acne: Should I take isotretinoin for severe acne? Healthwise

Allergy
- Allergies: Should I Take Allergy Shots? Healthwise
- Allergies: Should I Take Shots for Insect Sting Allergies? Healthwise

Alternative Medicine
- Complementary Medicine: Should I Use Complementary Medicine? Healthwise

Alzheimer's Disease
- Alzheimer's disease: Should I take medicines? Healthwise
- Alzheimer's or other dementia: Should I move my relative into long-term care? Healthwise
- Alzheimer's: Consider options for long-term care. Mayo Clinic
- Gene Test or Not. An online tool to help you decide whether or not to get tested to learn your genetic risk for late-or

https://decisionaid.ohri.ca/AZlist.html

Toma de decisiones compartidas

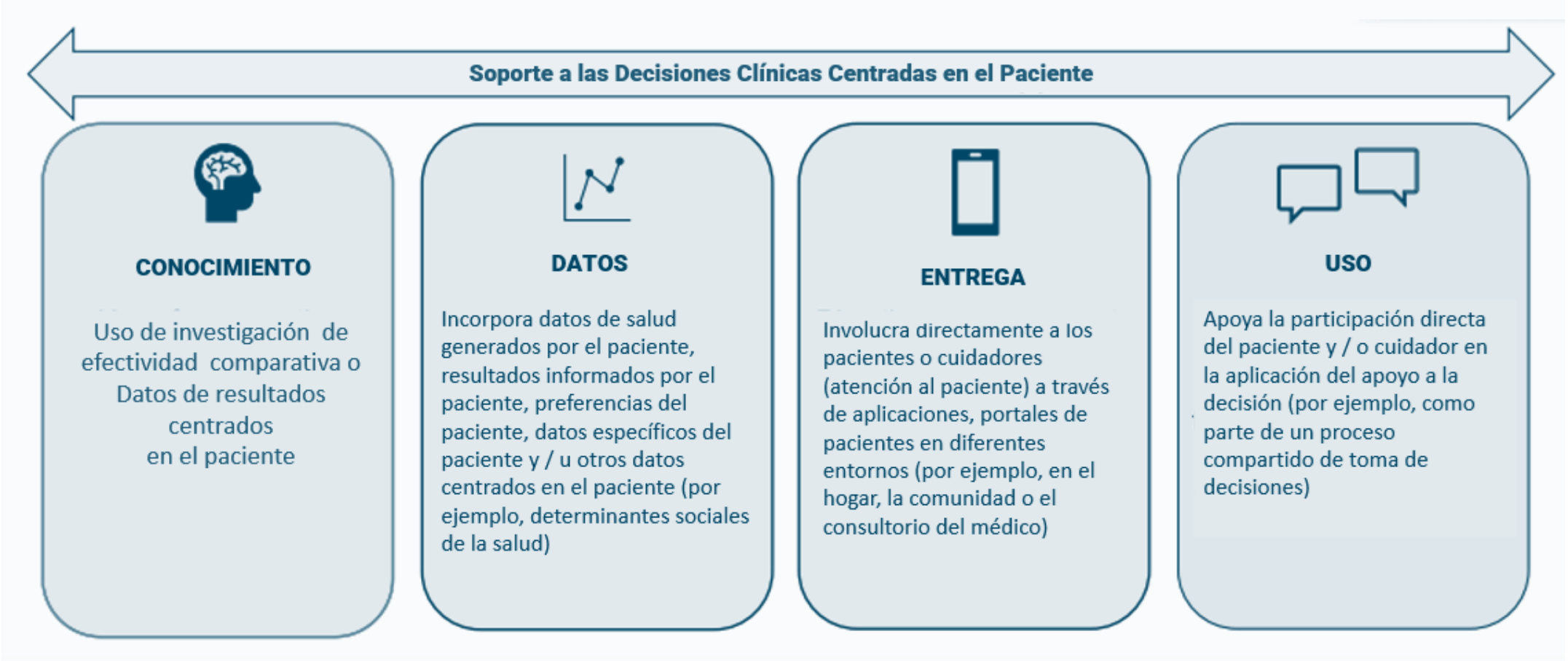
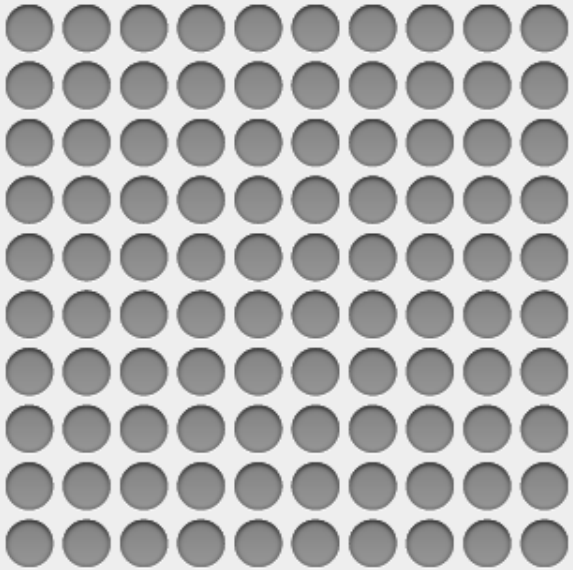


Figura 1. Factores centrados en el paciente para PC CDS. PC CDS existe en un continuo que refleja el grado en que su base de conocimientos, datos, entrega y uso se centran en las necesidades y experiencias de los pacientes. Abreviaturas: PC CDS: apoyo a la decisión clínica centrada en el paciente.

Journal of the American Medical Informatics Association, 29(7), 2022, 1233–1243



Bienvenidos a esta herramienta para ayudar en la toma de decisiones sobre el uso de **estatinas**

Esta herramienta le ayudará a usted y a su médico a discutir como le gustaría reducir su riesgo de un infarto cardíaco.

Empecemos

Atención: Esta aplicación es para ser usada exclusivamente durante la consulta con su médico

Notas | Documento

Ventajas vs. Desventajas según mis antecedentes médicos

Riesgo Actual

Seleccione una calculadora de riesgo

ACC/AHA ASCVD | Framingham | Reynolds

¿Tiene usted el antecedente de infarto cardíaco, accidente cerebrovascular, síndromes coronarios agudos (angina de pecho, angina inestable), angioplastia y/o colocación de stents, etc?

Sí | No

Estas cifras nos permiten calcular su riesgo de tener un infarto cardíaco en los próximos 10 años:

Edad	40 - 75	
Género	M / F	
Grupo de Población		
Fumador	Sí / No	
Diabetes	Sí / No	
HTA Sis Tratada	Sí / No	
	Unid Conv. / Unid SI	
Presión Arterial Sistólica	90 - 250	mmHg
Colesterol HDL	10 - 120	mg/dL
Colesterol Total	100 - 350	mg/dL

Seleccione la Intervención Actual

Estatinas No | Dosis Std | Dosis Alta

1 nueva notificaci

Riesgo Actual

Seleccione una calculadora de riesgo

ACC/AHA ASCVD | Framingham | Reynolds

¿Tiene usted el antecedente de infarto cardíaco, accidente cerebrovascular, síndromes coronarios agudos (angina de pecho, angina inestable), angioplastia y/o colocación de stents, etc?

Sí | No

Estas cifras nos permiten calcular su riesgo de tener un infarto cardíaco en los próximos 10 años:

Edad	55
Género	M / F
Grupo de Población	Blanca u otra
Fumador	Sí / No
Diabetes	Sí / No
HTA Sis Tratada	Sí / No

Unid Conv. | Unid SI

Presión Arterial Sistólica	130	mmHg
Colesterol HDL	39	mg/dL
Colesterol Total	214	mg/dL

Seleccione la Intervención Actual

Estatinas No | Dosis Std | Dosis Alta

Notas | Documento

Ventajas vs. Desventajas según mis antecedentes médicos
Utilizando la Calculadora **ACC/AHA ASCVD**

Actual
rto cardíaco

como Ud. que no
azón

Ninguna intervención ha sido seleccionada

Riesgo Actual

MAYO CLINIC

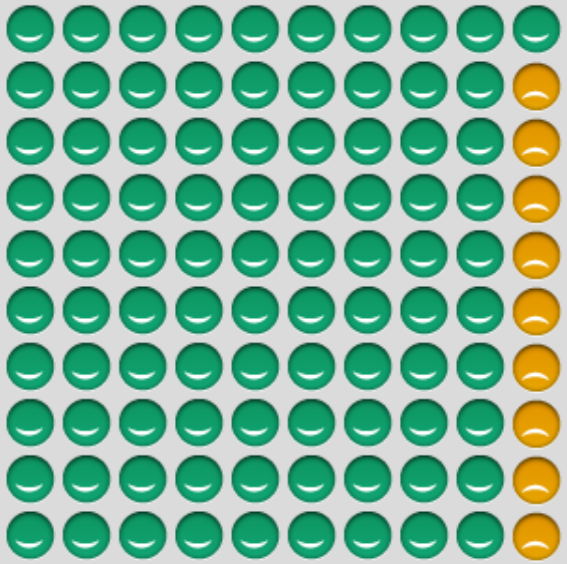
Decision sobre Estatinas
Ayuda en la Toma de Decisiones

Riesgo Actual | Intervención | Temas | Notas | Documento

Ventajas vs. Desventajas según mis antecedentes médicos
Utilizando la Calculadora **ACC/AHA ASCVD**

Riesgo Actual
de tener un infarto cardíaco

Riesgo para 100 personas como Ud. que **no usan** estatinas para el corazón



A lo largo de 10 años

9 personas tendrán un infarto cardíaco

91 personas no tendrán un infarto cardíaco

Riesgo a Futuro
de tener un infarto cardíaco

Riesgo para 100 personas como Ud. que usan **estatinas a dosis alta**

A lo largo de 10 años

5 personas tendrán un infarto cardíaco

91 personas no tendrán un infarto cardíaco

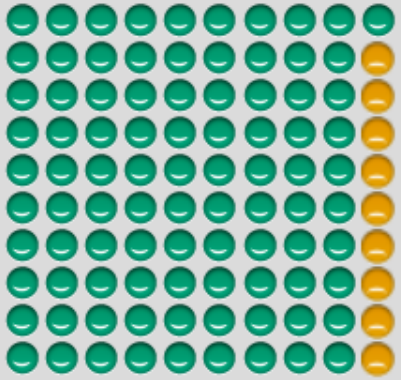
4 personas no tendrán infarto cardíaco por usar medicinas

Ventajas vs. Desventajas según mis antecedentes médicos

Utilizando la Calculadora **ACC/AHA ASCVD**

Riesgo Actual
de tener un infarto cardíaco

Riesgo para 100 personas como Ud. que no usan estatinas para el corazón



A lo largo de 10 años
9 personas tendrán un infarto cardíaco
91 personas no tendrán un infarto cardíaco

Costo

Dosis altas de estatinas
aprox. $150/mes

Rutina Diaria

Dosis altas de estatinas
Una tableta diaria

Otros Beneficios

Dosis altas de estatinas
Las estatinas reducen el riesgo de ataque al cerebro en un quinto.

Efectos Adversos

Dosis altas de estatinas

Efectos adversos comunes
náuseas, diarrea, estreñimiento
(la mayoría los tolera);

Dolor/rigidez muscular
en 5 de cada 100
(algunos deben dejar de tomar estatinas);

Laboratorios anormales
(pero sin dolor ni daño permanente al hígado):
2 de cada 100
(algunos deben dejar de tomar estatinas);

Daño en los músculos y en los riñones
en 1 de cada 20,000
(se debe dejar de tomar estatinas).

El riesgo de estos efectos adversos puede ser más alto cuando se usan estatinas de mayor potencia o en altas dosis.

Riesgo a Futuro
de tener un infarto cardíaco

Riesgo para 100 personas como Ud. que usan **estatinas a dosis alta**

A lo largo de 10 años
5 personas tendrán un infarto cardíaco
91 personas no tendrán un infarto cardíaco
4 personas no tendrán infarto cardíaco por usar medicinas

Toma de decisiones compartidas

Barreras

Toma de decisiones compartidas

“La barrera más común para la toma de decisiones compartida,
citado por pacientes y médicos, es el tiempo”

opinion

VIEWPOINT

Shared Decision Making and the Importance of Time

Uncertain evidence and the uniqueness of a patient's health care issues often make it difficult to identify the best course of care. These instances are becoming increasingly common as more people live longer with multiple chronic conditions and care becomes more complicated. Clinical decisions may involve screening or treatment with new toxic drugs in older patients, timely use of adjuvant, palliative, or pain care, or prioritizing care at the end of life. Shared decision making is essential in the care of patients in these complicated situations. For clinicians, being able to and choosing to spend time on understanding what truly matters to patients when making decisions together is an achievement that makes the work of clinicians meaningful and rewarding.[1] Yet many clinicians have insufficient time to engage in shared decision making.

The most common barrier to shared decision making, cited by patients and clinicians, is time.[2,3] Time can be considered an organizing tool that controls what happens and when. It is a constrained resource that makes caring for patients possible or not. Time starts, becomes available, can be wasted, and runs out. Regardless of whether shared decision making was planned to take place at a scheduled clinical encounter or needs to be improvised at the bedside when a patient's condition deteriorates, the shared decision-making clock sometimes starts earlier than expected. Patients may consult with family and friends, other trained clinicians, or online resources. Clinicians may review the relevant evidence and discuss their patient's situation with colleagues, all processes that may take place before, within, or in between clinical encounters. Time for shared decision making is most limited during clinical encounters.

> Time can be considered an organizing tool that controls what happens and when.

Clinical encounters, although uncommon in the lives of many patients, offer a place and time for clinicians to gather insight into what matters to each patient and for patients and clinicians to co-create care that fits each patient's situation. Time during encounters is usually set by the schedule, which is the result of algorithms that prioritize meeting the demand for access to available clinicians over offering enough time for unhurried consultations. The completion of recommended tasks and of clinical and administrative documentation further taxes the time in consultations. Clinicians often feel hurried and interrupt the conversation with a patient, on average, within 11 seconds.[4] When lacking time, clinicians may present information with a complexity or tempo that may easily overwhelm the attention of patients who are ill and worried. Information is then lost on patients, and time is wasted. Clinicians may not allow for a silent pause and miss key patient disclosures or questions. Conversely, revealing an unhurried visit's from a system that overbooks clinicians occurs by accident, such as, for example, when a patient does not show up for a visit, or requires a conspiracy between patients and clinicians to lengthen the visit and spend the necessary time together. The resulting delay may offend other patients who are waiting and frustrate the staff who will have to stay late at work.

Not Evidence Based, Yet True

Evidence shows that more shared decision-making processes are completed during longer encounters, but evidence is lacking on when clinicians and patients perceive that time has run out, and how better to allocate adequate time to these processes. It is also not clear to what extent clinicians' "lack of time" reflects their lack of control about how the time available should be used. Despite the absence of reliable evidence about time in consultations acting as a barrier to shared decision making and about the efficacy of strategies proposed to overcome it, it remains commonplace to conclude that there is no time for shared decision making. Although not "evidence based," to busy clinicians this conclusion rings true.

Also, little evidence exists about how patients and clinicians spend time on decision-making activities outside of clinical encounters. Sometimes, the task of learning and understanding is laborious for patients, and it may be tempting to ask patients to prepare ahead of time. Patient decision support tools for use at home, in particular patient decision aids and question prompt lists, have demonstrated effectiveness, but their implementation is lagging for unclear reasons. Patient-reported outcome measures are increasingly monitored, but it is not clear yet if they can support care decisions. These requests for patients to do work outside of the clinical encounter must consider that time is precious, particularly for people who live complex lives with illness. It is not always obvious how much of their time patients should spend reviewing information and completing questionnaires instead of pursuing their lives and loves. Clinician decision support tools may facilitate ways to care efficiently with evidence but seldom help clinicians ahead of time to become aware of available choices or to notice when a more deliberate discussion may be needed.

Overcoming the Barrier: From Attitudes to Practice Innovations to Policies

Time will continue to act as a barrier as long as aspects intrinsic to care, such as shared decision making, remain

Corresponding Author:

JAMA April 19, 2019

Toma de decisiones compartidas

Otras Barreras…

- Falta de Información
- Falta de Conciencia
- Falta de alfabetización en salud
- Sesgos
- Temores

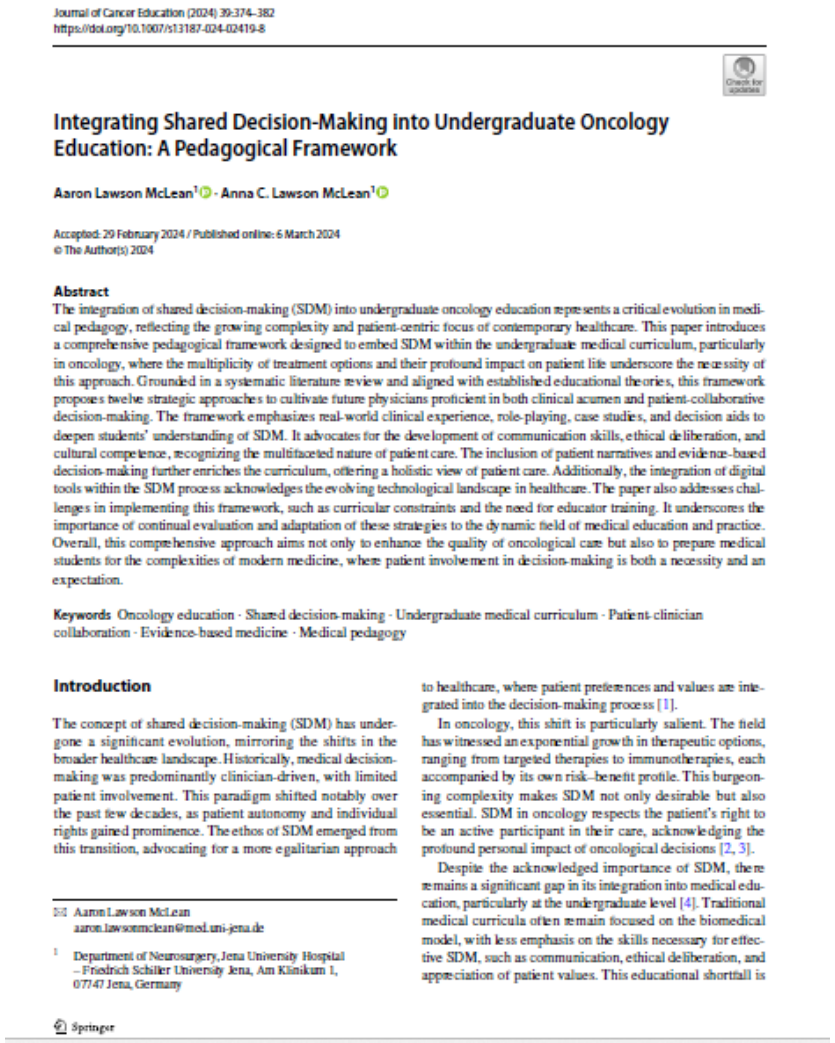
JAMA April 19, 2019

Toma de decisiones compartidas

¿Cómo educar en TDC?

Toma de decisiones compartidas

¿Cómo educar en TDC?



Journal of Cancer Education (2024) 39:374–382
https://doi.org/10.1007/s13187-024-02419-8

Integrating Shared Decision-Making into Undergraduate Oncology Education: A Pedagogical Framework

Aaron Lawson McLean[1] · Anna C. Lawson McLean[1]

Accepted: 29 February 2024 / Published online: 6 March 2024

Abstract
The integration of shared decision-making (SDM) into undergraduate oncology education represents a critical evolution in medical pedagogy, reflecting the growing complexity and patient-centric focus of contemporary healthcare. This paper introduces a comprehensive pedagogical framework designed to embed SDM within the undergraduate medical curriculum, particularly in oncology, where the multiplicity of treatment options and their profound impact on patient life underscore the necessity of this approach. Grounded in a systematic literature review and aligned with established educational theories, this framework proposes twelve strategic approaches to cultivate future physicians proficient in both clinical acumen and patient-collaborative decision-making. The framework emphasizes real-world clinical experience, role-playing, case studies, and decision aids to deepen students' understanding of SDM. It advocates for the development of communication skills, ethical deliberation, and cultural competence, recognizing the multifaceted nature of patient care. The inclusion of patient narratives and evidence-based decision-making further enriches the curriculum, offering a holistic view of patient care. Additionally, the integration of digital tools within the SDM process acknowledges the evolving technological landscape in healthcare. The paper also addresses challenges in implementing this framework, such as curricular constraints and the need for educator training. It underscores the importance of continual evaluation and adaptation of these strategies to the dynamic field of medical education and practice. Overall, this comprehensive approach aims not only to enhance the quality of oncological care but also to prepare medical students for the complexities of modern medicine, where patient involvement in decision-making is both a necessity and an expectation.

Keywords Oncology education · Shared decision-making · Undergraduate medical curriculum · Patient-clinician collaboration · Evidence-based medicine · Medical pedagogy

Introduction

The concept of shared decision-making (SDM) has undergone a significant evolution, mirroring the shifts in the broader healthcare landscape. Historically, medical decision-making was predominantly clinician-driven, with limited patient involvement. This paradigm shifted notably over the past few decades, as patient autonomy and individual rights gained prominence. The ethos of SDM emerged from this transition, advocating for a more egalitarian approach to healthcare, where patient preferences and values are integrated into the decision-making process [1].

In oncology, this shift is particularly salient. The field has witnessed an exponential growth in therapeutic options, ranging from targeted therapies to immunotherapies, each accompanied by its own risk–benefit profile. This burgeoning complexity makes SDM not only desirable but also essential. SDM in oncology respects the patient's right to be an active participant in their care, acknowledging the profound personal impact of oncological decisions [2, 3].

Despite the acknowledged importance of SDM, there remains a significant gap in its integration into medical education, particularly at the undergraduate level [4]. Traditional medical curricula often remain focused on the biomedical model, with less emphasis on the skills necessary for effective SDM, such as communication, ethical deliberation, and appreciation of patient values. This educational shortfall is

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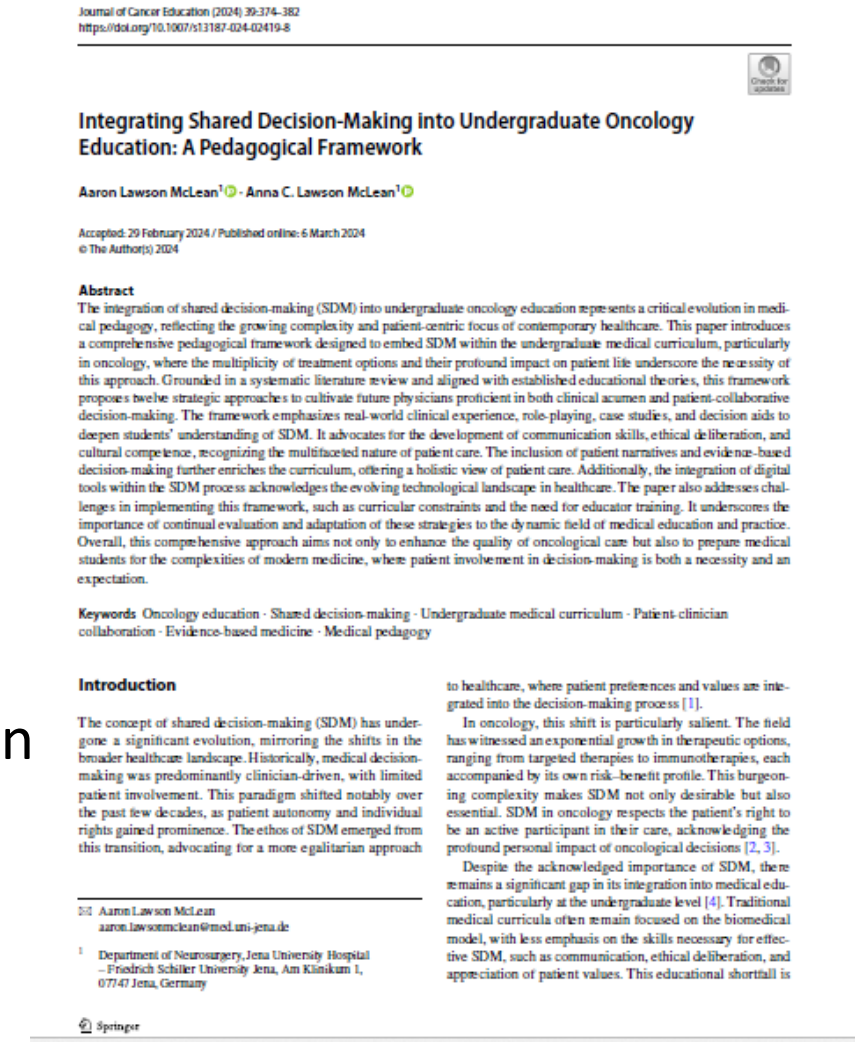
Journal of Cancer Education (2024) 39:374–382

Toma de decisiones compartidas

- Fundamentar el concepto de TDC en escenarios del mundo real.
- Facilitar ejercicios de juego de roles
- Análisis de casos
- Introducir ayudas para la toma de decisiones
- Enseñar habilidades de comunicación
- Fomentar el uso de la Medicina Basada en la Evidencia
- Adoptar herramientas digitales para TDC



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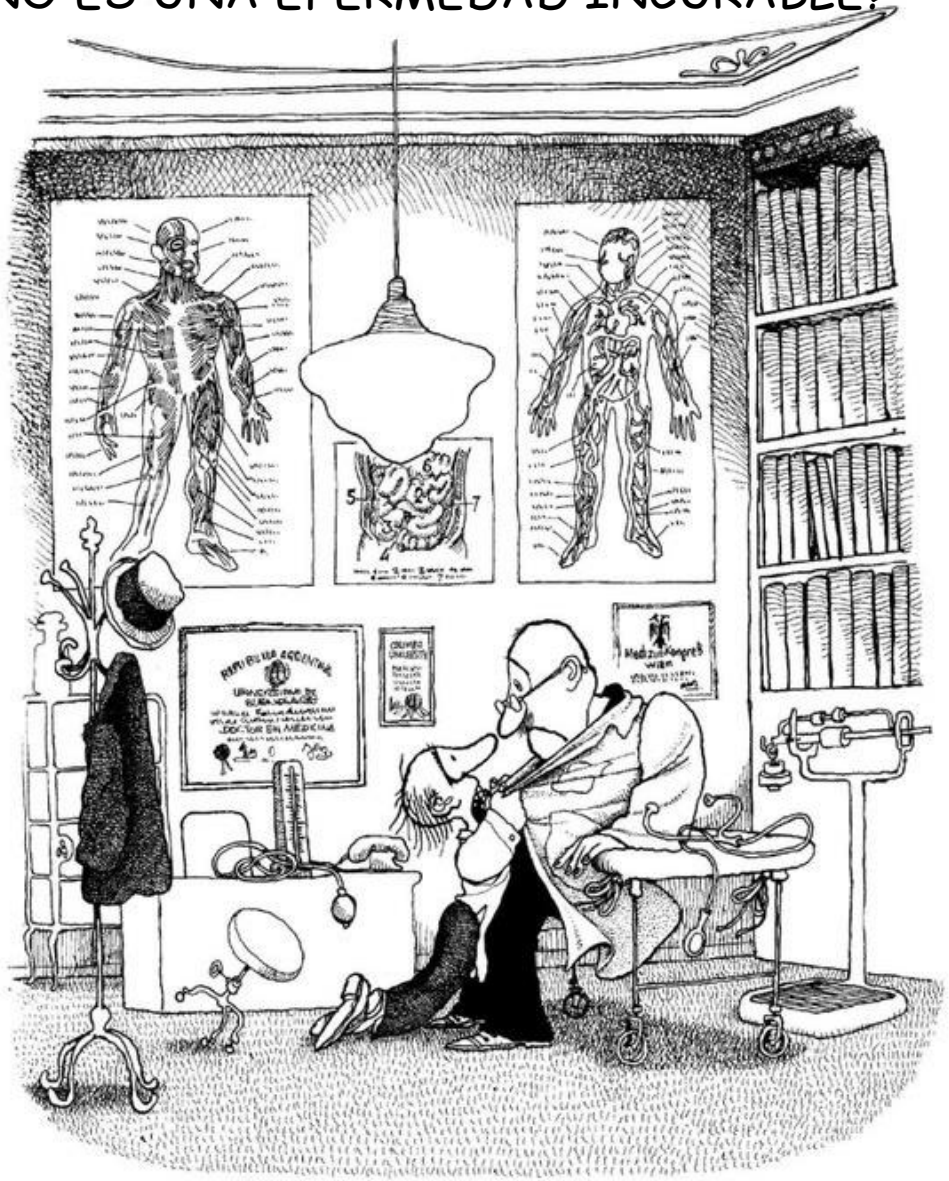
Journal of Cancer Education (2024) 39:374–382

-POR TERRIBLE QUE SEA QUIERO SABER LA VERDAD, DOCTOR : ¿SER UN SER HUMANO ES UNA EFERMEDAD INCURABLE?



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y Planetree Internacional

¡Muchas Gracias!

plemos@iecs.org.ar