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Barriers and facilitators of shared Decision-making in Emergency Surgery Patients

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Abstract:
Shared decision-making (SDM) between clinicians and patients is one of the pillars of the modern patient-centric philosophy of care. This study aims to explore SDM in the discipline of trauma and emergency surgery, investigating its interpretation as well as the barriers and facilitators for its implementation among surgeons.

Method:
Descriptive , cross sectional research study was utilized in this research, it was conducted at King Fahad Armed Forces Hospital.-One tools was developed to assess barriers and facilitators of shared decision in emergency surgery: It consisted of three parts: Part I: socio- demographic data, Part II: knowledge, and practice-based information regarding their SDM understanding and dynamics, and facilitators and barriers of SDM in emergency surgery. Finding: the patient profiles, The average age of the patients was 38.5 ± 16.1 years. The duration of the symptoms was 89.5 minutes till they were referred to the emergency department. 54.1 ± 41.3 minutes was the average wait time at the emergency room. Three variables remained after the model was ran in three steps: the patient's systolic blood pressure, marital status, and family member's SDM level. The model's adjusted coefficient of determination (adjusted R square) and coefficient of determination (R2) in the third stage were both 0.68. As a result, the variables included in the model might offer a decent fit. All three factors that were left in the model were able to predict changes in the patient's SDM level ($P < 0.05$), according to the model's results and making choices).
Conclusion: In concluding our work, we should begin from the premise that inspired it. SDM represents a critical and “hot” topic in today’s healthcare troposphere, involving all medical spheres. Emergency and trauma backgrounds often represent stimulating situations in which SDM may look problematic to apply. Amazingly, only less than half of the inquired surgeons are familiar with the term and meaning of SDM.

Introduction:

Emergency physicians, surgeons, anesthesiologists, and nurses are among the specialists from several specialties that comprise emergency teams. The requirement to deal with unforeseen

circumstances while having limited time to make clinical judgments is what defines these units. Clinicians working in trauma and emergency situations need to coordinate their efforts while also making sure that the right information is shared and transferred to achieve the best outcome for the patient. Involving the patient in the decision-making process could necessitate the use of extra tools and processes, even though such dynamics must be explicit and obvious within the team. In fact, there may not be enough time or any time at all to interact with the patient and their family in order to learn about their desires and preferred course of therapy. Even though shared decision-making, or SDM, is a cornerstone of the contemporary patient-centered healthcare environment, knowledge translation and transfer dynamics can seem especially difficult in emergency situations. The study examines the latest research on SDM before reviewing the literature on the obstacles, enablers, and dynamics of knowledge translation of SDM in trauma and emergency surgery. The findings evaluate the significance, instruments, and dynamics of SDM procedures.

Teams of specialists working together to give patients with high-quality care include trauma and emergency surgery specialists, which may comprise surgeons, emergency physicians, anesthesiologists, and nurses. These professionals deal with difficult situations, a lot of stress, and time constraints. The sources of the trauma, the patients' names, their current states, and their preferences for therapy are frequently unknown to them [1]. Patient-centered care and the unbreakable patient-physician relationship [4] depend on information translation and sharing processes [2, 3], even if team dynamics seem to be crucial to guaranteeing the highest quality of care from a patient-centric standpoint. As a matter of fact, the clinical team may not have enough time to discuss with the patients all of the options and treatment options, including prognostic information [5, 6].

In the context of modern healthcare, the importance of shared decision-making (SDM) in patient-centered care is widely acknowledged. SDM encourages patients and healthcare providers to work together to create decisions that take into account the patient's values, treatment preferences, and the best available evidence. It is believed that SDM will enhance patient treatment compliance and, as a result, improve health outcomes. SDM is especially the best option for decisions that need to take the patient's desires and preferences into account. Depending on how each patient weighs the advantages and disadvantages of each option, medical practitioners should assist the patient in choosing the appropriate course of action when two or more equivalent treatment alternatives are available [7].

As a result, SDM is a cornerstone of patient autonomy, and physicians have an ethical and moral obligation to assist patients in making choices that align with their goals and values [8]. Effective SDM techniques, however, are not a cure-all for surgical treatment. The patient's feelings and concerns, the intricacy of the relationships between diagnoses and treatments, a lack of time or training to have a productive conversation with the patient and their family or caregivers, and a gap in clinical knowledge between the patient and the doctor can all cause barriers. This implies that despite their disparate histories, levels of medical expertise, and other factors, clinicians and patients should both find efficient means and resources to translate and exchange knowledge.

The complexity of implementing and measuring SDM has been highlighted by recent experiences and research in trauma and emergency situations [8]. In fact, there may not always be enough time to make a professional choice when the patient's life is in jeopardy. However, in other cases, circumstances can give doctors hours or longer before starting therapy, allowing patients to research their options and decide on the best course of action.

The advantages of using SDM in trauma and emergency surgery have been emphasized in the surgical literature [13], including improved clinical outcomes by improving the quality of the

patient's recovery [14], better controlling the patient's expectations [15], and limiting surgical interventions when they are not necessary [16]. The hospital's organization can also benefit from SDM's improved patient management and flow [17], which promotes patient-centric care [18], and leads to patient empowerment and co-production practices [19, 20].

Overall, patients and their families have a better hospital experience when SDM is used in trauma and emergency settings [21], and physicians adhere to moral and ethical standards [22]. The most popular facilitators for the successful application of SDM in trauma and emergency situations seem to be training and counseling [21, 23].

The in-charge physician finds it challenging to have a productive talk with the patient due to time and resource constraints. Spending time with a single patient who has to comprehend and choose from a variety of clinical options is difficult when there is a high patient load.

Beginning with these suppositions and research gaps, the report uses a multi-national survey approved by the World Society of Emergency Surgery (WSES) to further explore the dynamics, facilitators, and challenges of SDM in trauma and emergency settings.Methods:

Methods:

Research design:

Descriptive, Quantitative descriptive correlational research design was followed to conduct the current study, using self-administer questionnaire research approach., it was conducted at King Fahad Armed Forces Hospital. The hospital provides a wide range of primary, secondary and tertiary medical services to members of the Saudi Arabian Armed Forces and their dependents. The Cardiac Center, situated within the main hospital, is the only adult cardiac surgical facility in the Western Region. In-service training and education are actively promoted by the Departments of Medical Education and Nursing Education and from within the individual departments. The program includes a weekly hospital Grand Round, monthly Nursing Grand Rounds and regular nursing study days. Inter- and intra-departmental activities include seminars, case presentations and Journal Clubs. The hospital is also a designated training center for junior medical and nursing staff. All departments and units, both medical and non-medical, have written Policies and Procedures to ensure delivery of consistent levels of quality care and service.

Subjects:

The Epi-Info application was used to choose the study's sample size. Out of 630 participants, 467 were chosen as the appropriate sample size (Charan and Biswas, 2013), with 80% power (=20%) and at a 95% level of significance (= 0.05).

Group II: It consists of a sample size of 62 patients who were observed in accordance with the selection of two operating rooms (OR) scheduled lists that underwent only emergency surgery procedures in the examined operating rooms during morning shifts.

One tools was developed to assess barriers and facilitators of shared decision in emergency surgery :

It consisted of three parts:

Part I: socio- demographic data: it was used to understand the participants' characteristic they included gender, the number of years of experience in trauma/emergency surgery, the kind of institution (academic vs non-academic), the country, the position held, the eventual participation within a trauma team (institutionalized or not, and of which kind), the type of trauma leader, the educational courses attended, and the presence of diverse team members.

Part II: knowledge, and practice-based information regarding their SDM understanding and dynamics. it was developed by the researcher based on the current related literature .To

assess patient and family , healthcare providers about their knowledge of informed consent pre emergency surgery**.**

Part III: facilitators and barriers of SDM in emergency surgery: it was developed by the researcher based on the current related literature to assess facilitators and barriers of shared decision making in emergency surgery from the prospective of healthcare providers in emergency surgical units

Data collection:

The study plan was approved by the Research Ethics Committee at Jaddah, An approval was obtained from the studied hospitals to conduct the study. Tools were developed by the researcher in English and then translated into Arabic and back translation was carried out. They were tested for their face and content validity by jury of five experts; to give their recommendations and suggestions regarding the tools contents, nature of questions and clarity of items. Their recommendations and suggestions were taken into consideration. Each expert individually asked to read and evaluate each statement within each tool regarding its relevance, clarity, simplicity and ambiguity on the four-point rating scale. The study tools 1 and 3 were tested for their reliability using Cronbach's Alpha Coefficient, where Cronbach's Alpha Coefficient was 0.935 and 0.764 respectively.

A pilot study was carried out for 10% (n=47) rather than the study sample subjects (managers/leaders and healthcare providers), in order to check and ensure clarity of the tool applicability feasibility, and identify obstacles and problems that may be encountered during data collection, and estimate the time needed to fill the tools which consumed about 20 to 30 minutes for each. In the light of the findings of the pilot study and Jury panel,.

Researcher started with an individual meeting with each of the medical and nursing directors of each studied hospital to explain the aim of the study to get their cooperation and support. This meeting consumed 15-20 minutes using a glossary of the corporate governance determinants/practices in order to provide the operational definition for main concepts in the current study.

Following this meeting, the researcher stated to meet the selected staff in the selected ORs and the non-clinical administrative departments to collect data through structured interview with each of them using tool " corporate governance practices assessment" by the end of each OR's schedule in the morning shift.

Ethical considerations:

Written informed consent from each of studied staff was obtained after explaining the aim of the study. Witness written approval was obtained from the first-line nurse manager of ORs in the selected setting to carry out the observation. Privacy of the staff and patients was assured, and confidentiality of the collected data was maintained during implementation of the study.

- The subjects' right to participate or withdraw without giving any reason at any time from the study was assured and explained.

Statistical Analysis:

- Statistical analysis was carried out using SPSS statistics software version 26 (SPSS, Inc., Chicago, IL). Quantitative data were tested for normality using Kolmogorov-Smirnov test and described accordingly. Kruskal Wallis test was used to compare three independent groups. Qualitative data was expressed by numbers and percent. Pearson Chi-square test

was used to test the association between qualitative variables. In all other applied statistical tests of significance*, P value* (*< 0.05)* was considered significant. The following statistical analysis techniques were done: χ^2: FE: Fisher Exact, r_s: Spearman coefficient, r: Pearson coefficient and MC: Monte Carlo test.

Results :

Throughout the study period, 467 participants in total were examined; of them, 353 healthcare professionals (75.6%) and 114 managers/leaders (24.4%). 250 (53.5%) of the study's participants are employed as managers or leaders in governmental hospitals and represent 23.2% of the healthcare workforce. 25.8% of managers/leaders and 74.2% of healthcare providers are represented by 217 private hospitals (46.5%). Only 2.8% of respondents are equal to or older than 60 years old, and 45.2% of respondents are under the age of 30. None of the managers are under the age of 30, and 43% are between the ages of 40 and less than 50. Unlikely: none of the healthcare professionals are equal to or older than 60 years old, and 59.8% of them are under 30. In the category of educational credentials, postgraduates make up 30.8% of the population, followed by master's degree holders (16.3%) and fellows (2.1%). On the university or high level of education, 20.2% have an associate degree and 27.4% have a baccalaureate degree. Therefore, compared to 30.3% of healthcare professionals, 32.6% of managers had post-university degrees, while 49% of managers had bachelor's degrees, the lowest percentage (20.1%) having a bachelor's degree and the highest percentage (22.5%) having an associate degree.

The respondents' years of experience are divided into groups, and 226 (48.4%) of them have less than five years' worth of experience, while only 11 (2.4%) of them have more than 20 years. The majority of managers, in particular, have varying levels of experience; 71 (62.3%) have less than five years of experience, and none have between 15 and 20 years. Additionally, the majority of healthcare professionals (44%) have fewer than 5 years of experience, as opposed to 3.1% who have equal to or more than 20 years.

Baseline data	**Total respondents N= 467**		**Managers N= 114**		**Healthcare providers N= 353**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Hospitals' sector						
Governmental hospitals	250	53.5%	58	23.2%	192	76.8%
Private hospitals	217	46.5%	56	25.8%	161	74.2%
Age (years)						
<30	211	45.2%	0	0%	211	59.8%
30-<40	81	17.3%	16	14%	65	18.4%
40- <50	116	24.8%	49	43%	67	19%
50-<60	46	9.9%	36	31.5%	10	2.8%
≥60	13	2.8%	13	11.5%	0	0%
Educational level						
a. Post graduate education	**144**	**30.8 %**	**37**	**32.6%**	**107**	**30.3%**

Diploma	37	7.9%	14	12.3%	23	6.8%
Master's degree	76	16.3%	14	12.3%	62	17.3%
Doctorate's degree	21	4.5%	8	7%	13	3.5%
Fellowship degree	10	2.1%	1	1%	9	2.5%
b. University & high-level degree	**323**	**69.2 %**	**77**	**67.4%**	**246**	**69.9%**
Bachelor's degree	128	27.4%	56	49%	72	20.1%
Associate degree	94	20.2%	16	14%	78	22.5%
Secondary Nursing diplomat	101	21.6%	5	4.4%	96	27.3%
Years of experience						
< 5	226	48.4%	71	62.3%	155	44%
5 -<10	144	30.8%	39	34.2%	105	29.7%
10-<15	56	12%	4	3.5%	52	14.7%
15-<20	30	6.4%	0	0%	30	8.5%
≥20	11	2.4%	0	0%	11	3.1%

Table 2:show the patient profiles, The average age of the patients was 38.5 ± 16.1 years. The duration of the symptoms was 89.5 minutes till they were referred to the emergency department. 54.1 ± 41.3 minutes was the average wait time at the emergency room. The patient's VAS scores for fear and pain were 6.04 ± 2.19 and 6.65 ± 1.93, respectively. The patients' mean pulse rate, mean respiration rate, diastolic blood pressure, and systolic blood pressure were 113.78 ± 21.8 mmHg,(60.8%) patients and (60.5%) patients' relatives thought their consent was swiftly received for this study. Additionally, 51%patients () said that the information given during surgery was in writing, and(49%) patients reported that the information was given both verbally and in writing.

Distribution of patient undergoing emergency surgery :

Variables	**No. (%)**
Gender	
Male	(57.2)
Female	(42.8)
Education	
Illiterate	(9.5)
High school	(19)
Diploma	(35)
College education	(38.5)
Marital status	
Single	(34.3)
Married	(65.7)
Residence	
Village	(28.1)
City	(71.9)
Job	
Employed	(45.7)
Retired	(7.2)
Unemployed	(11.8)
Housewife	68 (22.2)

Student	38 (12.4)
Triage level	
Level 1	2 (.7)
Level 2	139 (45.4)
Level 3	165 (53.9)
Type of surgery	
Neurosurgery	(24.8)
General surgery	(39.5)
Urological surgery	(3.9)
Orthopedic surgery	(24.2)
Obstetric surgery	(6.9)
Inpatient experience	
Yes	(73.2)
No)	

according to our findings, the family members of 55.6%) and 44.4%) patients, respectively, reported that the information given during surgery was given orally and in writing. Patients and their family members' mean SDM scores fell between non-participation and participation (Table 2). We discovered that 57.2%) and 56.5%) patients' relatives said they were not involved in the decision-making process for emergency surgery. Additionally, 42.5% patients' family members and 43.8%) patients themselves acknowledged taking part in treatment choice. At all three levels (information provision, counseling, and decision-making), more than half of patients and their families thought SDM was in the non-participation range (Table 3).

Table 2. Levels of Participation in Treatment Decisions from the Perspective of the Patients and Family Members

	Appropriate, %	**Inappropriate, %**
Information Patient	50.7	49.3
Information Family	46.4	53.3
Consult Patient	44.8	55.4
Consult Family	48	52
Decision-making Patient	41.2	58.8
Decision-making Family	**42.5%**	**48.5**

Table 3. Mean and Standard Deviation of the Questions of the Participation Questionnaire for Treatment Decision

Question	**Patient, Mean ± SD**	**Family, Mean ± SD**
My doctor clarified that a decision needed to be made	2.46 ± 1.45	**.** 2.28 ± 1.4
My doctor wanted to know how exactly I wanted to be involved in making the decision.	2.31 ± 1.34	2.36 ± 1.25
My doctor told me that there were different options for treating my medical condition	2.29 ± 1.25	**.** 2.31 ± 1.23

My doctor precisely explained the advantages and disadvantages of the treatment options.	2.53 ± 1.27	2.4 ± 1.2
My doctor helped me understand all the information.	2.15 ± 1.28	2.16 ± 1.23
My doctor asked me which treatment option I preferred	2.15 ± 1.29	**.** 2.21 ± 1.17
My doctor and I thoroughly weighed the different treatment options.	2.18 ± 1.26	2.23 ± 1.16
My doctor and I selected a treatment option together.	2.25 ± 1.32	2.29 ± 1.23
My doctor and I reached an agreement on how to proceed.	2.29 ± 1.28	2.32 ± 1.26
Total	20.59 ± 9.4	20.69 ± 9.02

The predictive variables of SDM were examined using a stepwise multiple regression model. Other characteristics were included as independent variables, while the fear of hospitalization was added as a dependent variable.

Three variables remained after the model was ran in three steps: the patient's systolic blood pressure, marital status, and family member's SDM level. The model's adjusted coefficient of determination (adjusted R square) and coefficient of determination (R2) in the third stage were both 0.68. As a result, the variables included in the model might offer a decent fit. All three factors that were left in the model were able to predict changes in the patient's SDM level ($P < 0.05$), according to the model's results (Table 4) and making choices) (Table 3).

Table 4. Multiple Regression Model to Examine the Predictors of Participation in Decision-making for Treatment a

Model	**Unstandardized Coefficients**	**Standardized Coefficients**	***t***	**P-Value**
Constant	0.24	0.03	0.133	***0.894***
SDM family member	0.86	0.60	25.64	0.001
Marital status 0	-1.52	0.08	**-2.52**	**0.012**
Systolic blood pressure	0.031	0.01	**2.20**	**0.028**

Table 4 reports the results related to the relevant items to SDM.

The participants worried that in emergency circumstances, decisions often need to be taken in within a very short period of time (mean 4.11, standard deviation 0.88). They also claimed that emergency and trauma teams collaborate positively (mean 3.83, standard deviation 0.94). Surgeons denied that SDM practices might be in contrast with clinical guidelines (mean 2.16, standard deviation 1.2). Therefore, that would not represent a barrier to its everyday submission. Situations or diagnoses in trauma and emergency surgery suitable for SDM Through an open question, participants were asked to name any situation and/or clinical condition in which SDM practices may be successfully applied.

Barriers of SDM in emergency surgery:

Item	Mean SD
Sometimes decisions are urgent and have to be made right away	4.11 ±0.88
Multidisciplinary emergency teams collaborate successfully with each other	3.83 ±0.94
Sometimes there are communication issues (e.g., language barriers)	3.66 ±1.03
Patients prefer to say: "You decide" or "Do what you think is best, doc"	3.60 ±1.02
Patients lack knowledge of treatment options	3.57± 1.08
There are many other things demanding the attention of healthcare professionals	3.44± 1.04
Healthcare professionals forget to apply SDM as it is not part of the routine	3.34± 1.08
Healthcare professionals feel that they lack knowledge about what SDM entails	3.21 ±1.06
Several colleagues do not believe in SDM	3.21 ±1.17
The inter-professional collaboration is inadequate (e.g., poor communication within the team)	3.10 ±1.09
Time should be dedicated to other tasks than SDM	2.99 ±1.12
SDM causes patients to question the expertise of healthcare professionals	2.83± 1.25
There is not enough time to apply SDM (e.g., consultation times are too short)	2.82± 1.20
Some treatment options are too expensive to be taken into account	2.74± 1.23
SDM is incompatible with clinical practice guidelines	2.16±1.20

Discussion:

One of the cornerstones of the contemporary health care environment is SDM [26]. Along with the responsible physicians or medical team, patients have the right to actively engage in clinical choices, according to academics, legislators, and healthcare organizations. SDM has many benefits [13], including improved patient satisfaction and hospitalization experience [14], and improved adherence to the selected course of therapy [19, 20].

Although SDM is commonly used in several medical specialties, such as oncology [27, 28], earlier research has highlighted challenges when implementing SDM principles in trauma and emergency situations [8]. Assume that some of these obstacles relate to the fact that patients' lives are occasionally in jeopardy or that they may be asleep and their identification is unclear. However, since there can be hours or more before the treatment starts, SDM may be used in some trauma and emergency scenarios.

The purpose of this study was to assess the patient's SDM and associated variables. Our findings demonstrated that the patient's SDM level was between non-participation in all three dimensions (information providing, counseling, and decision making). Among the associated variables, systolic blood pressure, marital status, and a family member's SDM degree could predict SDM for gaining informed permission. This study demonstrated that, from the standpoint of patients and

their families, the SDM level for gaining informed consent for urgent surgery is low. Consistent with our study's findings, other studies have demonstrated that the majority of patients do not take part in treatment decision-making; instead, physicians make these decisions (6, 9-11).

Emergency situations impacted the time needed for patient consultation and decision-making as well as the chance for appropriate notification in the current study (22. The patient in this study was presented to the preferred course of treatment, which is emergency surgery. Patients and their families were given written information regarding the surgical technique, including its introduction, advantages, dangers, and complications, in order to obtain their informed permission. Therefore, the patients and their families were forced to accept the suggested treatment in such a situation. After reading the material or listening to the staff members' (doctor or nurse) explanations, they were compelled to sign a consent form. While most of the patients' demographics (such as age, gender, educational attainment, and surgical history), the type of surgery, and surgical complications were associated with patients' SDMs in earlier studies, the majority of the related factors in the current study did not have a statistically significant relationship with the patient's SDM (11, 20).

One factor contributing to this discrepancy was the patient's poor SDM level for getting surgical informed consent. Systolic blood pressure, marital status, and the degree of family involvement were the only variables linked to SDM in the current study (11, 20). Given the severity of the patient's illness, the family's judgment and choice on surgical therapy will determine the patient's course of action. The majority of the time, the patient's spouse was the family member who gave their permission for surgery. Thus, their relationship with the patient (marriage status) and the SDM level of their family are predictors of the patient's SDM for surgery. As a result, decisions about treatment and getting the patient's informed permission shouldn't be made while they are in pain or experiencing sudden changes in their body. But occasionally, in order to preserve the patient's life, their autonomy is disregarded (9, 22, 24).

Despite the fact that the majority of the surgeons stated that they were aware with the term "SDM," candid answers regarding its definition paint an entirely different picture. In fact, just 45% of participants could offer a definition that aligned with the idea of patient involvement in clinical decision-making. Thirty percent of our participants had an entirely different (and incorrect) definition of SDM in mind, and over eleven percent had no concept what it meant. SDM was viewed by hundreds of surgeons as the clinical trauma or emergency team members who jointly decided and discussed the patient's treatment options.

he term "multidisciplinary" was used multiple times to emphasize the need to collaborate by asking colleagues with different backgrounds or specialties. Nevertheless, the procedure was viewed as "doctors-only." It's interesting to note that a number of surgeons refer to the necessity of finding a solution as being "in the best patient's interests" in order to emphasize how much doctors care about their patients' best interests. However, it appears that involving the patient and their family in the decision-making process is neither feasible nor beneficial. Clinical teams are competent at what they do, and when they work together, they can make the optimal clinical choice for the circumstances. In fact, every effort is made to ensure that the team has effective knowledge translation and communication procedures, using non-technical abilities like leadership.

Similar findings can also be obtained by delving deeper into the practices and obstacles associated with SDM processes. Surgeons typically understand how important it is to educate patients about the benefits and risks of a particular treatment option and, whenever feasible, to tailor the course of treatment to the patient's preferences and values. Surgeons, however, appear less willing to

"investigate" such preferences when they are opaque or perhaps when interacting with the patient requires speech[34-35].

The primary factor that defines barriers is the shortage of time that frequently defines emergency and trauma situations. However, when asked about potential circumstances or states in which SDM could be used successfully, surgeons did offer a number of instances. Participants listed clinical guidelines and training as facilitators to encourage such procedures, but surgeons appear to have less faith in online resources and technology[32-34].

Our research demonstrated that trauma and emergency surgeons appear more focused on ensuring that their teams function smoothly than on having conversations with their patients, and they lack a thorough awareness of the advantages of this approach. These outcomes are not surprising given the debate that is taking place in such a particular surgical specialty as well as the fact that emergency and trauma situations frequently need to be handled in a matter of minutes. It is true that team dynamics are essential to achieving the greatest therapeutic results, and a lot of work has been focused on subjects like communication, non-technical abilities, etc. Surgeons appear to get the greatest benefit from their teams functioning efficiently.

Given that the patient-physician emotional and competency gaps might be wide, the literature has emphasized the need for appropriate tools and facilitators when implementing SDM procedures [29]. Even in difficult circumstances like those involving trauma or emergency, a patient-centered philosophy of care cannot ignore these subjects. Even when reporting difficult clinical scenarios or conditions, surgeons should adhere to professional guidelines, which should include such principles and values, even though they firmly believe in training. According to this viewpoint, scientific societies like the WSES play a critical role in spearheading a paradigm shift where patient interactions and team dynamics are equally important .According to this perspective, other team members—such as nurses, who typically spend more time with patients and their families—may help surgeons deal with such dynamics [30–33].

Conclusion: In concluding our work, we should begin from the premise that inspired it. SDM represents a critical and “hot” topic in today’s healthcare troposphere, involving all medical spheres. Emergency and trauma backgrounds often represent stimulating situations in which SDM may look problematic to apply. Amazingly, only less than half of the inquired surgeons are familiar with the term and meaning of SDM. The results of this study showed that the urgency of the patient’s condition and the overloading of the emergency department affect the SDM level for surgery and subsequent patient’s informed consent. It is known that the participation of the patient and their family members increases treatment adherence and improves patient treatment outcomes and satisfaction. Therefore, the authors suggest that nurses and physicians try to provide appropriate physical and cerebral conditions for the greater participation of patients and their family members in decision-making about treatment.

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