Editorial

Who should have a joint replacement? A plea for more ‘phronesis’

Recently I met up with my old friend Eddie, whom I had not seen for over a year.

“How have you been?” I asked

“I’ve just had my hip replaced” he responded

“Oh, I didn’t realise you had been having hip pain”

“No, no, it was never painful” Eddie explained “Just slowing me up a bit and interfering with the long walks I like to take, and with my cricket on a Sunday. And apparently the X-ray showed it was bad, so I thought I would get it done”

“Are you pleased with it?”

“Yes, it’s great” he enthused “I can do anything I want to again, and I scored a half century last Sunday”

Should he have had a hip replacement I wondered? Who should? The answer seems to be both beguilingly simple and fiendishly complex.

In this edition of the journal there is an article by Laure Gossec and colleagues1 describing a large multi-national study which tried to find cut-off levels of pain and disability that correspond to an indication for total hip or knee joint replacement. They failed to find any cut-point, there being a huge overlap in levels of pain and function recorded in those who were recommended for surgery, compared with those who were not. Obviously. Previous studies have shown that there is a huge variation in the levels of pain and disability experienced by people coming to total joint replacement2–4, with some, like my friend Eddie, seemingly having very little wrong with them.

As part of a programme of work on joint replacement, we conducted qualitative studies investigating the views of patients and the public on who should have a joint replacement5–8. The answers they gave were often seemingly very simple – “those who are going to benefit most from the surgery”, for example. So, it is quite easy then – we operate on those who are going to get the most benefit – the answer is ‘capacity to benefit’ (see below). But how are we to assess what the likely improvement is going to be, and how do we cope with people like Eddie (who says he benefited greatly)? This is particularly difficult as there is a notable absence of good data on the determinants of good or bad outcomes after joint replacement9.

More detailed analysis of what the patients and the public told us revealed some further, fascinating perspectives. For example, some people held the view that it should depend on the length of time that someone had put up with pain and disability in the past (the ‘area-under-the-curve’ of pain and disability), rather than reported severity of symptoms at the time of decision making. That is an interesting and quite sophisticated viewpoint I think, as it relates to issues such as a short-lasting ‘flare-up’ of symptoms leading to an ill-judged decision to have surgery, and of the problem that a patient who wants the surgery, for whatever reason, can generally get it by saying he or she has awful night pain just now. Many people told us that they thought it wrong that some other people were able to get a joint replacement by ‘shouting a lot’. They also told us that those who were caring for someone else at home should have priority, even if their symptoms were not very severe. This is another interesting perspective, raising the whole area of social circumstances, which takes us way beyond the narrow focus of Gossec et al. on severity of pain and disability, along with X-ray changes. How often do we ask about the caring role of our patients, and have you ever seen this mentioned in the plethora of consensus statements10–12 that emerge from the professionals about the indications and prioritisation of joint replacement? Probably not. Work or care-giving is mentioned in the Canadian prioritisation criteria13, but care provision is not mentioned in most of the other documents and publications on who should have a joint replacement.

But patients and the public were also aware of, and concerned about the dangers of joint replacement, and the fact that not everyone gets better4. Based on these perspectives, and other research on joint replacement we have tried to develop the public’s concept of ‘capacity to benefit’ further, so that it can be used as a framework for decision making about joint replacement surgery14, an approach that we based firmly within a biopsychosocial framework14 (Fig. 1).

The decision whether to have a joint replacement or not is, of course, a judgment call that has to be made by the physician and patient working together, and which has to take account of a large range of complex psychological, social and other issues, in addition to pain, disability and X-ray changes. That is obvious enough, although how to operationalise it is not. And that, of course, is the art of medicine, and why humanity is just as important as science in medicine.

The Greeks (particularly Aristotle) wrote about the importance of ‘phronesis’ (practical wisdom) in health care15. It takes wisdom and experience, as well as scientific data, to make the right decision with people about whether they should undergo a major intervention like a joint replacement. It cannot be done with a ‘cook-book’ approach, or simply by measuring things such as pain, which are immeasurable anyway. And with respect to my friends and colleagues who contributed to the paper in this journal (and I too must share in some of the blame), I think we need more phronesis in our research as well. The study reported1 must have involved a lot of time and money and was a big undertaking; furthermore, it seems that it was driven, as so much of the research we do is these days, by the agenda of the pharmaceutical industry rather than a patient-related question. Surely there should have been more
reflection on the wisdom of such an undertaking. If we had listened more to what the patients and the public were telling us, and to folk like my friend Eddie before undertaking this research, we would surely have re-formulated the questions. The data that we need is on what determines good and bad outcomes after joint replacement.

Conflicts of interest

None.

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References


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