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LETTER TO THE EDITOR

Letter by d'Aloja et al Regarding Article, "Competitive Sport Participation Among Athletes With Heart Disease: A Call for a Paradigm Shift in Decision Making"

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To the Editor:

Recently, Baggish et al[1] published a call for a paradigm shift in decision making, dealing with a troublesome issue: competitive sport participation among athletes with heart disease.

Several arguments in favor of a progressive introduction of a shared decision-making approach, even in this field of medicine, seem to be robust and they move on a well-defined path walked down by physicians in their everyday medical activities.

The long way from the paternalism to autonomy (of both patient and physician) has reached a point of no return: no medical activity may, nowadays, be performed on a patient without exhaustive information and a valid consent.[2] From here, the shared decision approach takes its step[3] to fostering an active engagement of patient and physician with a clear preliminary definition of ethical values at stake.

Although a very interesting approach, our similitude between *athletae* and *aegroti* is functional to raise the following question: may we consider the medical safeguard of health identical in an illness context and in the highest level of fitness, as for competitive athletes?

The authors suggest a counseling process involving the athlete and also a wider group of care providers, or to better say stakeholders, including, when appropriate, coaches, sponsoring schools, and sport organizations. This statement seems to better clarify the good at stake: social values more than physical or psychological ones. The end goal of the shared decision approach is the magnificence of the patient's autonomy, being the final decision driven by individual values and stakes deeply rooted in a person, or in his or her parents when a minor. Third party involvement in the counseling introduces other stakes, which may result apart from the key point of the process that has to be the athlete's health (physical, psychological, and social well-being according to the World Health Organization definition). Albeit, people surrounding the athlete might have an important role supporting his or her final decision in such a delicate situation, a third party should never be allowed to take part in a procedure regarding a personal value as health is.

The contrast between the universal aim of guidelines, born to make medical activities uniform, and the shared decision process, fostering a personalized approach, appears to be evident. As stated by the authors, the December 2015 IIa and IIb recommendations acknowledge uncertainties from a clinical and legal point of view, widening the potential shared decision horizon. However, the lack of a robust piece of evidence in this scenario, although inborn in science, represents a challenge for the cardiology and sport medicine communities, being an insurmountable obstacle toward a personalized decision for laymen.

This breakpoint brings to subjective interpretation of the risk, not only from the athlete, which is righteous in his autonomy, but also from sport organizations/

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schools/universities, according to their (economic) interests, appearing totally extraneous to the health issue.

Last but not least, nonmaleficence, among all the fundamental bioethical principles of Western medicine, may be threatened whenever competitive sports eligibility is granted in athletes with a considerable risk of sudden death, even in a shared decision context.

Please, *primum non nocere*.

ARTICLE INFORMATION

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Disclosures

None. AQ4

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