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COMMENTARY

Commentary on "Value in co-creation: Subjecting innovative in-hospital technologies to multi-stakeholder appraisal"

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In many health care systems, health technology assessment (HTA) for decision making remains circumscribed to the use of evidence provided by the experimental/quantitative research. HTA legitimizes a set of values related to managerial and financial decision making, based on scientific evidence for the efficacy, safety and mostly cost effectiveness of health technologies, in a health system perspective. It reflects an epistemological positioning for "hard sciences" that has been operationalized since the seventies, and is considered for many HTA practitioners and users, as the core model for their practice [1-2]. Such a positioning could be perceived as denying, to a certain extent, the contribution of contextual information that have been added on over the years to the core model as the "other dimensions", the social, ethical, organizational and legal ones.

This positioning may also deny the contribution of qualitative experiential data obtained from surveys or interviews analysed using various human sciences methods such as phenomenology or ethnology. This so called "soft data" has been used for decades in other evaluative practices, such as program evaluation, to document the strategic, contextual and implementation issues as well as the various impacts of programs on beneficiaries. In program evaluation, qualitative data obtained from discursive analysis are often combined to empirical data to inform decision making [3].

In an evaluative perspective, HTA can be considered as a form of strategic evaluation, examining the pertinence of introducing a new program or technology into a specific environment [4]. This analysis takes into account the possible impact of innovative technologies in context such as local and hospital settings. It should address the possible consequences of technology introduction at managerial level, on material, financial and human resources; but also at an individual human scale, on patients and carers [5-6]. Patients and carers should be considered as full-fledge stakeholders, as are managers and care providers, with their own and diversified agenda and interests, values and preferences.

At a societal level, citizens' perspective should also be taken into account. This form of participative evaluation involving stakeholders for shared decision making in a constructivism perspective could probably be considered as the most advanced form of evaluative practice [6] and for some evaluators as the best in the field [7].

In the last edition of the International Journal of Hospital-Based Health Technology Assessment (IJHBHTA), Abrishami and colleagues [8] are supportive of this constructivist vision for shared decision making for adoption and implementation of highly contextualized configurational technologies, in hospital settings. Configurational technologies are innovative technologies with high impact on organisational settings, professional practices and most importantly on social interaction between stakeholders [9].

Thus, for addressing this social interactive issue, these authors are proposing a very democratic vision of stakeholders' involvement in decision making for innovative technologies introduction in local and hospital settings. Inspired from the Responsible Research and Innovation model (RRI) of Von Shomberg [10], they are proposing the *multi-stakeholder deliberation (MSD)*.

The MSD is based on discursive consensus issuing from direct exchanges between key stakeholders, including patients and citizens. This method allows confrontation of individual and societal values for the co-construction of an added value for the local health system resulting from the adoption of an innovative technology.

A discursive appraisal tool is presented by the authors in table 1 [8, p.23]. Its aim is to guide multi-stakeholders' deliberation for collective responsibility in decision-making for in-hospital innovations. The spectrum of value appraisal must cover both the "why" and the "how" and takes into account "desirability" and "plausibility". To operationalize the appraisal, different aspects of value are proposed and each of these is illustrated by questions that are matters of concerns related to the values. These aspects vary from general values such as social desirability, ethical acceptability, to more concrete aspects to be valued such as necessity, added benefits, evidence in co-creation and implementation. Familiar to other RRI, the author's approach rests on an impact analysis of the technology where the impacts must be appraised by values and discussed in order to reach agreement in resolving value conflicts. However, in our view, the process of value appraisal of the multiple impacts of implementing a technology is not sufficiently developed to guide collective deliberation on value evaluation and resolving conflict of values.

This discursive method is presented as a nonlinear iterative process that may take time and efforts for attaining consensus, thus delaying decision making with the risk of missing windows of opportunities for decisions such as financing new technologies.

It also needs local know how and competencies from HTA professionals for managing and diplomatically balance the diversified confronting interests between various stakeholders involved in this decisional process.

HTA practitioners' capabilities for discursive analysis and use of consensus methods could also represent a barrier for implementing these methods, as the staff in local and hospital-based HTA units are mainly trained for the "main core" empirical and economical methods with little or no training in human sciences methods such as discursive analysis.

Introducing MSD in such a context would represent a challenge by confronting the HTA practitioners' evaluative to human sciences cultures. Interdisciplinary collaboration with ethics and human sciences trained experts could ease the local adoption of this method. MSD could also benefit from the interaction between HTA practitioners and human scientists for co-constructing a fully adapted MSD method. Full operationalization of the method by competent professionals would need to be tested in real life conditions. Resistance to MSD may also come from the local political and decisional culture, as this democratic constructivist approach might not fit with local values.

The MSD, a discursive appraisal for (complex) in-hospital innovations is an interesting proposal for improving contextual value-laden decision making in

hospital settings. However, many challenges need to be faced for operationalizing this method and make sure that it is culturally accepted as appropriate for responding to local social and decision maker's needs.

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Conflicts of interest
None.

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