Hip Arthroscopy for Femoroacetabular Impingement / Labral Repair — Surgeon Crib Sheet

Walsh / Orthoscenius LLC • Generated 2026-06-10 • Use during the patient-counseling visit alongside the patient handout.

EXPLAIN cues — what to do this visit

Educate. Open with the diagnosis in plain words. Avoid 'bone on bone' — say the joint is irritated and not gliding smoothly. Hip where the ball and socket pinch on each other and the rubbery rim of the socket has a tear.

eXample. Place this patient in the population: 'People like you, who fail PT and have daily pain, are the ones who get the most benefit from surgery.' Concretize.

Purpose. State the goal of hip arthroscopy for femoroacetabular impingement / labral repair explicitly: not a better-than-new joint, but a joint that lets the patient walk, sleep, work, and play with less pain.

Language. Pick the patient's vocabulary. If they say 'joint,' don't say 'articulation.' Define 'complication' and 'satisfaction' if you use those words.

Analogy. Use a sanctioned analogy (see handout). Default lubrication/resurfacing frame. AVOID damage metaphors — they drive kinesiophobia and worse PROMs.

Illustrate. Show the icon array. Anchor on the typical band. If a risk factor applies (age ≥75, BMI ≥35, diabetes, ASA ≥3), point to the elevated band: 'For someone with [factor], the picture shifts a bit this way.' Then deliver the **ergodicity reframe** (Taleb / Peters / West): 'The picture shows the room. You're one person on one path. The average tells the odds, but it doesn't tell us which dot you'll be — and some dots (infection, chronic pain) are paths you can't easily come back from.' This is the expectation-calibration that prevents the technically-good-surgery-dissatisfied-patient outcome.

Navigate. End with the questions sheet. Confirm next steps in writing — appointment, optimization, or referral. Send the handout home.

Numbers (typical band, per 100 patients)

Outcome	n / 100
Back to comfortable function	72
Satisfied with some residual symptoms	18
Dissatisfied with the result	7
Had a serious complication	3

Teach-back prompts — confirm before the patient leaves

- Out of 100 people like you, about how many feel back to comfortable function at one year?
- What is the chance you might still need a hip replacement later?
- What is one thing you'll do BEFORE this surgery to give yourself the best chance?

Elevated-band escalation cues

Age ≥75 / BMI ≥35 / diabetes (HbA1c >8) / ASA ≥3 / active smoker → anchor on elevated band (more dissatisfaction and complications). Offer optimization before surgery if modifiable. Document expectation conversation in the chart.

Catastrophizing / depression screen positive → consider deferral pending mental-health evaluation; expectation mismatch is the single best predictor of dissatisfaction.

Shared decision-making + informed consent — quick reference

SHARE Approach (AHRQ)	
Seek.	Seek the patient's participation. Invite them in. 'There's more than one good answer here — we want to decide together.'
Help.	Help the patient explore and compare options. Use the icon array side by side.
Assess.	Assess the patient's values and preferences. 'What outcome would matter most to you?'
Reach.	Reach a decision together. Confirm both parties heard the same thing.
Evaluate.	Evaluate the decision. Plan a follow-up to revisit. SDM is rarely a one-visit event.

Three-Talk Model (Elwyn)	
Team Talk	Frame the conversation as a team effort. 'We have a decision to make, and I want your input.'
Option Talk	Compare options side by side. Use the icon array for the contrast.
Decision Talk	Move toward a decision only after preferences are clear.

Informed consent — 6 elements	
Diagnosis.	State the diagnosis in plain words. Confirm the patient can repeat it
Procedure.	Describe the proposed procedure, what it is, and where it is
Material risks.	Cover the risks a reasonable patient would want to know before cor
Benefits.	State what success would look like. Use the icon array's 'comfortabl
Alternatives.	Cover non-surgical and surgical alternatives, INCLUDING the option
Questions.	Invite questions explicitly. Document the response. Teach-back is th

Patient self-administered tools (included in handout appendix): **SURE** (4-item decisional-conflict screen — Légaré 2010) • **CollaboRATE** (3-item SDM post-visit measure — Elwyn 2013) • **Decisional Conflict Scale** (low-literacy excerpts — O'Connor 1995).

Counseling crib sheet for surgeon use. Numbers reflect typical-risk population means with 95% confidence intervals; low / elevated bands shift in the expected direction.