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Editorial: The Metabolic (Dysfunction)-Associated Fatty Liver Disease (MAFLD) and Non-Alcoholic Fatty Liver Disease (NAFLD) Debate: Why the American Association for the Study of Liver Diseases (AASLD) and European Association for the Study of the Liver (EASL) Consensus Process is Not Representative

AEG 1 **Yasser Mahrous Fouad**
 EF 2 **Ahmed Gomaa**
 EF 3 **Rasha Mohammed El Etreby**
 AE 4 **Mohamed AbdAllah** 
 AEF 5 **Dina Attia** 

1 Department of Endemic Medicine and Gastroenterology, Faculty of Medicine, Minia University, Minia, Egypt

2 Department of Endemic Medicine and Gastroenterology, Faculty of Medicine, Fayoum University, Fayoum, Egypt

3 Department of Hepatology and Endemic Medicine, Faculty of Medicine, Cairo University, Cairo, Egypt

4 Medical Research Division, National Research Centre, Giza, Egypt

5 Department of Endemic Medicine and Gastroenterology, Faculty of Medicine, Beni-Suef University, Beni-Suef, Egypt

Corresponding Author: Yasser Mahrous Fouad, e-mail: Yasser.abdallah@mu.edu.eg, yasserfouad10@yahoo.com

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Abstract A debate has recently arisen in hepatology on the redefinition of fatty liver disease associated with metabolic dysfunction. The definition of metabolic (dysfunction)-associated fatty liver disease (MAFLD) has been widely endorsed by multiple stakeholders and societies. More importantly, although robust evidence supports the utility of the definition of MAFLD in clinical practice and research, and for increasing awareness of liver disease, controversy still abounds. Recently, the American Association for the Study of Liver Diseases (AASLD) and the European Association for the Study of the Liver (EASL) have undertaken similar consensus approaches for MAFLD. However, there are serious concerns with these regional consensus approaches. The views of hepatologists from the Middle East, North Africa, and sub-Saharan Africa are not represented. Also, the selection of experts raises concerns regarding the validity of the outcomes of the expert consensus process. We conclude that unless the process has global involvement, there will be no incentive for global adherence to these regional recommendations. This Editorial aims to highlight these concerns and to call for those involved in leading the AASLD and EASL consensus process to be more inclusive, which may facilitate the adoption of more unified recommendations that have global clinical importance.

Keywords: Editorial • Global Consensus • Hepatology • MAFLD • NAFLD

Background

A debate has recently arisen in hepatology on the redefinition of fatty liver disease associated with metabolic dysfunction. The definition of metabolic (dysfunction)-associated fatty liver disease (MAFLD) has been widely endorsed by multiple stakeholders and societies [1-6]. More importantly, although robust evidence supports the utility of the definition of MAFLD

in clinical practice and research and for increasing awareness of liver disease, controversy still abounds [1-6].

During the past two years, national and international societies representing most of the world's population, including patients with MAFLD, have endorsed the new terminology and definition [7-11]. The Asian Pacific Association for the Study of the Liver (APASL), the Latin American Association for the Study of

the Liver (ALEH), the Chinese Society of Hepatology, the Arabic Association for the Study of Diabetes and Metabolism, and societies and clinicians in the Middle East and North Africa (MENA) and sub-Saharan Africa have been supportive [7-11]. Stakeholders that include patients, primary care providers, nurses, pharmaceutical, and regulatory experts have supported the positive attributes of the redefinition [12-15]. A global grassroots consensus of more than 1,000 stakeholders from 135 countries has endorsed MAFLD [16]. This international support has resulted in the development of guidelines in clinical practice and medical training programs incorporating MAFLD [17]. However, reaching a universal agreement remains challenging.

Recently, the American Association for the Study of Liver Diseases (AASLD) and the European Association for the Study of the Liver (EASL) have developed a consensus process on the definition of fatty liver disease. It must be noted that the recent consensus definition was initially mooted in 2020. Although this consensus view is not distinct from any other, given the historical regard in which these societies are held, there was an expectation of global input and synthesis of opinions not limited only to representatives of these two societies so that there would be an acceptable outcome for the field of hepatology. However, rather than using their position to reach a global accord, the process has served instead to force a particular point of view.

The current use of the Delphi method to achieve consensus opinions may not be the best way to reach a scientific consensus. This method may have introduced opinion bias by perhaps failing to provide balanced accounts to inform the debate by under-representation of views that counter a predetermined outcome [18]. For academic and inclusive reasons, ensuring the broadest breadth of stakeholders and academic societies is essential to inform the debate adequately. With the omission of two large regions, MENA and sub-Saharan Africa, there has been a predominantly North American and European viewpoint that is far from demographically representative of the global population with fatty liver disease.

The selection of experts is also seriously flawed and has it appears, sought to suppress one view while empowering the other; the latter we believe is poorly representative of the of the majority of real-world physicians and active academics. Although evidence from many studies supports the utility of a change, this evidence has had little impact on informing the debate. Instead, an increased sense of uncertainty and reluctance to change or move forward has abounded, with the hope that the previous order will prevail [19]. So called experts claiming that the process is not a “popularity contest” implies a false sense of superiority and does not help in accepting the outcome of the process.

Unless there is a truly global consensus, rather than unifying the field, it will limit the uptake of recommendations due to their lack of general relevance. The current status of the AASLD/EASL consensus approach directly limits the power and benefits of a robust academic debate and has resulted in division. Therefore, either a consensus is developed that is representative and inclusive, or it will face the likelihood of failure hanging like a cloud and there will be a persistent lack of uniformity and uptake. The failure of the current process may be attributed to the false consensus effect and naïve realism.

The ‘False Consensus’ Effect

The false consensus effect refers to the tendency that individuals have, when forming expectations concerning the decisions of others, to perceive their views as being more commonly held and to give them more weight than others [20]. The false consensus effect leads to overestimating how common one’s own perspectives are [20]. The false consensus effect may result from ego protection and cognitive availability mechanisms, which may work separately or in conjunction [21]. With the ego protection mechanism, people holding less common views have an aversion to their minority status and perceive an inflated rate of agreement with others to counter that reality [21]. Resolving conflicts and debates through false consensus is usually power-driven and results in misperceptions of consensus and potentially breeds conflict.

Naïve Realism

However, naïve realism is the failure to grasp how much our opinions are affected by our thoughts and expectations, believing that we see things as they are, even when there is evidence to the contrary [22]. Individuals may believe their decisions are clear, unbiased, and unaffected by their personal beliefs or influences [22]. Therefore, naïve realism and false consensus may shape consensus processes [21,22]. While the leaders of any process, including clinical and academic panels, are expected to be objective and to evaluate all the evidence and input objectively, problems arise when they incorporate personal views or opinions during decision-making [21,22]. Importantly, if the coordinating group of a process expresses views that favor one side or another on social media platforms and other channels, they may lose the objectivity required to obtain true consensus [21,22]. In contrast, the definition of MAFLD was agreed upon scientifically and objectively, without confounding complex regional and national confounders [1,7,14]. Currently, the debate that has arisen following the AASLD/EASL consensus continues to drive inertia and controversy.

The Limitations of the Delphi Consensus Method

The Delphi method is commonly used to achieve medical consensus [23]. However, the Delphi method lacks universally accepted methodological guidelines for conducting and evaluating research involving achieving consensus [23,24]. The Delphi method is susceptible to the way questions are framed [23,24]. Therefore, the coordinating team must consult widely to ensure that statements are presented unbiased and accurately [24]. The success of the process and the validity of the results then depend on the appropriate and inclusive selection of internationally representative experts if the outcomes can be expected to be internationally relevant. Also, good management of the study questionnaires and an optimal flow of information during the consultation rounds are vital [24]. Perceptions of consensus are also linked to beliefs in several important ways [24]. For example, responses may alter if individuals holding one view misperceive that a majority have a different opinion [24]. Also, even a vocal minority may have the power to shift beliefs against the acceptance of apparent facts [24]. For these reasons, there has been concern about the validity of the Delphi process to achieve consensus [23,24]. A concern with an imperfect evaluation process is stakeholders' reduced sense of ownership of the outcomes, which reduces their ability to promote the consensus outcomes [23].

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The Risks of International Division

The current situation regarding the controversy following the recent AASLD/EASL consensus process continues to fuel international division. The effects will oppose the intended outcomes of developing a clinical expert consensus. This outcome continues to be challenging for academia, research, the pharmaceutical industry, and international clinical practice. As an example of the problems involved, several years ago, there was an international east-west divide on defining acute-on-chronic liver failure, which resulted in confusion and affected international clinical practice [25]. Therefore, we urge that societies running the process under their umbrella and experts involved in developing this consensus aim for truly international consensus and share the power of consensus decision-making to facilitate universal benefit for patients [19]. To have truly global acceptance, we urge the societies running the process under their umbrella

Conclusions

In conclusion, there are severe and ongoing concerns about the current consensus on the terminology for fatty liver diseases achieved using the Delphi consensus method and developed by AASLD/EASL. Unless a truly international consensus process is involved, the views of two regional societies are unlikely to achieve global uptake. Either the process will be global, or will else be the views of two regional societies with no obligation from others to adhere to it. Therefore, we urge inclusive international representation and input into developing true consensus on this important area of liver disease.

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