

Communicating risk in primary care:

what the Academy of Medical Sciences' report means in practice

In 2014, the National Institute for Health Care Excellence (NICE) changed its guidelines for offering statins to patients, reducing the threshold from 20% cardiovascular risk to 10%.¹ This ignited a fervent debate about the wisdom and practicality of the change and raised three key questions: Do we really have the right evidence on which to make a decision about the risk/benefit balance? Is that evidence trustworthy when applied to patients seen in general practice? How can we communicate the best possible evidence to the people who need to make the relevant decisions: policy makers, clinicians, and the public?

These questions are not, of course, specific to the issue of statins; they go to the heart of how healthcare decisions are made and as a result were the trigger for a request from the Chief Medical Officer of England to the Academy of Medical Sciences (AMS) to examine the issues in detail. The resulting report was finally published last month.² The report presents 12 recommendations (Box 1) that are planned to address nothing less than the scientific basis of medicine: from deciding how research efforts should be targeted, to guidelines for science reporting in the media; from improving the methodology of clinical trials to the design of patient information leaflets. But what does it mean for GPs?

We believe that it raises a number of significant issues relating especially to shared decision making, the capacity and capabilities of health professionals and overmedicalisation.

SHARED DECISION MAKING

The theory of shared decision making is wonderfully simple: a healthcare professional will sit down with a patient and together they will discuss the potential benefits and risks of different treatment options, coming to a joint decision on the course of action that best suits the individual patient's needs and priorities.

The report oversight group, however, in talking to GPs and the public, identified several familiar challenges in reaching this ideal. Time, trust, and understanding were all lacking, from the perspective of both clinicians and patients.

The report tackles the issues of trust with sections on the design, implementation, and interpretation of clinical research. That leaves the issues of communication of the resulting information, the skills to interpret it,

and the time to do so.

The report attempts to anticipate how patients might frame their questions, how clinicians might prepare for such questioning, and how both might be supported in terms of resources. Within primary care, NHS Choices and patient information leaflets were identified as key means to share trustworthy information on the potential risks and benefits of treatments and signpost resources that tend to be on disparate sites at present.

Much work has been done on how to get information across in ways that are clear and easily understood by a majority of people. One example mentioned in the report is the use of 'facts boxes',³ which summarise the key information that patients and healthcare professionals need to know, often using graphics alongside numbers to make comprehension easy at a glance. The report suggests that NHS Choices should consider including this sort of structured information on the potential benefits and harms of alternative options. Additionally, the report suggests that NHS Choices should provide tried-and-tested decision aids. These range from a simple set of suggested questions for a doctor to ask a patient (and vice versa) to online sites into which a patient's personal information can be entered in order to produce individualised information and suggestions for the clinician and patient to discuss. Decision aids have been experimentally developed by both NICE⁴ and NHS England,⁵ but the AMS report aims to put them firmly into the mainstream, suggesting that NICE coordinates their development, National Institute for Health Research and others fund their evaluation and assess their effectiveness, and that NHS Choices hosts them.

The report also formulated a series of questions that patients and healthcare professionals are encouraged to consider in advance of every appointment, or to ask during it. The oversight group drew on many previous initiatives to add support and momentum to this movement, especially for patients who may not consider questioning their doctor.

THE CAPACITY AND CAPABILITIES OF HEALTH PROFESSIONALS

The idealised view of shared decision making is that in a comfortable consultation GPs will be able to present the evidence, discuss the pros and cons of any intervention and, with

the patient's involvement and agreement, proceed with an effective form of therapy or treatment to achieve the patient's goals. There would be time for reflection and the patient would return to clarify any prevalent issues. The report's oversight group recognised that none of this is easy to deliver in the current environment.

Many GPs already use a variety of online resources to aid discussion of treatment options with patients,⁶ but having decision aids and other resources scattered over the internet makes it difficult to know the best place to turn. As mentioned, the report's suggestion of adding clear information summaries to a trustworthy centralised resource (for example NHS Choices) where they can be kept up to date is, we hope, an ideal solution, if it can be funded and maintained to do this.

Until very recently, much medical training has (understandably, but perhaps problematically) concentrated on the theory and practice of *medicine*, and not covered the theory and practice of *conducting research*. Thus many, if not most, practising clinicians do not feel confident assessing the reliability of the methods and statistics employed in individual research papers, and even less so in communicating this evidence to patients.⁶

The report therefore calls for increased training at undergraduate and postgraduate levels in both the evaluation of scientific evidence and its communication, and encourages the Royal Colleges to provide continuing professional development (CPD) in both these areas for practising doctors. The RCGP already has a curriculum that includes the need to develop critical appraisal skills and its CPD programme complements the needs of speciality trainees to meet the requirements of the curriculum for the MRCGP examination. More on the communication of risk to patients may be called for, and the report recommends training in shared decision making and the use of decision aids as part of both medical school and CPD curricula for all clinicians.

REDUCING OVERMEDICALISATION, ESPECIALLY FOR PATIENTS WITH MULTIMORBIDITY

Up to 44% of patients aged ≥ 75 years attending GP practices will have more than one medical condition.⁷ The RCGP has already raised concerns about the way that medicines are prescribed to this group

Box 1: The 12 recommendations

Ensuring evidence is robust and relevant:

1. Patients, carers and the public should be more involved in the direction, delivery and dissemination of clinical research.
2. All those involved in clinical research and all healthcare professionals (at all career stages) should get a grounding in the research methods and statistics used to evaluate the benefits and harms of treatment options.
3. The importance of robust, reproducible and reliable research should be recognised and emphasised.
4. That new sources of evidence should be used to best advantage, with more emphasis on finding ways to extract and share useful data from every opportunity.

Ensuring evidence is trustworthy:

5. That research findings and data should be published in as open, balanced and full way as possible.
6. That any potential conflicts of interest are routinely declared and then managed in an open and transparent way.
7. That academia-industry relationships are managed under a set of clear guidelines.

Ensuring evidence is communicated and used effectively:

8. That patient information leaflets are improved to give a clear and balanced appraisal of the potential risks and benefits of treatment options.
9. That NHS Choices becomes a central repository of clear, balanced and up to date evidence on healthcare options.
10. That improved reporting of scientific evidence in the media is encouraged, with a role for academic establishments in ensuring their research is accurately reflected.
11. Increased support for shared decision-making, including adequate resourcing of primary care services and the provision of decision aids through NHS Choices.
12. Continued dialogue and engagement with patients and the public to monitor the impact of these recommendations and ensure responsiveness to changing public needs in health care.

in particular⁸ and the report recognises that. Since patients with multimorbidity are usually excluded from clinical trials, there is doubt over the scientific basis for treatment decisions in their cases, along with the concern of potential unexpected drug interactions.⁹

The report suggests that this gap in knowledge is addressed by clinical research; that planning is done to ensure that patients with multiple needs get the time they deserve; and that their treatment is focused on what really matters to them, encompassing lifestyle as well as medical interventions, and with a more personalised and self-managed approach in line with the recent NICE guidelines on dealing with

multimorbidity.¹⁰ Decision aids, we believe, can help with these aims.

We recognise, though, that this approach will need GPs to spend adequate time with patients (often older patients) to go through their care options, understand their priorities and values, and discuss possible alternative options with them in a considered and appropriate way. Thus the report recommends that longer appointment times are prioritised for these patients in particular to establish a new system of care; clearly a challenge at the present time.

CONCLUSION

The 12 recommendations in the report are precise, with responsibilities and tasks assigned to particular institutions. Our hope is that this will encourage actual delivery of the resources and support that those working in primary care require in order to make the laudable ambitions of shared decision making a practical reality at last.

We know that doctors have always attempted to involve their patients in decisions where there is a genuine choice to be made, to keep abreast of the latest evidence on effectiveness, and to care for their patients with multimorbidity in a personalised way. Equally, we recognise that the ambitions of health professionals in primary care will continue to be constrained by workforce pressures, patient demand, and the increased management required around polypharmacy and multimorbidity, unless significant cultural and structural changes are made. We hope that this report stimulates exactly those sorts of changes.

Alexandra Freeman,

Executive Director, Winton Centre for Risk & Evidence Communication, University of Cambridge, Cambridge.

Martin Marshall,

Vice Chair of Council, Royal College of General Practitioners, London.

Julian Treadwell,

Wiltshire and National Institute for Health Research in-practice fellow, Nuffield Department Primary Care Health Science, Oxford.

David Spiegelhalter,

Professor, Winton Centre for Risk & Evidence Communication, Statistical Laboratory, University of Cambridge, Cambridge.

Imran Rafi,

Chair, Clinical Innovation and Research, Royal College of General Practitioners, London.

Competing interests

Martin Marshall, Julian Treadwell, David Spiegelhalter, Imran Rafi are members of the

ADDRESS FOR CORRESPONDENCE

Imran Rafi

Royal College of General Practitioners, 30 Euston Square, London NW1 2FB, UK.

E-mail: imran.rafi@rcgp.org.uk

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REFERENCES

1. National Institute for Health and Care Excellence. *Cardiovascular disease: risk assessment and reduction, including lipid modification*. [CG181]. NICE, 2016. <https://www.nice.org.uk/guidance/CG181/chapter/2-Implementation-getting-started> [accessed 22 Jun 2017].
2. Academy of Medical Sciences. *Enhancing the use of scientific evidence to judge the potential benefits and harms of medicines*. AMS, June 2017. <https://acmedsci.ac.uk/file-download/44970096> [accessed date 2 Jul 2017].
3. Schwartz LM, Woloshin S, Welch HG. The drug facts box: providing consumers with simple tabular data on drug benefit and harm. *Med Decis Mak* 2015; **27**(5): 655–662.
4. National Institute for Health and Care Excellence. *Shared decision making*. NICE, 2017. <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making> [accessed 22 Jun 2017].
5. NHS England. *Shared decision making*. <https://www.england.nhs.uk/ourwork/pe/sdm/> [accessed 22 Jun 2017].
6. Anderson BL, Schulkin J. Numerical reasoning. In: Anderson BL, Schulkin J, eds. *Judgments and decision making about health*. Cambridge: Cambridge University Press, 2014: 59–79.
7. Salisbury C, Johnson L, Purdy S, *et al*. Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. *Br J Gen Pract* 2011; DOI: <https://doi.org/10.3399/bjgp11X548929>.
8. Royal College of General Practitioners. *Responding to the needs of patients with multimorbidity. A vision for general practice*. London: RCGP, 2016.
9. Smith SM, Soubhi H, Fortin M, *et al*. Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. *Cochrane Database Syst Rev* 2016; DOI: [10.1002/14651858.CD006560.pub2](https://doi.org/10.1002/14651858.CD006560.pub2).
10. National Institute for Health and Care Excellence. *Multimorbidity: clinical assessment and management*. [NG56]. NICE, 2016. <https://www.nice.org.uk/guidance/ng56> [accessed 22 Jun 2017].