

Risks — listen and don't mislead

WE are increasingly aware of the value of patients making 'informed choices' about their treatment or care. There is evidence that greater levels of informed choice are associated with greater satisfaction with the process of care and, crucially, improved adherence to the chosen treatment.¹ We should therefore move towards greater levels of information sharing as the norm in health care. However, closer examination suggests a number of pitfalls that must be recognised and avoided first. In this issue, Misselbrook and Armstrong² remind us of the powerful effect when information is 'framed' in different ways. Framing concerns the portrayal of logically equivalent information in different ways.³ Misselbrook and Armstrong show that relative risk formats are much more persuasive than absolute risk formats (including percentages and numbers-needed-to-treat). These findings are consistent with other work from the United States and New Zealand.⁴ Other framing manipulations are also influential. Presenting choices, such as whether or not to undergo mammography, in terms of the potential losses (of health and family life) from not undergoing screening may persuade more people to undergo tests than presenting the potential gains. When discussing treatments, positive framing of the benefits (e.g. 97% survival rate) appears more effective in persuading people to take treatments than negative framing, concentrating on the risks (e.g. 3% mortality).⁴

In previous years such findings were latched onto vigorously. It appeared 'health education' messages could be communicated with greater prospects of achieving their goals, such as increasing uptake of screening programmes, or ensuring that people chose treatments that their doctors felt were most beneficial. If these were the chosen goals then this could be justified; however, questions began to be raised about what the goals of health messages should be. Achieving behaviour change can be justified from the community perspective as risks were reduced and actual health gain was achieved for the population. But on the other hand, individuals were not being provided with the fullest information. From an ethical perspective, individual 'autonomy' was afforded lower priority than 'beneficence' for the population.

The pendulum is now swinging towards higher priority for the individual. There is increasing emphasis on autonomy but also greater value placed on truthfulness of information — the whole truth. The current trends are towards enhanced patient choice in health care.^{5,6} If these are built on relevant information being made available then the prospects for 'informed choice' will also be greater. In practical terms, we may expect evidence of such informed choices to include different treatment decisions by patients compared with the 'conventional' or professional-led decisions.⁷ For example, the uptake of cervical smears may fall among groups of women who know themselves to be at low risk.

However, further problems arise. Public attitudes to risk are changing and attention to risks is increasing. We now live in the 'risk society'⁸ where everything is questioned and

assessed for its effect on life. But even if information is presented in a balanced fashion, with both absolute and relative dimensions, there are dangers of misinterpretation, particularly when the information is taken out of context by the popular media. The archetypal case was the 1995 'scare' about third-generation contraceptive pill risks. Professional and consumer perspectives on the absolute risks of venous thrombo-embolism (VTE), that were small, were outweighed by the relative risk information ('that the risk of VTE was doubled'). The comparative risk of pregnancy was left unmentioned.

Consequently, policy-makers and professional and consumer groups have tried to learn lessons from this episode so that inaccurate scare stories are not repeated. In his lecture on risk issues, Calman highlighted how we should draw on the principles of mass 'risk communication' to improve our discussions with patients.⁹ We must demand high standards and rigour in the research and data provided to aid clinical decision-making. There should be a spirit of openness and honesty in which the patients are involved as partners, uncertainty is shared where relevant, and we listen to the patient's concerns about the risks in question. If we realise these ambitions for communication with patients then professional credibility will be enhanced.

These principles seem acceptable but the practicalities are more challenging. Calman⁹ proposes a 'standardised language of risk' in which certain terms equate to particular frequencies (such as 'high' for over 1 in 100, 'moderate' for 1 in 1000, and so on). Paling has also suggested an equivalent scale but with the added value of anchoring points in which everyday risks (such as road traffic accidents) or rare risks (such as plane crashes) are available to add perspective.¹⁰ However, a range of primary care professionals in the United Kingdom (UK) anticipated difficulties with such approaches.¹¹ Standardising the language does not allow the flexibility required for dealing with individual patients with different levels of literacy, numeracy, and attitudes to risks. Furthermore, a risk that is 'high' in one specialty (e.g. 1 in 100 risk of Down's syndrome on triple testing) may not be viewed so in another situation, such as a risk of side-effects of treatment for a life-threatening condition. The nature of the risk, its burden, the context, and the timeframe over which one has to 'live' the risk are all important determinants of how individuals interpret risk for themselves and of whether one chooses to accept a risk.

The language of risk is fundamental to meeting the needs of patients. Language is dynamic and cannot be regulated or standardised. If we are to achieve credibility we must avoid trying to impose definitions of what is safe or unsafe. People's perceptions of safety change from one day to the next — as when Concorde went from having an immaculate safety record one day, to being grounded the next after it crashed. And it is perhaps individual (patient) perceptions that are crucial, rather than bald facts or professional opinion. Vaccine scares or the risks of bovine spongiform encephalopathy and genetically modified food are further

examples. Each bears witness to the attempts of authorities to minimise a risk and describe it as 'safe'. However, the public disagrees and if we take rigid positions it undermines our ability to contribute to continuing discussions with patients. We must recognise that the arbiters of safety are the consumers not the providers.

In practical terms, much effort is concentrating now on decision aids for patients.^{1,12} The common objectives of such aids are to provide information for patients and to facilitate involvement in decisions if patients so desire. Through the use of illustrations (verbal and pictorial), charts, and figures, decision aids portray the relevant treatment options and associated risks and benefits. The information should be balanced and aware of the risks of framing manipulations. This includes using absolute and relative risk information and different formats for presentation. Framing effects may be minimised when using low integer values to present data.¹³ When it comes to clinical decisions, key elements of these decision aids often include processes of clarifying the important values ('utilities') that patients bring to the decision under consideration. To take one example, Man-Son-Hing *et al* evaluated a decision aid comprising an audiocassette-guided booklet and worksheet for patients with atrial fibrillation at low risk of stroke.¹⁴ It sought to help patients decide whether they would prefer the benefits, risks, and lifestyle effects associated with the use of aspirin or warfarin to prevent stroke, providing a basis for further discussion with their physician.

The philosophy behind such approaches has perhaps been encapsulated in the phrase 'evidence-based patient choice'.^{5,15} Patient choice is thus explicitly recognised. Informed choice is seen as a goal, even if this apparently compromises public health gain (e.g. by reducing uptake of screening programmes). What constitutes 'informed choice', however, remains debatable, though some have explored in practice what can be learnt from the 'reasonable person's standard' — that is, what the reasonable person would want to know.¹⁶

Discussion of risks is a significant part of clinical discourse. A number of principles are important towards improving the way we discuss risks (and benefits). If we adhere to these we should go some way towards minimising the framing effects and enhancing informed choices by patients. Wider use of decision aids is one practical way in which informed choice can be achieved. Perhaps ironically, if the principles of evidence-based patient choice are borne out in practice, professional credibility is likely to increase. For those concerned about apparent further erosion of professional authority, adopting such approaches is appreciated by patients and will thus probably enhance the standing of the profession.

ADRIAN EDWARDS
GLYN JONES ELWYN

Department of General Practice,
University of Wales College of Medicine

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Address for correspondence

Dr Adrian Edwards, Department of General Practice, University of Wales College of Medicine, Llanedeyrn Health Centre, Llanedeyrn, Cardiff CF3 7PN. E-mail: email.edwardsag@cf.ac.uk

Outreach clinics in the New NHS: not yet the end of outpatients

THE last decade saw a significant expansion of specialist outreach activity in general practice.¹ Many factors fuelled this growth, including the development of new pharmaceuticals and near-patient diagnostics, the growing popularity of services closer to home and, of course, fundholding.² With the end of fundholding many of these services have come under scrutiny. Primary care groups are seeking to ensure equity of access to such services but, while some have 'levelled up', many former fundholders have reported cutbacks in practice-based outreach clinics, physiotherapy or counselling.³ Many early primary care trusts wish to expand the range of consultant-led services provided in the community. They may come to employ these specialists themselves; however, for the time being they seek evidence for their primary care investment plans on the most cost-effective models. Was anything learnt from fundholders' outreach experience that might assist them?

Apart from shorter waiting times, the main advantages claimed from specialist outreach clinics have been greater efficiency because of a reduction in unnecessary follow-up attendances,⁴ better communication and educational exchange between consultant and general practitioners (GPs),^{5,6} and improved patient satisfaction.^{1,6,7} In contrast, apart from potentially longer waiting times for the patients of practices unserved, suggested disadvantages include reduced access to diagnostic facilities, less efficient use of consultant time, and reduced efficiency for some patients attending both clinic and hospital.⁸

The research literature is disappointingly sparse. Few studies have been controlled and only one allowed for case-mix differences between clinics.⁶ Nor have they addressed the question of whether certain patient groups are more appropriately seen in the community rather than hospital settings. Some important messages emerge nonetheless.

Regarding the key questions of cost-effectiveness and efficiency, the available data are ambiguous. Surprisingly, the presence of outreach clinics does not consistently reduce waiting times for first appointments.⁴ Outreach clinics can provide an effective filter to secondary care. For example, outreach ophthalmology clinics reduced referral on to conventional outpatients departments by 60%.⁷ However, there is also evidence that, with easier access, GPs may lower their referral thresholds. Walshe and Shapiro found higher proportions of new referrals among outreach patients; they were also discharged more rapidly.⁹ The use of outreach clinics as a filter for hospital services could easily prove inefficient. Filtering has traditionally been the task of the competent generalist and individual patients may end up receiving more appointments than they otherwise would do.

Most studies find the unit costs of patients seen in outreach clinics compare unfavourably with the costs of conventional outpatient care.^{6,9} The reasons are not hard to discern. Total costs differ little with the bulk being comprised of salaries; however, compared with the throughput in conventional outpatients departments, outreach clinics tend to be low volume affairs. The costs and benefits of outreach clinics need to be assessed on a specialty-by-specialty basis for

costs are crucially dependent on clinic organisation. Staff costs per outreach appointment may be greater but costs per episode of outreach care may be reduced if episodes are shortened as a result of outreach.⁹ Longer term follow-up studies are required to address this issue.

Unsurprisingly, being seen in familiar surroundings closer to home engenders high levels of patient satisfaction.^{6,7,9} Patients' personal costs may be reduced with shorter waits, shorter travel times, and less demand on carers.⁶ The educational impact of outreach clinics has generally been disappointing. They provide limited face-to-face contact between specialists and busy practice staff with little evidence of skills transfer.^{1,7} However, where the motivation exists and proper processes are established, outreach clinics could offer opportunities for training GP registrars.

The outreach model could not easily replace hospital outpatient clinics on a wide scale. Most specialists feel that present patterns of hospital activity could not be sustained if they were doing much more practice-based work.¹⁰ New models for training junior hospital staff would be implied. Furthermore, expansion of outreach work would require much capital development in primary care, requiring disinvestment in hospital buildings or opportunities to use hospitals in different ways.

However, 'community resource and treatment centres' could come to provide the setting for many primary and intermediate care services.¹⁰ The NHS Plan announced the establishment of 500 one-stop primary care centres by 2004.¹¹ Consultants will be seeing outpatients in these settings while 'specialist general practitioners' will be taking referrals from their colleagues.

The Plan extends new approaches to the management of demand. NHS Direct and Walk-In centres are already graduating access to primary care. Extended roles for nurses, pharmacists, and GPs and the expansion of intermediate care should shift the locus of much hospital-based care into the community. Traditional boundaries between primary and secondary care are breaking down; however, new forms of service delivery should still be subject to rigorous economic analysis.

In summary, while outreach clinics may provide some benefits for patients, they may not represent a cost-effective use of specialist time and do not currently meet their educational potential. Primary care trusts will provide more appropriate population bases from which to develop such schemes. These new organisations should grow the infrastructure to underpin new forms of community-based provision. They may indeed come to employ their own psychiatrists, paediatricians, geriatricians, and other relevant consultant staff. The evolving processes of clinical governance should help to exploit the educational potential of such schemes and the means for assuring their quality. In the meantime, if new models of outreach are to substitute efficiently for existing services rather than provide costly additional drains on limited resources, wise purchasers will ensure that thorough evaluation is built in at the outset.

STEPHEN GILLAM

Director, Primary Care Programme, King's Fund, London

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Address for correspondence

Dr Stephen Gillam, Primary Care Programme, King's Fund, London W1M 0AN.

Quality, general practice, and the NHS Plan

The principles of the National Health Service (NHS) plan¹ have been supported by a wide range of primary care organisations. However, the question is: will the detail actually improve quality of care and how should general practitioners (GPs) respond to the challenge? This future NHS blueprint has many plans for GPs and their teams. The structure of primary care will change although the practice will remain the basic unit for the provision of care. There will be more one-stop clinics and NHS Direct will triage all out-of-hours calls. Primary Care Trusts (PCTs) will take on the recruitment and payment of primary care staff and new Care Trusts will commission all social and medical care. There will be a greater use of 'skill mix' in primary care. Practice nurses, health visitors, pharmacists, receptionists and new mental health workers will all be involved in first contact with patients. Practice nurses will triage demands for care. There will be quicker access for patients through NHS Direct, one-stop clinics and greater telephone consultations with the stated aim of the patient being able to see a GP within 48 hours and a practice nurse within 24 hours as the norm by 2004. 'Jobbing GPs' will refer to a new cohort of GP specialists within PCTs or directly book hospital appointments with secondary care specialists. GPs and their teams will have better access to the NHS Net and a better IT infrastructure and electronic patient records, with electronic prescribing links to pharmacists. It is claimed that GPs therefore will be able to provide a greater range of services, with greater freedom for practices and an improvement in quality. To top it all there will be a new contract for GPs nationally.

Can this really be achieved and would it improve the quality of care that patients would receive?

There is some research evidence to support elements of the plan. Some patients just want better access to primary care but others still wish to see their personal doctor and have continuity of care for significant illnesses,² even if this is at the cost of poorer access.³ Nurse practitioners can replace GPs for certain tasks with patient satisfaction remaining high or increased,⁴ and this may be cost-effective when nurse practitioners are forced by patient demand or management directive to consult at the same rate as GPs do at present. Nurse telephone triage can reduce GP out-of-

hours contacts in a cost-effective manner.⁵

Can GPs be all things to all people? Owing to time pressures, it will not be possible for GPs in the future to provide traditional first-contact primary care, by triaging the wide variety of symptoms and problems that are brought to primary care and also to diagnose, deal with illnesses, manage diseases, follow up patients' chronic conditions, co-ordinate care for all, manage complicated patients with co-morbidity, practise specialised care, manage their practice, and lead on a number of practice or PCT-related activities, such as education. It is ironic that future GPs will be providing less frontline care at a time when hospital consultants are being encouraged to provide more firstline care.⁶

The principal reason, apart from the NHS plan,¹ is that there will soon be a large deficit in the number of GPs required to provide the present model of British general practice care,⁹ for the following reasons: junior hospital doctors are showing less interest in general practice, insufficient numbers of GPs are being trained, there is a large cohort of GPs who are nearing retirement, and more consultant expansion is planned.⁶ The planned expansion of the number of GPs is woefully inadequate to keep up with practices' present replacement needs for retiring or resigning GP principals. The recent announcement by the Secretary of State for Health,⁷ of one-off payments to new GPs and to older GPs is welcome but is likely to have only a transient impact. Averaged over five years it is the equivalent of a small percentage pay increase and does nothing to address the major problems of inappropriate GP training, inadequate GP support staff or insufficient remuneration of the majority of GPs. If the NHS Plan is implemented as it stands then many patients will soon have major problems in even registering with an NHS GP, let alone consulting one. Unless there is a vast increase in doctors' immigration then there will simply be insufficient numbers of GPs to go around in the next five years. So how can these various factors be brought together into a coherent future of quality British general practice?

Future British general practitioners will need to concentrate on diagnosis, on the management of patients with co-morbidity, and on co-ordination of care.⁹ By doing so, they will keep interventions and referrals to a sensible level, contain

costs, and still improve health outcomes.¹⁰ Their competencies in sifting research evidence, applying it appropriately,¹¹ being patient centred,¹² diagnosing, and managing patients with a wide range of co-morbidity are their strengths and should be built on for the future. As Barbara Starfield states in her keynote lecture for NAPCRG 2000,¹⁰ these are the strengths of primary care and British general practice must build on these to continue to improve the quality of care that patients receive and limit the cost increases of the overall NHS organisation. However, it is important that GPs have the flexibility to provide appropriate care in areas of expertise and interest or take on other tasks, such as research, teaching or management.¹³ However, the key for those GPs providing a specialised clinical service is that they are providing it to their fellow GPs within the PCT. They themselves, with their GP colleagues, must decide their range of competencies, required qualifications, and the limits of their activities. Such GP specialists should not work as the equivalent of clinical assistants in primary care and should not be under the direction of consultants. If secondary care has a problem in providing certain investigations or low level medical care then they should employ more nurse consultants or practitioners and not drain the GP pool further.

General practice must be made more attractive¹⁴ and the training of future GPs will have to change. It will need to be longer and have greater flexibility. It should be comparable in length to that of hospital specialists, i.e. five years, and contain an elective period and a period of training in research; however, its nature will be different. Future GPs will need to have high-level diagnostic and management skills as soon as they become independent practitioners. Those leaving the present vocational training schemes are not in such a position and the call for higher professional education¹⁵ can be met by lengthening the training to five years and by having more time in training practices. Moves in some regions to lengthen the GP registrar year from 12 months to 18 months is welcome but the structure in which training is organised must be overhauled and the merging of Joint Committee for Postgraduate Training in General Practice and the Special Training Authority are a welcome opportunity to bring together the duration and structure of training for GPs with that of specialists. The key point is that GPs need to be trained intellectually and diagnostically to as high a level as hospital specialists, perhaps even higher, in view of the wide range of problems that will be presented to them after triage by NHS Direct, practice nurses, and other members of the primary health care team. This is an opportunity for British general practice to grasp and those involved in leading the profession politically, academically, and in training matters must lobby as one to ensure this opportunity is not lost to improve the quality of GP training and consequent patient care. It remains to be seen whether implementation of the NHS Plan will simply result in cheaper NHS primary care services, better quality care or in the privatisation of British general practice. We must all be mindful of the evidence: as Starfield⁹ says, 'countries with strong primary care have lower costs and generally healthier populations'.

LINDSAY F P SMITH

Lead GP, East Somerset Research Consortium

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Address for correspondence

Dr Lindsay F P Smith, Westlake Surgery, High Street, West Coker, Somerset BA22 9AH. Email: esrec@globalnet.co.uk