In my former role as an NHS Prescribing Adviser, I advised GPs about cost-effective prescribing. Evidence-based considerations went hand in hand with an eye on the drug budget. We routinely performed drug switches with only a passing regard for patients’ wishes. Until one day, during a visit to a GP practice, I informed the GP partners that their prescribing for benzodiazepines was considerably higher than the national average. They explained that they had tried to wean their patients off benzodiazepines, in line with local guidelines, but one of their patients reacted badly to the news of his coping strategy being threatened, and committed suicide. Naturally, this had made them somewhat cautious.

Therein lies the problem, our expectations of how things ‘should’ be, are revealed to us in carefully considered evidence-based guidelines. Meanwhile, our perception of what reality ‘is’ confronts us through our lived experience (Box 1). The often opposing demands of following evidence-based guidelines and acting in partnership with patients can leave GPs with the stark choice of guidelines and acting in partnership with their patients, and for the best decisions in complex circumstances. He says his over-riding concern is debt. He is afraid to open his mail, and eats to alleviate anxiety. He has a good knowledge of diabetes, its complications, and healthy eating (the ‘should’). They agree on a ‘could’ to lose weight. The ‘is’ for the nurse is offering him a 10-minute consultation and a generic healthy eating leaflet. She asks the patient about the ‘is’ of his living circumstances. He says his over-riding concern is debt. He is afraid to open his mail, and eats to alleviate anxiety. He has a good knowledge of diabetes, its complications, and healthy eating (the ‘should’). They agree on a ‘could’ to lose weight. The ‘is’ for the nurse is offering him a 10-minute consultation and a generic healthy eating leaflet. The nurse appreciates his concern that healthy eating is expensive. They discuss walking to work rather than driving. This helps him to save money, lose weight, improve his mood, and builds trust in the nurse.

The original intention of evidence-based medicine was to provide a tool for that purpose. A new way of thinking was proposed in which clinical decisions would be based on scientific evidence. At first sight this may appear as though evidence dominates other factors in the decision making process, but the original definition of evidence-based medicine focused on evidence as an addition to the existing factors of clinical expertise and the patient’s values, needs, and wishes, not a replacement. Thus, the patient’s lived experience was key to the decision making process.

Why then, do we experience a tension between evidence-based guidelines and the patient’s circumstances? In the evolution from evidence-based medicine to guidelines there has been a drift away from the original concept. Evidence-based medicine gave clinicians autonomy to make decisions with individual patients, considering their comorbidities and life context, in combination with the best available clinical evidence, without an overt concern about costs. However, guidelines consider single conditions and populations of patients. They reflect a policy perspective with considerations of costs, and reduce clinician autonomy. Thus, in original evidence-based medicine the ‘should’ of evidence, being consciously applied to individual patients, was closer to the ‘is’ of the patient’s lived experience, and the clinician had autonomy to use judgement to pull these two aspects together in decision making. Whereas, with the development of guidelines and incentivised targets, the population and policy based ‘should’ is estranged from the patient’s lived experience and the clinician lacks the autonomy to bridge the gap.

INTRODUCING THE TRIANGLE OF REALITY

We therefore struggle to reconcile the ‘is’ and the ‘should’ dimensions of reality. Treatment plans built on the ‘is’ alone, risk being ineffective or harmful. Treatment plans built on the ‘should’ alone, risk being ineffective due to a lack of cooperation with patients in terms of medication adherence or lifestyle changes, or incompatibility with the context. It follows that effective plans should be anchored in both the ‘is’ and the ‘should’, aiming towards what could be and the collaborative achievement of therapeutic goals. This introduces a third dimension, how things ‘could’ be, in to our construct of reality. These dimensions can be visualised as a triangle, on axes of subjectivity and unpredictability (Figure 1).

The left-hand corner of the triangle reflects controlled and objective environments, for example, drug development in laboratory conditions. Progressing along the triangle the ‘is’ and the ‘should’ diverge with increasing human involvement, individuality, and therefore subjectivity, accompanied by an increasingly uncontrolled environment and therefore increasing unpredictability. We see this progression moving from the use of drugs in clinical trials, through secondary care, primary care, and finally through to...
is fundamental for the process of co-creating realistic treatment plans, and primary care should seek to nurture trust and effective communication.

Returning to the example at the beginning, the clinician’s ‘should’ was to consider the long-term dependency issues of benzodiazepines and the clinician’s ‘is’ was the availability of appointments to call in the patient for a review. The patient’s ‘is’ was that being on a benzodiazepine provided a crucial coping strategy. It is not known what the patient’s understanding of the ‘should’ was in terms of knowing about the side-effect profile and options for other treatments. Consideration of all of these factors could have led to the provision of an alternative coping strategy of a support group and a slower detox to support the patient through this painful process.

APPLICATION TO DEPRESCRIBING

The issue of decision making in deprescribing is also explored by Wentink et al in a recent BJGP research paper. They conducted a concept mapping study with 37 patients and 27 professionals to generate factors that were considered to be important for inclusion in decision making about the discontinuation of antidepressant medication. A total of 50 separate topics were generated, which highlights the complexity of these decisions.

As Wentink et al comment: ‘Obviously, reviewing and sharing scientific knowledge is an essential element of clinical decision making that should not be disregarded. However, it may not be the entire story.’ That other ‘part of the story’ is the lived experience, and this is a key consideration in successful decision making in partnership with patients.

The authors call for more concrete tools to aid shared decision making, and their study provides a valuable evidence base for developing a decision aid for the discontinuation of antidepressant medication.

Together these approaches show that supporting holistic consultations, that take into account the best scientific evidence along with the lived reality for both clinicians and patients, in the co-creation of individualised treatment plans offers our best hope of delivering effective medical practice in the face of complexity and uncertainty.

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REFERENCES