

# Newsletter des Förderschwerpunktes "Der Patient als Partner im medizinischen Entscheidungsprozess"

No. 5  
02.06.2005

Herzlich willkommen! Hier finden Sie - gestützt auf deutsch- und englischsprachige Quellen - Informationen zur Partizipativen Entscheidungsfindung/Shared Decision Making und allen im engeren und weiteren Sinne damit in Verbindung stehenden Themen, wie z.B. Transparenz im Medizinsystem, Patientensicherheit usw. Die Informationen erhalten Sie in Form von Links, Meldungen und Abstracts sowie gelegentlich als Dateianhang. Der Newsletter richtet sich an alle Personen und Institutionen, die zur Stärkung der Rolle der Patienten im Gesundheitswesen beitragen wollen.

## I.

---

Health Expectations June 2005 - Volume 8 Issue 2, 114-126

### **Treatment decision aids: conceptual issues and future directions**

Cathy Charles, Amiram Gafni, Tim Whelan, Mary Ann O'Brien

#### \*Background \*

In the last 10 years, there has been a major growth in the development of treatment decision aids. Multiple goals have been identified for these tools. However, the rationale for and meaning of these goals at the conceptual level, the mechanisms through which decision aids are intended to achieve these goals, and value assumptions underlying the design of aids and associated values clarification exercises have often not been made explicit.

#### \*Objective \*

In this paper, we present ideas to help inform the future development and evaluation of decision aids.

#### \*Results \*

We suggest,

- (i) that the appropriateness of using any decision aid be assessed within the context of the wider decision-making encounter within which it is embedded;
- (ii) that goal setting activities drive measurement activities and not the other way round;
- (iii) that the rationale for and meaning of goals at the conceptual level, and mechanisms through which they are intended to have an impact be clearly thought through and made explicit;
- (iv) that value assumptions underlying both decision aids and associated values clarification exercises be communicated to patients;
- (v) that taxonomies developed and used to classify various types of decision aids include a section on value assumptions underlying each tool;
- (vi) that further debate and discussion take place on the role of explicit values clarification exercises as a component of or adjunct to treatment decision aids and the feasibility of implementing valid measures.

#### \*Conclusion \*

Further debate and discussion is needed on the above issues.

## II.

---

Journal: Social Science & Medicine

Volume:60, Issue:11, Date:Jun-2005, pp 2575-2584

### **The experiential knowledge of patients: a new resource for biomedical research?**

J.F. Caron-Flinterman, J.E.W. Broerse, J.F.G. Bunders

**\*Abstract\***

Both governments and patients' movements are increasingly making a plea in favour of the active participation of patients in biomedical research processes. One of the arguments concerns the contribution that patients could make to the relevance and quality of biomedical research based on their 'experiential knowledge'. This article reflects on the validity of patients' experiential knowledge in the context of biomedical research processes. Since a conclusive argument on the validity of patients' experiential knowledge could not be reached on the basis of theoretical reflection alone, a pragmatic approach was chosen that assessed the validity of patients' experiential knowledge in terms of its practical usefulness for biomedical research. Examples of patient participation in biomedical research were sought through literature research and more than 60 interviews with (bio)medical scientists, patients, representatives from patients' organisations, and health professionals in the Netherlands and the United Kingdom. These examples were analysed for a concrete contribution by patients to the research process. Twenty-one cases of patient participation in biomedical research were identified. After further analysis, concrete use of patients' experiential knowledge could be traced for nine of these cases. These findings suggest that patients' experiential knowledge, when translated into explicit demands, ideas, or judgements, can contribute to the relevance and quality of biomedical research. However, its deliberate use would require a more structural and interactive approach to patient participation. Since the implementation of such an approach could face various obstacles in current biomedical research practices, further research will be needed to investigate its feasibility.

**III.**

---

Journal: Social Science & Medicine  
Volume:60, Issue:11, Date:Jun-2005, pp 2585-2595

**Assessing patients' preferences for treatments for angina using a modified repertory grid method**

G. Rowe, N. Lambert, A. Bowling, S. Ebrahim, I. Wakeling, R. Thomson

**\*Abstract\***

A current popular theme in medicine concerns whether and how patients should be involved in treatment choice. Assuming patient involvement is desirable, how should one go about eliciting preferences? A variety of quantitative and qualitative methods exist that may be used for this purpose, one of which is the repertory grid method. This method involves eliciting constructs (reasons) for preferences through comparing sets of three options. This method allows the structured elicitation of the reasons behind individual preferences, but also, when used with generalised procrustes analysis (GPA), allows aggregation of individual data to reveal general preference patterns. In this study the repertory grid method was used to examine patient preferences for angina treatments with the goal of, first, gaining some understanding of general patterns of patient preference, and second, examining the likely utility of the technique in this setting. A sample of 21 patients with mild and stable angina from two general practices in Norfolk, UK was interviewed using the repertory grid method to elicit the constructs underlying their preferences amongst seven angina treatments (including 'no treatment'). Individualised questionnaires were then produced and sent to the patients for self-completion, which required rating the extent to which each construct was relevant for each treatment (scored on visual analogue rating scales). Analysis of the ratings, using GPA, showed that the constructs clustered around two dimensions: 'some treatment' versus 'no treatment', and drug treatment versus surgical treatment. While /some/ treatment was generally preferred to /no/ treatment, individuals varied in preference for drug treatments or surgical treatments. Although the latter were generally perceived as 'effective' they were also perceived, for example, as 'invasive', 'frightening', related to 'negative experiences', and being more appropriate for when symptoms are severe ('proportionate'). We consider the implications of these results for involving patients in choosing amongst treatments.

**IV.**

---

[British Journal of General Practice](#), April 2005, vol. 55, no. 513, pp. 305-312(8)

**Motivational interviewing: a systematic review and meta-analysis**

Rubak, Sune ; Sandbaek, Anneli; Lauritzen, Torsten; Christensen, Bo

\*Background:\* Motivational Interviewing is a well-known, scientifically tested method of counselling clients developed by Miller and Rollnick and viewed as a useful intervention strategy in the treatment of lifestyle problems and disease.

\*Aim:\* To evaluate the effectiveness of motivational interviewing in different areas of disease and to identify factors shaping outcomes.

\*Design of study:\* A systematic review and meta-analysis of randomised controlled trials using motivational interviewing as the intervention.

\*Method:\* After selection criteria a systematic literature search in 16 databases produced 72 randomised controlled trials the first of which was published in 1991. A quality assessment was made with a validated scale. A metaanalysis was performed as a generic inverse variance meta-analysis.

\*Results:\* Meta-analysis showed a significant effect (95% confidence interval) for motivational interviewing for combined effect estimates for body mass index, total blood cholesterol, systolic blood pressure, blood alcohol concentration and standard ethanol content, while combined effect estimates for cigarettes per day and for HbA<sub>1c</sub> were not significant. Motivational interviewing had a significant and clinically relevant effect in approximately three out of four studies, with an equal effect on physiological (72%) and psychological (75%) diseases. Psychologists and physicians obtained an effect in approximately 80% of the studies, while other healthcare providers obtained an effect in 46% of the studies. When using motivational interviewing in brief encounters of 15 minutes, 64% of the studies showed an effect. More than one encounter with the patient ensures the effectiveness of motivational interviewing.

\*Conclusion:\* Motivational interviewing in a scientific setting outperforms traditional advice giving in the treatment of a broad range of behavioural problems and diseases. Large-scale studies are now needed to prove that motivational interviewing can be implemented into daily clinical work in primary and secondary health care.

## V.

---

### **BMBF-Broschüre Versorgungsforschung**

<http://www.bmbf.de/pub/versorgungsforschung.pdf>

Häufig vergeht zu viel Zeit, bis neue Erkenntnisse aus der Gesundheitsforschung den Patientinnen und Patienten zugute kommen. Um die Umsetzung der Ergebnisse in den Versorgungsalltag zu beschleunigen, fördern das Bundesministerium für Bildung und Forschung (BMBF) [...] und die Spitzenverbände der gesetzlichen Krankenkassen unter Beteiligung des Bundesministeriums für Gesundheit und Soziale Sicherung seit 1999 gemeinsam Forschungsprojekte. Die Ergebnisse dieser Förderung werden in der aktuellen Broschüre "Versorgungsforschung" dokumentiert, die das BMBF und die Spitzenverbände gemeinsam herausgegeben haben.

## VI.

---

### **Long-term Medical Conditions Alliance(LMCA)**

<http://www.lmca.org.uk/>

LMCA is the umbrella body for national voluntary organisations working to meet the needs of people with long-term health conditions.

\*LMCA's Vision\*

Our vision is of a society in which people with long-term health conditions have control over their lives and can live them to the full.\*

## VII.

---

DEUTSCHES ÄRZTEBLATT ONLINE 02.05.2005 - P O L I T I K  
**BGH: Arzt muss Patienten eine Wahl der Therapie ermöglichen**

KARLSRUHE. Ärzte müssen ihre Patienten über Alternativen der Behandlung aufklären und ihnen die Wahl einer Therapiemethode ermöglichen. Kommen Ärzte dieser zusätzlichen Aufklärungspflicht nicht nach, haften sie für die Folgen der Behandlung, entschied der Bundesgerichtshof (BGH) in Karlsruhe in einem am 2. April veröffentlichten Urteil.

Im zugrunde liegenden Fall war das gebrochene und eingegipste Handgelenk einer Patienten nicht wie erhofft zusammengewachsen, sondern in einer Fehlstellung verheilt. Die Frau hatte den Arzt daraufhin verklagt, weil er ihr nicht mitgeteilt hatte, dass der Bruch auch durch erneutes Richten oder durch eine Operation hätte behandelt werden können, um die drohende Fehlstellung zu vermeiden. (AZ: VI ZR 313/03)

Dem BGH-Urteil zufolge ist die Wahl der Behandlungsmethode zwar zunächst Sache des Arztes. Gibt es aber mehrere Behandlungsmethoden mit jeweils unterschiedlichen Risiken und Erfolgschancen, muss der Arzt einen Patienten über diese Wahlmöglichkeiten informieren und ihm die Entscheidung überlassen auf welches Risiko er sich einlassen will.

Da der Arzt im zugrunde liegenden Fall seine konservative Behandlung trotz drohender Fehlstellung des Handgelenks fortgesetzt habe, ohne die Klägerin an der Entscheidung zu beteiligen, sei die Behandlung rechtswidrig gewesen. Der Arzt müsse deshalb für deren Folgen haften, heißt es im Urteil. /afp

\*Links zum Thema\*  
Bundesgerichtshof (BGH)  
<http://www.bundesgerichtshof.de>

## VIII.

---

Buchtipps:  
Norbert Schmacke. **Wie viel Medizin verträgt der Mensch?**  
KomPart Verlagsgesellschaft, Bonn/Bad Homburg 2005 ISBN: 3980662187

## IX.

---

JAMA 2005 (16);293;S 1995-2002

### **Influence of Patients? Requests for Direct-to-Consumer Advertised Antidepressants: A Randomized Controlled Trial**

Richard L. Kravitz, MD, MSPH; Ronald M. Epstein, MD; Mitchell D. Feldman, MD, MPhil; Carol E. Franz, PhD; Rahman Azari, PhD; Michael S. Wilkes, MD, PhD; Ladson Hinton, MD; Peter Franks, MD

\*Context\* Direct-to-consumer (DTC) advertising of prescription drugs in the United States is both ubiquitous and controversial. Critics charge that it leads to overprescribing, while proponents counter that it helps avert underuse of effective treatments, especially for conditions that are poorly recognized or stigmatized.

\*Objective\* To ascertain the effects of patients' DTC-related requests on physicians' initial treatment decisions in patients with depressive symptoms.

\*Design\* Randomized trial using standardized patients (SPs). Six SP roles were created by crossing 2 conditions (major depression or adjustment disorder with depressed mood) with 3 request types (brand-specific, general, or none).

\*Setting\* Offices of primary care physicians in Sacramento, Calif; San Francisco, Calif; and Roches-

ter, NY, between May 2003 and May 2004.

\*Participants \* One hundred fifty-two family physicians and general internists recruited from solo and group practices and health maintenance organizations; cooperation rates ranged from 53% to 61%.

\*Interventions \* The SPs were randomly assigned to make 298 unannounced visits, with assignments constrained so physicians saw 1 SP with major depression and 1 with adjustment disorder. The SPs made a brand-specific drug request, a general drug request, or no request (control condition) in approximately one third of visits.

\*Main Outcome Measures \* Data on prescribing, mental health referral, and primary care follow-up obtained from SP written reports, visit audiorecordings, chart review, and analysis of written prescriptions and drug samples. The effects of request type on prescribing were evaluated using contingency tables and confirmed in generalized linear mixed models that accounted for clustering and adjusted for site, physician, and visit characteristics.

\*Results \* Standardized patient role fidelity was excellent, and the suspicion rate that physicians had seen an SP was 13%. In major depression, rates of antidepressant prescribing were 53%, 76%, and 31% for SPs making brand-specific, general, and no requests, respectively ( $P < .001$ ). In adjustment disorder, antidepressant prescribing rates were 55%, 39%, and 10%, respectively ( $P < .001$ ). The results were confirmed in multivariate models. Minimally acceptable initial care (any combination of an antidepressant, mental health referral, or follow-up within 2 weeks) was offered to 98% of SPs in the major depression role making a general request, 90% of those making a brand-specific request, and 56% of those making no request ( $P < .001$ ).

\*Conclusions \* Patients' requests have a profound effect on physician prescribing in major depression and adjustment disorder. Direct-to-consumer advertising may have competing effects on quality, potentially both averting underuse and promoting overuse.

## X.

---

Ärzte Zeitung, 27.04.2005

### **Beratung von Patienten wird zentral organisiert**

BERLIN (hak). Die Krankenkassen wollen unabhängige Patientenberatung künftig in einem Modellverbund zentral organisieren. Ein entsprechendes Eckpunktepapier verabschiedeten die Spitzenverbände auf Arbeitsebene.

Danach soll eine Art Geschäftsstelle aufgebaut werden, die bundesweite Beratungsaufgaben (Internetauftritt, Qualitätsmanagement und Pressearbeit) langfristig übernimmt.

Die unkoordinierte Vielfalt der bestehenden 23 Beratungsstellen, die von den Kassen aktuell mit jährlich 5,113 Millionen Euro unterstützt werden, wäre dann Vergangenheit. Einzelheiten wollen die Kassen Mitte Mai beschließen.

Wer den Modellverbund führt, soll über Ausschreibungen geklärt werden. Bestehende Beratungsstellen bekommen keine Bestandsgarantie, können sich aber bewerben. Die Förderung der Projekte läuft zum 30. Juni aus. Neugestartet werden kann die Patientenberatung wahrscheinlich erst nach einer Pause.

## XI.

---

Ärzte Zeitung, 26.04.2005

### **Neue Datenbank über Angebote zur Patientenberatung**

Netzwerk in NRW gestartet

\*DÜSSELDORF (iss). Patienten in Nordrhein-Westfalen können sich jetzt einen schnellen Überblick über das Beratungsangebot im Gesundheitswesen verschaffen. Die nordrhein-westfälische Gesund-

heitsministerin Birgit Fischer (SPD) hat eine Datenbank freigeschaltet, die Angaben zu rund 1200 Beratungseinrichtungen enthält.\*

Das "Netzwerk Patientenberatung NRW" ist nach Angaben der Initiatoren bundesweit einzigartig. "Wir wollen den Patienten Transparenz darüber bieten, was im Gesundheitswesen geschieht", sagte Fischer. Um Eigenkompetenz und Eigenverantwortlichkeit der Patienten zu erhöhen, sei es wichtig, ihnen Zugang zu unabhängiger und neutraler Information zu verschaffen.

Das Netzwerk ist eine Initiative der Landesgesundheitskonferenz in NRW. An ihm beteiligen sich 24 Organisationen, darunter Ärztekammern und KVen, Landeskrankenhausgesellschaft, Kassen und Selbsthilfverbände. Das Netzwerk wird von den Kassen und dem Ministerium finanziell gefördert.

"Mit der Bestandserhebung ist ein Stück Pionierarbeit geleistet worden", sagte der Geschäftsführer der Arbeitsgemeinschaft Netzwerk Patientenberatung Dr. Michael Schwarzenau, im Hauptberuf Geschäftsführer der Ärztekammer Westfalen-Lippe. Die Vielfalt der Beratungseinrichtungen habe alle Beteiligten überrascht. Rund zwei Drittel der Angebote stammen aus der Selbsthilfe.

Die Mitglieder des Netzwerks haben für die Informations- und Beratungseinrichtungen, die in die Datenbank aufgenommen werden, Qualitätskriterien entwickelt. Die Nutzer können nach Schlagworten oder in der Freitextsuche recherchieren und die Suche regional eingrenzen.

"Die kontinuierliche Erweiterung der Datenbank bleibt eine Daueraufgabe des Netzwerkes", sagte Schwarzenau. Geplant ist, für die Berater eine Plattform über ein netzwerkeigenes Intranet zu schaffen.

Weitere Informationen unter  
<http://www.netzwerk-patientenberatung-nrw.de>

## XII.

---

Health Expectations, Volume 8 Issue 1 Page 34 - March 2005

### **The OPTION scale: measuring the extent that clinicians involve patients in decision-making tasks**

Glyn Elwyn, Hayley Hutchings, Adrian Edwards, Frances Rapport, Michel Wensing, Wai-Yee Cheung, Richard Grol

\*Objective \*To examine the psychometric properties of a revised scale, named 'observing patient involvement in decision making' (OPTION), by analysing its reapplication to a sample of routine primary care consultations. The OPTION instrument assesses to what degree clinicians involve patients in decision making.

\*Design \*Cross-sectional assessment of medical interaction by two calibrated raters.

\*Setting \*Primary care.

\*Participants \*Twenty-one general practitioners provided 186 consultations for assessment.

\*Measurements \*Observational score using the OPTION instrument.

\*Results \*Compared with the first version of the OPTION scale, the revised scale that uses a /magnitude/ instead of an /attitude/ scale, when applied to the same data set, resulted in improvement in the scale's reliability and to lower scores for the levels of involvement achieved by the practitioners. Factor analysis confirms that it is acceptable to regard the scale as a single construct. Although there is moderate variability when raters are assessed on an item by item basis, the agreements between raters at the level of the overall OPTION score is high (the intraclass correlation coefficient scores for total OPTION score was 0.77), a level that is acceptable for the evaluation of a set of consultations per practitioner (e.g. between 5 and 10 consultations), where aggregate scores would be used for determining overall performance.

\*Conclusions \*We conclude that OPTION is sufficiently reliable to be used for formal assessment at the level of the whole instrument (all 12 items)

### XIII.

---

aus Newsletter <http://www.evimed.ch>

#### **In der Sprache von Patienten sprechen**

**\*Frage:\***

Welchen Einfluss auf die Patientenzufriedenheit hat es, wenn der Hausarzt das nicht-medizinische Vokabular der Patienten in der Sprechstunde bewusst selbst anwendet?

**\*Hintergrund:\***

In der Sprechstunde ist die Kommunikation zwischen Patient und Arzt ein komplexer Prozess, der Auswirkung auf die Behandlung und Betreuung hat. Dabei kann die Wortwahl (medizinisches Vokabular oder Laienausdrücke) besonders bei Themen aus dem Intimbereich (z. B. Sexualität, urogenitale Beschwerden; Probleme mit dem Stuhlgang) die Qualität der Kommunikation beeinflussen.

**\*Einschlusskriterien:\***

- Erwachsene Patienten aus einer Praxis der Grundversorgung
- Patienten sprechen von sich aus Themen aus folgenden Bereichen an: Sexualität, Ausscheidungsfunktion (Blase/Darm), Anatomie.

**\*Ausschlusskriterien:\***

- Personen ohne Kenntnisse der englischen Sprache
- Blindheit oder deutliche Sehbehinderung
- Schwere mentale Beeinträchtigungen (z. B. Schizophrenie)

**\*Studiendesign:\*** Randomisierte, kontrollierte Studie

**\*Studienort:\*** Grundversorgerpraxis, England (Zeitraum des Patienteneinschlusses: keine Angabe)

**\*Intervention:\***

- Interventionsgruppe (?matched consultations?): Während der Konsultation konsequente Verwendung der jeweils von den Patienten bevorzugten Wortwahl aus den definierten Bereichen auch durch den Arzt (z. B. Hintern, ?Liebe machen?)
- Kontrollgruppe (?unmatched consultations?): Während der Konsultation konsequente Verwendung von medizinischem Vokabular aus den definierten Bereichen durch den Arzt (z. B. Defäkation, Urinieren, Geschlechtsverkehr)

**\*Outcome:\***

- Primär: Patientenzufriedenheit
- Sekundär: Zufriedenheit des Arztes mit der Konsultation

**\*Resultat:\***

- Von insgesamt 855 konsekutiven erwachsenen Patienten wiesen 713 keine Ausschlusskriterien auf.
- Von diesen 713 Patienten sprachen 62 Patienten von sich aus Themen aus den Bereichen Sexualität, Ausscheidungsfunktion und Anatomie an und wurden eingeschlossen (mittleres Alter: keine Angabe; 72% Frauen).
- 60 Patienten konnten ausgewertet werden (2 Patienten ohne Abgabe des Fragebogens).
- Die von den Patienten angesprochenen Themen kamen aus folgenden Bereichen: Symptome bei Wasserlassen, vaginale Blutungen, Verstopfung, Durchfall.
- Die Patienten benutzen Worte wie ?aufs Klo gehen?, ?Sex haben?, ?unten herum?, ?Pinkeln?.
- Der Score für die Patientenzufriedenheit in der Interventionsgruppe (?matched consultations?) war höher als in der Kontrollgruppe (?unmatched consultations?): siehe Tabelle.
- Die Zufriedenheit des Arztes mit der Konsultation war für beide Gruppen ähnlich.

**\*Kommentar:\***

- Die Studienfrage ist interessant, wirft jedoch bei dem gewählten Design (randomisierte Studie) verschiedene methodische Probleme auf: Da die Randomisierung vor dem definitiven Ein- oder Aus-

schluss in die Studie erfolgte, könnten unbekannte Störgrößen nicht zufällig zwischen den Gruppen verteilt sein; eine Verblindung des Arztes war verständlicherweise nicht möglich; es bleibt unklar, ob die Patienten sich ihrer Gruppenzuteilung bewusst waren; es war nur 1 Arzt und 1 Praxis beteiligt (schränkt die Übertragbarkeit der Ergebnisse ein)

- Es liegt keine Information vor, ob die Patientenfragebogen anonym ausgefüllt werden konnten.

- Die Autoren sprechen von "signifikant" höherer Zufriedenheit in der Interventionsgruppe und bezeichnen den gemessenen Unterschied als relevant (11 Punkte, unteres Ende des 95%-CI 3.4, auf einer Skala von 29-203). Die Grundlage für diese Aussage bleibt unklar.

\*Literatur:\*

Williams N. et al.: The impact of matching the patient's vocabulary: a randomized control trial. Family Practice 2004; 21: 630-635.

#### XIV.

---

Medical Care Volume 43(3) Supplement March 2005 pp I-42-I-47

##### **Assessing Patient Safety in the United States: Challenges and Opportunities**

Background: In 1999, the US Congress mandated the Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services (DHHS), to report annually to the nation about healthcare quality. One chapter in the National Healthcare Quality Report (NHQR) is focused on patient safety.

Objectives: The objectives of this study were to describe the challenges in reporting the national status on patient safety for the first NHQR and discuss emerging opportunities to improve the comprehensiveness and reliability of future reporting.

Research Design: This study is a selective review of definitions, frameworks, data sources, measures, and emerging developments for assessing patient safety in the United States.

Results: Available data and measures for patient safety assessment in the nation are inadequate, especially for comparing regions and subpopulations and for trend analysis. However, many opportunities are emerging from the recently increased investments in patient safety research and many ongoing safety improvement efforts in the private sector and at the federal, state, and local government levels.

Conclusion: There are many challenges in assessing national performance on patient safety today. Ongoing developments on multiple fronts will provide data and measures for more accurate and more comprehensive assessments of patient safety for future NHQRs.

#### XV.

---

Medical Care Volume 43(3) March 2005 pp 276-281

##### **Quantitative and Qualitative Differences Between Handout and Mailed Patient Satisfaction Surveys.**

Gribble, Robert K. MD; Haupt, Cherie BS, CPHQ

Background: Patient satisfaction surveys are widely used to measure patients' opinions of the quality of the health care they have received. There are a variety of methods for distributing patient satisfaction surveys. Different distribution methods may yield significantly different satisfaction ratings.

Objective: We sought to compare survey ratings obtained via 2 distribution methods: handout versus mailed.

Design: Patients were randomized to receive either a handout survey or a mailed survey.

Subjects: Patients who had an appointment with a family practice provider in one of the regional outpatient centers of a large medical clinic during a 3-week period.

Measures: An 11-item visit-specific patient satisfaction survey was used to survey patient satisfaction.

Results: Handout surveys yielded higher satisfaction scores than mailed surveys. The response rate was higher with handout surveys than with mailed surveys. However, handout surveys were returned with more skipped questions, a lower variation in ratings, and fewer written comments than the mailed surveys.

Conclusions: Both quantitative and qualitative differences between the 2 distribution methods were revealed. Attempts to compare data obtained from the 2 different distribution methods need to be approached with caution.

## XVI.

---

BMJ 2005;330:667-670, doi:10.1136/bmj.330.7492.667

### **Doctor-patient relationships in chronic illness: insights from forensic psychiatry**

Colin Campbell, Gill McGauley

## XVII.

---

BMJ 2005;330:633-636 (19 March), doi:10.1136/bmj.330.7492.633

### **Learning in practice**

#### **What should undergraduate medical students know about psoriasis?**

#### **Involving patients in curriculum development: modified Delphi technique**

Abdelaziz Alahlafi, Susan Burge

\*Objective\* To identify the content of a psoriasis curriculum for medical students.

\*Design\* Literature review and modified Delphi technique.

\*Setting\* Primary and secondary care in Oxfordshire and Buckinghamshire.

\*Subjects\* 19 dermatologists (7 teaching hospital consultants; 6 consultants in district general hospitals; 6 registrars); 2 general practitioner senior house officers working in dermatology, 5 dermatology nurses, 7 rheumatologists, 25 general practitioner tutors, and 25 patients with chronic psoriasis.

\*Main outcome measures\* Percentage of agreement by participants to items derived from literature and our existing psoriasis syllabus.

\*Results\* 71 (84.5%) of 84 questionnaires were returned. A 75% level of consensus was reached on key items that focused on the common presentations of psoriasis, impact, management, and communication skills. Students should be aware of the psychosocial impact of psoriasis, examine the skin while showing sensitivity, and be able to explain psoriasis to patients in a way that enables patients to explain the condition to others.

\*Conclusions\* The panels identified the important items for a psoriasis curriculum. The views of patients were particularly helpful, and we encourage educators to involve patients with chronic diseases in developing curriculums in the future. The method and results could be generalised to curriculum development in chronic disease.

## XVIII.

---

This article 1st appeared on 2005-02-14 in HHN Most Wired online site.

<http://www.hhnmostwired.com/>

### **Evidence-Based Medicine Gets Personal**

By Michael L. Millenson

At a time when so-called "consumer-driven health plans" are starting to establish themselves as a prominent part of the health insurance landscape, a very different sort of consumer-driven movement is quietly promising to revolutionize the delivery of care.

The clinical version of consumer-driven care involves the routine therapeutic use of detailed and highly individualized health information. The phenomenon has been called personalized medicine, prospective medicine or information therapy. Whatever the label, the ultimate impact on providers promises to be profound. Take the burgeoning science of genomics, stir in the sophisticated capabilities of medical information technology systems and place the whole mixture into the hothouse environment of evidence-based medicine. It's a recipe guaranteed to breed extraordinary change in the breadth and depth of information available for treatment decisions.

#### Infomedicine on the way

Although far too many hospitals still believe that bar coding pharmaceuticals is the latest in high tech, an eclectic group of institutions around the country is pioneering genuine "infomedicine." Some initiatives involve well-known organizations. The Mayo Clinic and IBM, for example, are using pattern recognition and data mining to help doctors determine how patients with a similar gender, age and medical history are likely to respond to treatment. IBM is also helping Mayo identify candidates for clinical trials by drawing on databases of patient genomic and proteomic information. Why are they using both to determine candidates? A University of Minnesota expert explains: "DNA is just predisposition. Protein is function."

Meanwhile, Duke University, already working to develop individualized predictive information on cardiovascular disease and infectious disease, recently hired a molecular cardiologist as director of its new Center for Genomics Medicine in order to help connect "leading-edge genome science to leading-edge clinical medicine."

But it's not just the biggest names exploring this new territory. Hartford (Conn.) Hospital, in collaboration with local biotech firm Genomas, is drawing on genetic technology to develop "customized and evidence-based clinical programs" to treat obesity, metabolic syndromes and diabetes. In Milwaukee, Aurora Health Care is using genetic data to develop individualized patient care plans designed to prevent venous thrombosis. And Dallas' Baylor Health Care System has formed a separate for-profit subsidiary to develop individualized cancer treatments based on the material from a patient's own cells.

Consumers are also getting involved. Use of genetic tests to pinpoint a predisposition to breast or ovarian cancer or Alzheimer's disease is so widespread that Francis Collins, head of the Human Genome Project, was asked to speak on the topic to the American Academy of Family Practice. Separately, the American Medical Association is offering continuing medical education on genetic therapy.

#### Personalized medicine

What is less appreciated as yet is the potential for personalized medicine to spread across the treatment continuum. With today's tools, for example, a woman with a family history of breast cancer can explore genetic factors in an interactive Web guide. If she is later diagnosed with cancer, she can input her specific clinical signs into a separate Web-based interactive tool and be matched with evidence-based therapies that apply to "patients like me." She can, of course, also examine evidence-based treatment guidelines. The patient may then have one more question: "Is my physician, and my hospital, as well-informed as I am?"

The availability of genomic-guided therapy at some institutions will increase the pressure on all institutions to use similarly sophisticated information. This pressure dovetails with a growing use of hospital-specific and physician-specific outcomes information propelled by the financial incentives in that "other" version of consumer-driven health care. Some health insurers are already musing about customizing insurance coverage based on how effective a treatment is for an individual; e.g., patients could pay more out-of-pocket if they choose a treatment that is not "best" and, perhaps, an institution that is not "best."

#### A bright future

Infomedicine is not a futurist fantasy; it is on providers' doorsteps today. Pharmaceutical and device

companies are already pouring millions of dollars into the development of personalized therapies; hospitals and physicians must be prepared with the knowledge necessary to scrutinize those therapies, discuss them with patients and advocate for reimbursement as appropriate. Medical IT systems will be required to process more than the traditional clinical variables, such as lab values; they'll also be asked to include information ranging from drug reactivity data based on genomic analysis to individualized patient treatment preferences based on in-depth standardized questionnaires.

The traditional cottage industry structure of health care cannot hope to cope with the complex and intense financial, clinical and ethical challenges that personalized medicine will pose. Changing the way providers process information is no longer optional, it's urgent. And that's good news.

*\*/Michael L. Millenson,\*/ based in Highland Park, Ill., is an author, consultant and a visiting scholar at Northwestern University's Kellogg School of Management./*

## **XIX.**

---

JAMA Volume 293(10) 9 March 2005 p 1223?1238

### **Effects of Computerized Clinical Decision Support Systems on Practitioner Performance and Patient Outcomes: A Systematic Review.**

Garg, Amit X. MD; Adhikari, Neill K. J. MD; McDonald, Heather MSc; Rosas-Arellano, M. Patricia MD, PhD; Devereaux, P. J. MD; Beyene, Joseph PhD; Sam, Justina BHSc; Haynes, R. Brian MD, PhD

**\*Context\*:** Developers of health care software have attributed improvements in patient care to these applications. As with any health care intervention, such claims require confirmation in clinical trials. **\*Objectives\*:** To review controlled trials assessing the effects of computerized clinical decision support systems (CDSSs) and to identify study characteristics predicting benefit.

**\*Data Sources\*:** We updated our earlier reviews by searching the MEDLINE, EMBASE, Cochrane Library, Inspec, and ISI databases and consulting reference lists through September 2004. Authors of 64 primary studies confirmed data or provided additional information.

**\*Study Selection\*:** We included randomized and nonrandomized controlled trials that evaluated the effect of a CDSS compared with care provided without a CDSS on practitioner performance or patient outcomes.

**Data Extraction:** Teams of 2 reviewers independently abstracted data on methods, setting, CDSS and patient characteristics, and outcomes.

**\*Data Synthesis\*:** One hundred studies met our inclusion criteria. The number and methodologic quality of studies improved over time. The CDSS improved practitioner performance in 62 (64%) of the 97 studies assessing this outcome, including 4 (40%) of 10 diagnostic systems, 16 (76%) of 21 reminder systems, 23 (62%) of 37 disease management systems, and 19 (66%) of 29 drug-dosing or prescribing systems. Fifty-two trials assessed 1 or more patient outcomes, of which 7 trials (13%) reported improvements. Improved practitioner performance was associated with CDSSs that automatically prompted users compared with requiring users to activate the system (success in 73% of trials vs 47%;  $P = .02$ ) and studies in which the authors also developed the CDSS software compared with studies in which the authors were not the developers (74% success vs 28%; respectively,  $P = .001$ ).

**\*Conclusions\*:** Many CDSSs improve practitioner performance. To date, the effects on patient outcomes remain understudied and, when studied, inconsistent.

## **XX.**

---

JAMA Volume 293(10) 9 March 2005 p 1239?1244

### **The Unintended Consequences of Publicly Reporting Quality Information**

Werner, Rachel M. MD, PhD; Asch, David A. MD, MBA

**\*Abstract\***

Health care report cards publicly report information about physician, hospital, and health plan quality in an attempt to improve that quality. Reporting quality information publicly is presumed to motivate quality improvement through 2 main mechanisms. First, public quality information allows patients, referring physicians, and health care purchasers to preferentially select high-quality physicians. Second, public report cards may motivate physicians to compete on quality and, by providing feedback and by identifying areas for quality improvement initiatives, help physicians to do so. Despite these plausible mechanisms of quality improvement, the value of publicly reporting quality information is largely undemonstrated and public reporting may have unintended and negative consequences on health care. These unintended consequences include causing physicians to avoid sick patients in an attempt to improve their quality ranking, encouraging physicians to achieve "target rates" for health care interventions even when it may be inappropriate among some patients, and discounting patient preferences and clinical judgment. Public reporting of quality information promotes a spirit of openness that may be valuable for enhancing trust of the health professions, but its ability to improve health remains undemonstrated, and public reporting may inadvertently reduce, rather than improve, quality. Given these limitations, it may be necessary to reassess the role of public quality reporting in quality improvement.

---

## Disclaimer/Impressum

\*\*\*\*\*

Der Inhalt dieser Nachricht ist ausschließlich für den bezeichneten Adressaten bestimmt. Die Nachricht wurde durch einen Virenschanner auf Viren und sonstigen schädlichen Inhalt geprüft, jedoch wird keinerlei Haftung für Schäden wegen Viren übernommen. Auch wird keine Haftung für Schäden übernommen, die aus einer Veränderung des Inhalts dieser Nachricht durch Dritte entstehen können.

Für den Inhalt der Nachrichten übernehmen wir keinerlei Gewähr. Sie sind nicht als Meinungsäußerung des Förderschwerpunktes oder einzelner Mitglieder zu verstehen.

Erscheinungsweise: unregelmäßig

\*\*\*\*\*

Redaktion, ViSdP:  
Prof. Dr. med. David Klemperer  
Kontaktadresse Newsletter:  
Fachhochschule Regensburg, Fachbereich Sozialwesen  
Seybothstraße 2  
93053 Regensburg  
Email: [klemperer@klemperer.info](mailto:klemperer@klemperer.info)  
Website: <http://www.klemperer.info>

\*\*\*\*\*

Kontaktadresse Förderschwerpunkt "Der Patient als Partner im medizinischen Entscheidungsprozess":  
PD Dr. Dr. Martin Härter  
Universitätsklinikum für Psychiatrie und Psychosomatik  
Abt. Psychiatrie und Psychotherapie  
Hauptstr. 5  
79104 Freiburg  
Email: [martin\\_haerter@psyallg.ukl.uni-freiburg.de](mailto:martin_haerter@psyallg.ukl.uni-freiburg.de)  
Website: <http://www.patient-als-partner.de>