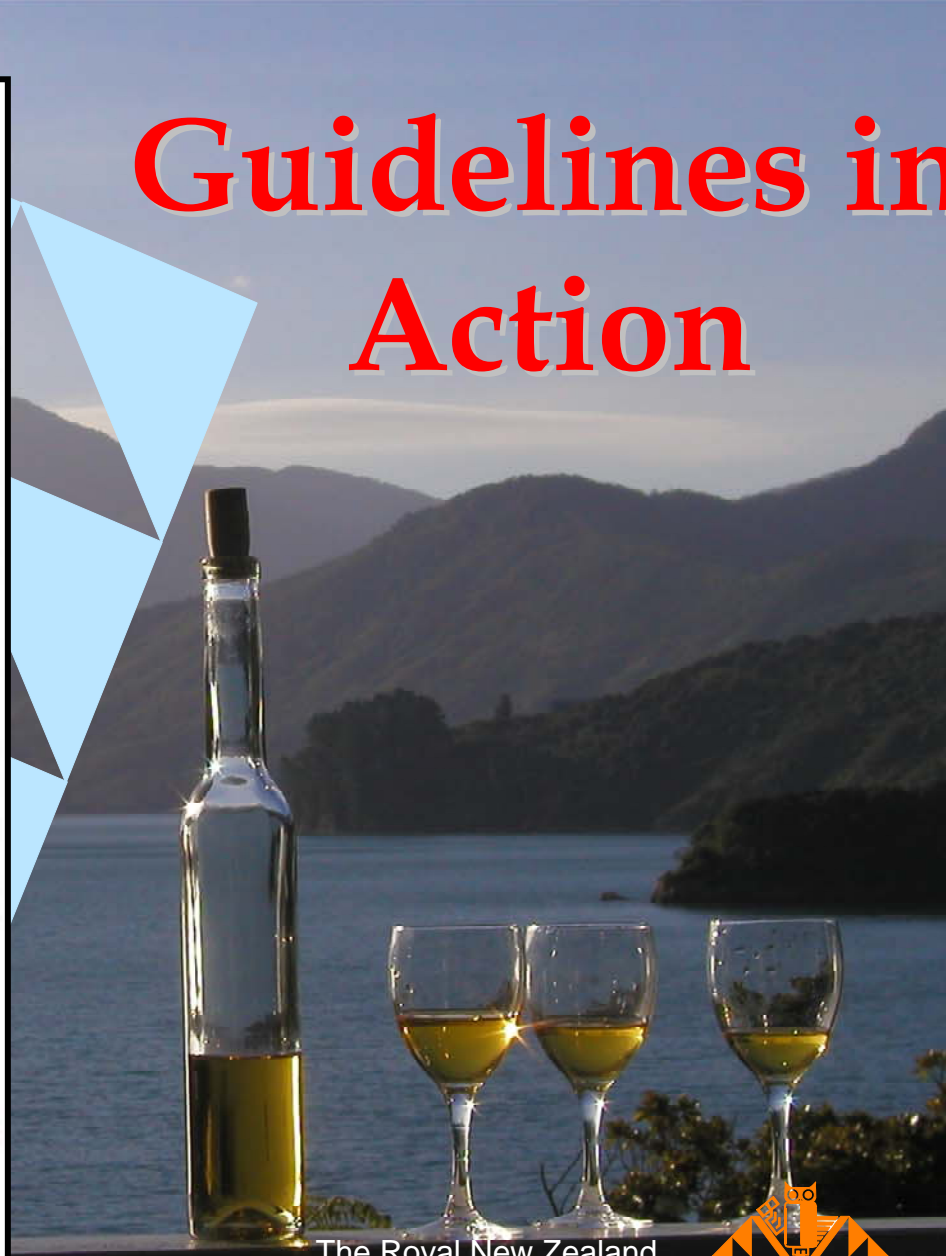


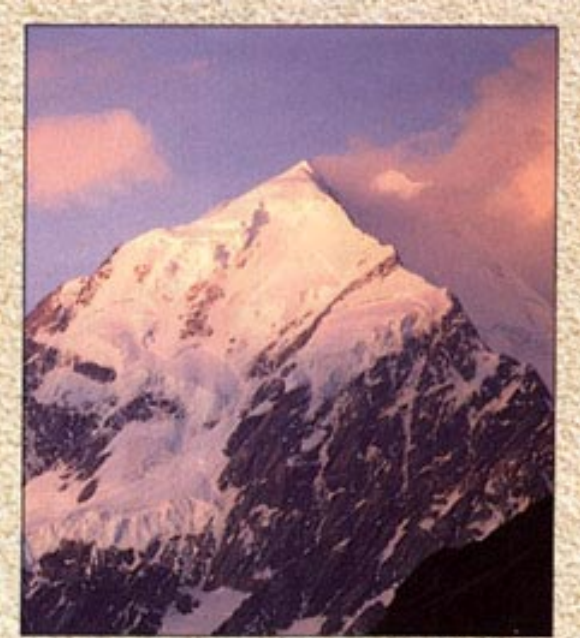
# Guidelines in Action



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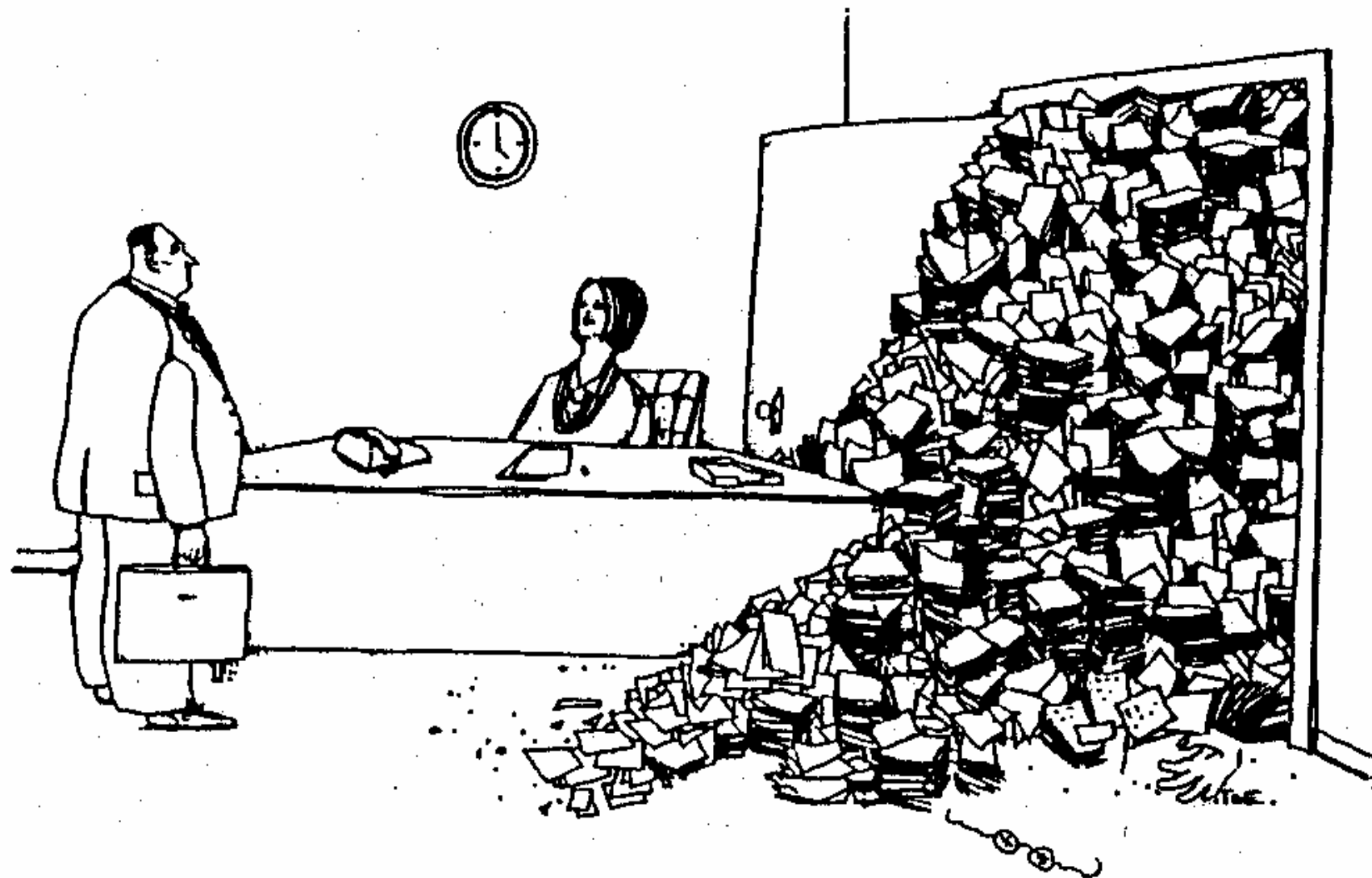


**AORAKI (Mt Cook) B. High**





ISS005E21472



"Dr. Hartson can't see anyone until he's finished his paperwork."

# Innovation in guideline implementation



# End user issues for guidelines

- **Patients**
- **Doctors, nurses**
- **Medicolegal standards setters**
- **Regulators**
- **Funders, planners**
- **Public health**



# Implementation in the swamp:

Education: large, small

Peer groups: controlled

Experts

Reminders: timely and outreach

Facilitation: outreach?

Audits/templates

Limitations on prescribing:

ranging from rigid to flexible: Mooda

# Muriel

- **90 years PH bronchial telangectasia**
- **AF, minimal failure, osteoarthritis, moderate renal failure, can't drive, not hypertensive, no strokes**
- **Assessment: high risk by virtue of age (off the chart)**
- **Discussed options: chose aspirin...had trouble relating to 5 year survival rate**

# Muriel continued

- Admitted following a fall, discharged on warfarin. Anaemia develops
  - Patient brings up issue of osteoporosis and hip fractures but decides against Rx because
  - “I’m 90 and I don’t feel that extra years matter now”
  - When asked about warfarin
- “But the hospital doctor said I had to....”

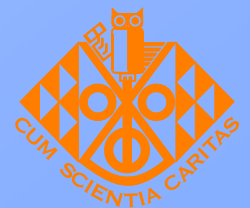
# Guideline implementation problems in NZ

Effective implementation of guidelines requires more than guidelines endorsement by policy stakeholders and passive dissemination strategies, but rather an understanding of the issues facing general practitioners and their attitudes to guideline use.

McKinlay, McLeod et al. **Clinical practice guidelines' development and use in New Zealand: an evolving process** NZMJ 6 August 2004, Vol 117 No 1199 Page 1 of 11

# Australia

- **Unrealistic patient expectations**
- **Time**
- **Skills and money**
- **Attitude of GP**



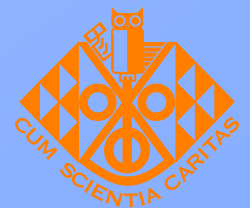
- **The largest single barrier, noted by almost half these Australian GPs, was that patients demand treatment despite a lack of evidence of effectiveness, and one GP in five was concerned about unrealistic patient expectations driving treatment choice, rather than the evidence.**
- **Time was a huge problem, whether for locating, reading and appraising evidence, or for discussing the evidence with patients.**
- **One in four GPs was worried about the cost of purchasing resources for evidence-based practice, and lack of skills was important to a minority of GPs.**

# Proposals from McKinlay et al

- **Strategy to ensure recognisability of NZGG guidelines**
- **Strategy to identify stakeholders**
- **Strategy to address guideline development priorities**
- **Strategy to address the need for appropriate information**
- **Strategy to address guidelines implementation issues**

# Suggestions

- Evidence based guideline planning
- Evidence based guideline implementation
- Rationalisation of guideline production
- Guidelines focused on evidence
- Guidelines tailor made to the end user (not a one guideline does all)
- KISS





# Are we missing something?

ZEISS

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# Patients

Who makes the final choice?

Using what?

Opinion or numbers?

Numbers are universal

Comprehension is contextual and cultural

# *H&DC Code Right 6*

## *Right to be Fully Informed*

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including

.....

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option;

.....

**USA**

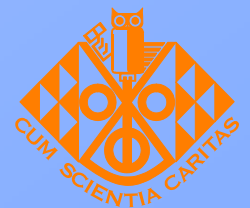


# Public enthusiasm for Cancer Screening in the United States

Schwartz et alH. Gilbert Welch, MD, MPH *JAMA*. 2004;291:71-78

- **A substantial proportion believe that an 80-year-old who chose not to be tested was irresponsible: ranging from 41% with regard to mammography to 32% for colonoscopy.**

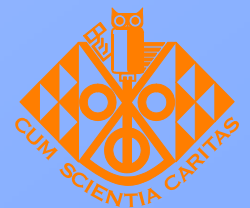
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# Risk?

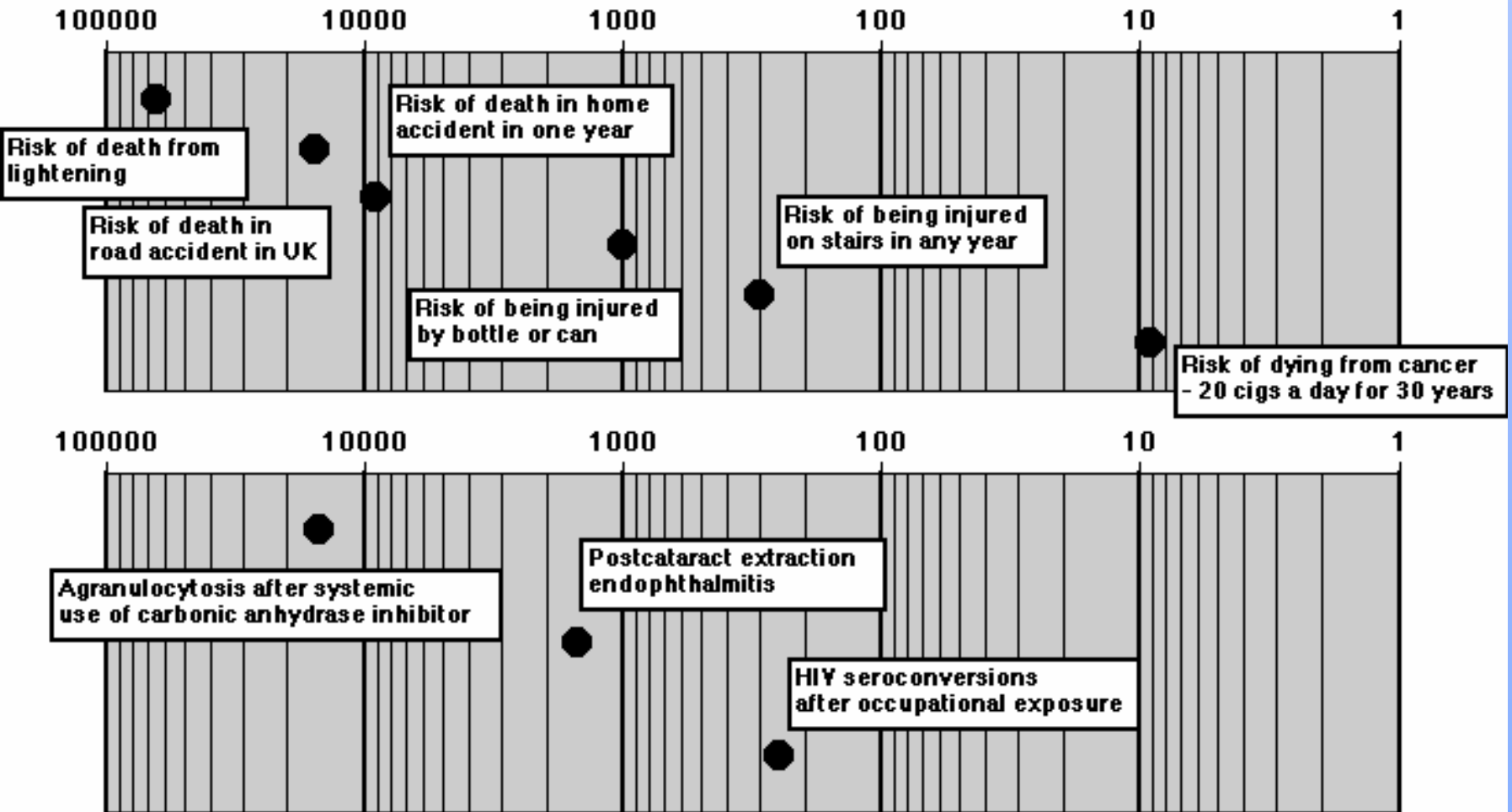
Quantifiable  
Applicable to health, injury etc  
Behavioural

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# Risk assessment

The risk for any event is 1 in:



**Reference:** AD Singh, J Paling. Informed consent: putting risks into perspective. Survey of Ophthalmology 1997 42: 83-6.

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# Assessing risk: the ideal process

- identify possible options (car versus motorcycle)
- identify the consequences of each option
- evaluate the desirability or otherwise of each consequence (*and the benefit of each activity*)
- estimate the likelihood of each consequence
- combine all these according to some rational decision rules

From Bandolier

# Does prevention based on risk change behaviour?

....unrealistic optimism as being a major contributor to why people do not use precautionary behaviours - with an underestimate of one's own risk and an overestimate of the risk of others as being contributory to this.

.....providing risk information is generally not sufficient to change behaviour. Other factors, such as the efficacy and costs of preventative behaviour, social pressure and perceived self-efficacy play a major role in helping people to change their behaviour. It is just not enough to give people the facts.

J van der Pligt. Perceived risk and vulnerability as predictors of precautionary behaviour. British Journal of Health Psychology 1998 3: 1-14.

# Experience

Risk of death from  
gliding 1 in 1700/year  
Modify for



# Intervention

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# **Patients acceptance of cholesterol lower medication at NNT of 71 over 5 years**

- **Relative risk reduction** **88%**
- **Absolute risk reduction** **42%**
- **NNT** **31%**
- **Gain in disease years** **40%**
- **Stratified gain** **56%**

**Hux JE, Naylor CD**

**Communicating the benefits of chronic preventative therapy**

# How good are NNT's for patients

## Medication for hip fracture prevention

NNTs of	10	50	100	400
Acceptance	65%	61%	63%	57% (NS)
Postpone hip fracture by	1 month	6 months	1 year	4 years
Acceptance	25%	40%	39%	53%

**Christensen PM, Brosen K, Brixen K, Andersen M, Kristiansen IS.**

**A randomized trial of laypersons' perception of the benefit of osteoporosis therapy**

Clin Ther. 2003 Oct;25(10):2575-85.

# How good are NNT's Medication for hip fracture prevention

- Forty-three percent of respondents indicated that the concept of NNT was difficult to understand,
- 38% interpreted NNT in a way that was probably incorrect.

**Christensen PM, Brosen K, Brixen K, Andersen M, Kristiansen IS.**  
**A randomized trial of laypersons' perception of the benefit of osteoporosis therapy**

Clin Ther. 2003 Oct;25(10):2575-85.

# Intervention benefit:

## Doctors' perception of NNT

Hypothetical drug to prevent premature death over 5 years

NNT of 50 71.6% would prescribe

NNT of 200 52.3%

- 36% of the doctors would not prescribe the drug,
- 77.4% of those agreed with an argument stating that only one out of NNT patients would benefit from the treatment.

Doctors (< 36 of age) more sensitive to the difference in NNTs.

Halvorsen PA, Kristiansen IS, Aasland OG, Forde OH. Medical doctors' perception of the "number needed to treat" (NNT).

Scand J Prim Health Care. 2003 Sep;21(3):162-6.

Information framing had some effect on family physicians' intentions to prescribe HRT, but the effects were smaller than those previously reported, and they were modified by the presence of serious potential adverse treatment effects.  
(Australia)

**Nikolajevic-Sarunac J, Henry DA, O'Connell DL, Robertson J. Effects of information framing on the intentions of family physicians to prescribe long-term hormone replacement therapy.**

J Gen Intern Med. 1999 Oct;14(10):591-8.

NNT always represents the intrusion of population-based reasoning into clinical decision-making.

**Dowie J.** The 'number needed to treat' and the 'adjusted NNT' in health care decision-making.  
J Health Serv Res Policy. 1998 Jan;3(1):44-9.

# Summary

**We need better methods of presentation of  
risk/harm/benefit to patients  
Something of personal impact**

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**Kia ora tatou**

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