The future of medicine: truly shared decision making

Could the public play a greater role in helping reform the healing profession?

One of the welcome shifts under way in medicine is the move towards “shared decision making,” where hubris and hierarchy give way to humility and equality. Part of a wider reshaping of the roles and responsibilities of patients and professionals, the shift is challenging the long held belief that doctors know best. Rather than experts who persuade, in the new model the professionals support people in making more informed decisions about their health. But what if we take this notion of a meeting of equals seriously? Could people help professionals to make more informed decisions? Not by offering tips to the surgeon from the operating table but rather by citizens playing a more active role in some of the big and pressing debates about the future health of medicine.

As more and more voices inside the medical establishment identify the problem of too much medicine (bmj.com/too-much-medicine), a broader conversation with a wider public may be indicated. With calls to put the very culture of medicine under increasing scrutiny, perhaps we need more playwrights and poets and philosophers looking down the microscope too—searching for those unhealthy myths that may do more harm than good.

One such unhealthy myth underpins the way we commonly think about defining, diagnosing, and treating disease: the perceived dichotomy between patient and doctor. On the one hand is the rational doctor, working with objective and reliable evidence on disease and how best to treat it. On the other hand there’s the emotional patient, presenting the subjective and unreliable experience of their symptoms and illness. It’s a powerful old dichotomy, still deeply etched in our thinking about science and medicine, yet surely it demands a major reality check.

The definition of “disease” is itself highly controversial, with one camp arguing that diseases are defined by objective malfunctioning and another arguing they’re more the product of culture than of nature. The boundaries defining disease are often arbitrary: a simple line on a graph that could medicalise millions of people overnight may have been drawn by a group of tired individuals at the end of a long day in a poorly lit hotel room. Reliability of the tools to “diagnose” these “diseases” is often poor, resulting in all manner of false results and the potential for unnecessary labelling and harm. As to the data on treatments, the evidence based folks and the research on conflicts of interest have shown many examples of poor evaluation and a systemic bias in industry funded studies, which make it extremely hard to divine the difference between unreliable marketing and reliable medical information. Wider public appreciation of these uncertainties and their implications for human health is long overdue.

Similarly, medicine’s love affair with surrogate outcome measures warrants much more widespread scrutiny. Clearly surrogates can prove extremely valuable, such as in testing new treatments for life threatening new illnesses. But reliance on surrogates to demonstrate success—rather than genuine improvements in health—can be disastrous. Flecainide reduced irregular heartbeats but killed thousands. Long term hormone replacement drugs lowered concentrations of “bad cholesterol” but raised the risks of heart attacks and strokes. The fact that surrogates are still so prominent in medical research and regulation is another sign that we need more shared decision making—about the future of medicine.

The tendency to individualise and medicalise problems caused by a suite of social or environmental factors is another issue ripe for more vigorous debate. Should the growing “epidemic” of type 2 diabetes be conceived primarily as a medical problem caused by endocrine malfunctioning that requires mass surveillance and mass medication or a masking of the results of misguided policies on transportation, advertising standards, and workplace design?

In a sense these are the easy questions; it’s harder to know how medicine might reach outside itself more effectively. The popular work of writers such as Ben Goldacre and others is helping to bring greater public attention to these debates, particularly about relations with the industry. For generations the relationship has provided doctors with free food, flattery, and friendship, but now a wider friendship group might bring in fresh ideas—and not just the stale smiles of marketing reps selling spin.

Perhaps medical journals and professional associations could play more of a role in providing space for informed thinkers outside medicine. Perhaps citizens’ groups could augment the population’s health literacy to help build a more coherent and confident public voice to take part in debates about too much medicine. Citizen juries, town hall meetings, and social media networks are other obvious ways to engender discussion.

Just as when we’re sick or uncertain about our health a meeting with a doctor can offer much needed help in making a decision, confronting the unhealthy nature of medical excess and drilling deep into its causes may well be made easier by sharing decisions with a few more of those outside the surgery.

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EDITORIAL, p 7, ANALYSIS, p 21, PERSONAL VIEW, p 27

bmj.com
Articles from the BMJ on shared decision making are at bmj.com/bmj-series/shared-decision-making

Analysis: Shared decision making: really putting patients at the centre of healthcare (BMJ 2012;344:e256)

bmj.com/podcasts
What can patients get online that they’re not getting from clinicians?
Cameron’s cave-in is a boost to the tobacco industry

The government should reflect on its responsibility for the deaths and suffering it could have prevented but didn’t

On 29 April 2010 the Australian government announced it would introduce plain packaging of tobacco products as part of a comprehensive approach to reducing the prevalence of smoking. The legislation came into effect on 1 December 2012. The tobacco industry openly acknowledges packaging as its core form of promotion, and all tobacco advertising and promotion have been banned in Australia since 1992. This legislation closed a major remaining promotional door.

The three tobacco companies that dominate the Australian market opposed plain packaging fiercely. They spent tens of millions of dollars on advertising, lobbying, consultants’ reports, misleading surveys, campaigns aimed at retailers, and covert operations. Having for two decades operated like cockroaches that spread disease but avoid sunlight, the three companies publicly re-emerged to defend their last bastion of marketing. British American Tobacco (BAT) even took to Twitter.

They argued that plain packaging would “not work” but also that this allegedly useless policy would put retailers out of business. That it would be a massive step towards the end of freedom, as a military officer boomed in a television campaign from Imperial. That it was against the constitution and international trade agreements and would cost the government billions in legal costs and compensation. That it would be impossible to implement in the proposed timeframes. That it would cause a dramatic boost to the illegal tobacco trade (the official estimates are that this is 1-2% of the market—they claimed a wonderfully precise 15.9%) and would result in an influx of “Chinese gangs.” That it would cause long queues at retail outlets. And that it should not be introduced because nobody had ever done it before.

The industry’s arguments in the United Kingdom were similar, apart from the claim that nobody else had done it. As in Australia, the industry tried to discredit the evidence, the research, the minister, the government, the health department, health organisations, and tobacco control advocates.

In Australia, the minister, government, and department remained resolute. Backing from all parliamentary parties was confirmed after the opposition’s most senior doctor in parliament, the general practitioner Mal Washer, robustly declared to the media, “The tobacco industry is jumping up and down because they’re worried about their businesses. I support these reforms unequivocally, and whatever my party decides to do I don’t give a shit.”

Since the introduction of plain packaging in Australia, all the companies’ dire predictions have come to naught. Implementation has been smooth, notwithstanding industry attempts at distraction. The biggest losers in legal expenditure so far have been the tobacco companies, which not only humiliatingly lost their High Court challenge 6-1 but had to pay the government’s costs.

In the UK, as in Australia, the case for plain packaging as part of a comprehensive public health approach was compelling—indeed stronger, as the prevalence of smoking in the UK is higher and has remained at a plateau in recent years.

But after clear earlier indications that it intended to act, the government has backed off. Whitehall sources reportedly cited other priorities (a long way from Disraeli’s view on the health of the people as the highest priority) and the lack of evidence of the effects thus far in Australia. This is a nonsensical argument, given that the main goal of plain packs has always been to see future generations of children grow up never having seen a box of 60 carcinogens beautifully packaged like a designer consumer good. No one aged under 21 in Australia has ever seen a local tobacco advertisement, and smoking by young people is lower than it has ever been.

The UK government’s decision to favour the interests of tobacco companies over public health is all the more disturbing because many countries still look to the UK for a lead in this area. In a world where six million people die each year because they smoke, the UK government’s simpering cave-in will provide great encouragement to this lethal industry, which is eager to sell as many cigarettes as possible, with minimal constraints, to vulnerable populations in developing countries.

Overwhelming support from international and national health authorities and from the UK government’s own public health minister has been overridden by a government with a senior minister, Kenneth Clarke, who was formerly deputy chairman of BAT, and a former adviser to the prime minister, Lynton Crosby, whose Australian company still proudly proclaims its association with the tobacco industry.

Since 1950, when the BMJ published the first unequivocal evidence that smoking killed, smoking has been responsible for well over seven million British deaths. The government and industry alike know that cigarettes kill one in two regular users.

When Australia’s former health minister Nicola Roxon was asked about the need for action at the launch of the report that recommended plain packaging, she said, “By not acting we are killing people.” The UK prime minister and his colleagues would do well to reflect on their responsibility for the deaths and suffering that they could have prevented.

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