PROMOTING CONSUMERS’ DEMAND FOR EVIDENCE-BASED MEDICINE

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Abstract
The widespread implementation of rationing and priority-setting policies in health care opposes the stochastic practice of medicine induced by professional uncertainty and professional vested interests in market-oriented clinical environments. It also clashes with consumers’ overly optimistic and “mythical” view of the effectiveness of medicine, which is bound to support a potentially unlimited provision of health services. Thus, for consumers and society at large, it is necessary to create conditions favorable for a more conscious demand of evidence-based health care. In pursuit of this goal, we suggest the adoption of a community-oriented strategy based upon delivery of information to the public in order a) to generate greater awareness (“healthy skepticism”) among consumers, through disclosure of data on the true effectiveness of health care interventions and on the existing variation in their utilization, and b) to provide tools to empower consumers in dealing better with both the uncertainty in their own individual patient-physician relationships and with the health policy issues to be faced in the future. Such a community-oriented strategy could also reinforce and support, through the generation of a “bottom-up” pressure from consumers toward physicians, a wider adoption of evidence-based interventions by health care professionals. This paper, using data from surveys on public opinions and attitudes toward the practice of medicine, focuses on how consumer demand for more evidence-based medical practice can be promoted.

Recently we have witnessed the birth and diffusion of a cultural movement promoting scientific information as the basis for clinical decisions concerning the use of diagnostic, therapeutic, and preventive interventions. The evidence-based medicine movement has provided the basic stimulus and inspiration for the organization of the Cochrane Collaboration network (1), which makes available to clinicians the updated results of systematic reviews on the effectiveness of an increasing number of health care interventions (12;13). The rationale underlying these efforts is to provide individual clinicians with the best updated scientific information in order to reduce their uncertainty, promote the delivery of effective interventions, and

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minimize the waste of resources in health care represented by the use of ineffective medical or surgical procedures.

It is questionable whether these efforts will succeed, however, without being supported by and integrated with other strategies aimed at creating, in the clinical environment and society at large, a culture willing to accept scientific information as its frame of reference. Moreover, it is worth exploring whether, among the many strategies aimed at promoting evidence-based medicine currently under scrutiny (6), there is any role for those targeted to the general public. As consumers are the potential beneficiaries of health care, they have an obvious vested interest in encouraging and supporting the use of those procedures more likely to provide benefit than harm. Therefore, efforts to promote the adoption of interventions proven effective and to discourage those proven ineffective should, in principle, find natural allies among consumers and in the public at large.

Although the creation of an evidence-based culture and practice of medicine among health professionals is increasingly acknowledged to be a difficult enterprise, it is even more difficult to target the same complex message to lay people. Among the many obstacles to be overcome, the main ones are: a) the myth surrounding the effectiveness of medicine, still prevalent among the public; and b) the paternalistic patient-physician relationship, still predominant in the clinical environment of many countries.

MEDICAL PRACTICE FROM THE CONSUMERS’ POINT OF VIEW: AN EXACT SCIENCE

In June 1997 we conducted a survey on a representative sample of 1,000 citizens in Switzerland, the United Kingdom, Germany, France, and Italy. Not surprisingly, it was found that approximately 70–80% of participants stated that medicine was to be considered an “exact (or almost exact) science” (Figure 1). Far fewer Swiss
physicians (8–40%, depending upon medical specialty) shared that view. Medical science, and accordingly medical practice, seem to be perceived by the public as a scientific practice. Much of this view is due to the influential role of the mass media. Every discovery of a new gene or procedure by biologists and every innovation in health care are touted by the media as a major achievement that will immediately and inevitably lead to benefit for the population, either reducing the burden of disease or increasing life expectancy. This type of reporting by the media contributes to giving the medical community a demiurgic image, increasing public hopes and expectations, and eventually fostering uncritical demand for health care services.

Therefore, it is urgent to promote a “healthy skepticism” about the actual effectiveness of health care interventions among consumers. Better acknowledgment by the public of the stochastic nature of medicine and of the uncertainty and pitfalls of many medical and surgical procedures (8:15) is an essential step toward consumer empowerment and the creation of demand for evidence-based medical practice.

WHICH DOCTOR-PATIENT RELATIONSHIP?

In the framework of the survey mentioned above, questions concerning the patient-physician relationship were also asked. Figure 2 shows the proportion of respondents who declared that they have an “active role” in dealing with their doctors, that is, who agreed with the statement “After I have listened to my doctor’s opinion, I make my own decision about the treatment option I would like to receive.” The highest agreement was in the United Kingdom, where 16% responded as having an active role in their treatment. About 50% of the national samples (in particular in the United Kingdom, France, and Italy) agreed with the statement “I leave all the burden of the decision to my doctor,” thus suggesting an attitude favoring a passive role. It seems that such a passive pattern of interpersonal relationships

![Figure 2. Results from telephone survey (1997). Doctor-patient relationship. Percentage of patients who report taking an active role.](image-url)
Figure 3. Components of consumer empowerment.

would be less favorable to a shared exchange of doubts and certainties, and to a shared search for therapeutic options more likely to fit with patient’s values and preferences.

EMPOWERING THE PUBLIC

According to the editor of the British Medical Journal, today’s health consumer environment is conducive to a “folie à deux” relationship, where “the public like the idea that doctors will cure them or keep them from death.” (15) This commonly held, overly optimistic belief about medical practice has supported the view that medicine is somehow similar to car repair.

The time is ripe for consumer empowerment (2). This can be encouraged through community programs aimed at promoting better self-management of health at the individual level and greater awareness about the yield of health care interventions (Figure 3). There is some empirical evidence supporting the effectiveness of such an approach.

In 1984 in Canton Ticino, Switzerland, a public information campaign was launched to raise the issue of hysterectomy rates across the general population. In particular, hysterectomy rates in Canton Ticino were compared with the much lower rates in West Midlands, U.K. The disclosure of this information by the six local newspapers and radio and television programs spurred a drop of 26% in the use of this procedure, while no change was observed in a control area unexposed to the mass media campaign (5). The effect of the campaign seems to have lasted, since recent data still confirm that Canton Ticino has the lowest hysterectomy rates compared to other areas in Switzerland, despite the fact that the number of
gyneocologists doubled over recent years. During the same period, mortality rates for cancer of the cervix also decreased.

The findings of this study have been echoed more recently by a systematic review of 17 empirical evaluations of the effect of mass media campaigns on health services utilization (7). The review, performed for the U.K. National Health Service Research and Development Programme, found that mass media campaigns targeting the general public may have an impact in promoting the use of specific health services, although many important issues still remain unanswered. In particular, it is difficult to untangle from the evidence in this review what is attributable to an effect on the supply (i.e., doctors) versus the demand side (i.e., consumers). In principle, mass media may have an impact on both. In the case of the study conducted in Canton Ticino, the observed effect on hysterectomy rates could have been due to the induction of a more “skeptical” attitude among consumers about the worth of the intervention (i.e., women were less likely to accept the procedure when proposed by the clinician, and more prone to search for a second opinion, as suggested in the message of the mass media campaign). At the same time, gynecologists were probably prompted to be more restrictive in their clinical recommendations for hysterectomy.

THE WAY FORWARD

As in any other field of social life, knowledge is power in health care. Strategies aimed at empowering consumers should have increased public knowledge, through the provision of appropriate information on the yield of health services, as their major goal. But what does “appropriate information” mean? Although it is obvious that evidence on the effectiveness of medical and surgical procedures constitutes appropriate information to be conveyed to the public, it seems that also highlighting aspects of uncertainty in clinical practice (and perhaps poor quality and inequity of access) could be useful in increasing consumers’ awareness. These messages have the potential to reinforce and support the promotion of other initiatives aimed at improving the quality of medical care (such as guidelines and quality assurance programs) through a “bottom-up” pressure of consumers toward clinicians.

The rationale for involving society, through public and private agencies, in dealing with professional uncertainty derives from one of the most fascinating, inefficient, and inequitable aspects of the medical landscape (as defined by the Scottish health economist Gavin Mooney [10]), that is, the extent and the nature of variations in medical practice. Policy makers’ efforts in dealing with variations in clinical practice are virtually nonexistent, as is the current awareness of this phenomenon by the most concerned actor on the health market scene, the consumer/patient.

In addition to the results of the Canton Ticino study, there is other research that suggests that providing consumers with information on the existing variations in clinical practice may have some impact. In late 1996 we published a report on lifetime prevalence of some common surgical procedures in Switzerland (3), which has been the object of a great deal of attention by the media in Switzerland, with about 130 newspaper articles and 10 radio and television news broadcasts as of March 1997. The report also highlighted surgical variations across Swiss cantons, and levels of patient education, insurance status, and income. We found that the
most coveted Swiss surgical patient is poorly educated but well insured (Figure 4). These findings suggested to the Swiss population that the practice of medicine is not only not evidence-based, but that it may be market-based as well.

Nine months after the report was published, in the June 1997 telephone survey noted earlier of a representative sample of 1,000 people in several countries, we found that 50% of Swiss citizens strongly agreed (while another 16% agreed partially) with the statement that surgeons perform unnecessary surgical procedures. Only about 19% of British and Italians shared that opinion (Figure 5).

This project suggests that informing the public about variations in the use of health services may be a way to promote a cultural re-education about uncertainty in medical science. Generating a “healthy skepticism” among consumers may lead to a demand for increased evidence-based medical practices, and such “bottom-up” pressure could lead to a change in professional practice. Health professionals should have a professional moral duty to make public, outside the traditional “camera caritatis,” the reasons underlying the variable pattern of use of health services, and therefore find their way to reach a professional consensus on appropriate indications. This will ultimately help promote an evidence-based health culture and practice (Figure 6).

When consumers become aware of the uncertainty of clinical decision making and are more skeptical about the yield of health care interventions, they will need to know how to deal with this in their relationships with health care professionals. Our evidence suggests that higher education is associated with a lower probability of having surgical procedures (4). In order to help consumers at large, regardless of their social status and educational level, make explicit their demands for evidence-based medical practices, we suggest they be encouraged to ask physicians the questions outlined in Table 1. These questions will be published soon in a booklet targeted to all households in Canton Ticino, Switzerland.
Promoting demand for evidence-based medicine

Figure 5. Results from telephone survey (1997). “Do you think that surgeons perform unnecessary surgical procedures?” Percent answering “yes.”

Although we acknowledge that in an era of evidence-based medicine it should no longer be acceptable to rely on anecdotal experience, we cannot resist reporting what just happened to one of us who, when admitted to an emergency department for a minor knee injury, asked about the evidence on which the proposed invasive intervention was based. Merely mentioning the word “evidence” stimulated a new

Figure 6. Quality improvement.
Table 1. Some basic questions physicians should be asked, concerning all medical and surgical procedures:

1. Why is the procedure/treatment necessary?
2. What are the risks and benefits involved?
3. What are the outcomes expected if the procedure/treatment is not implemented? And what are the probabilities of these outcomes?
4. Is there a different procedure/treatment available? If yes, what are the risks and benefits involved in comparison with the one you proposed?
5. Is the procedure/treatment evidence-based (supported by good quality scientific research)?
6. Would you be willing, in a similar situation, to accept the same procedure/treatment? Would you propose the same procedure/treatment to your relatives? If not, why not?

Additional questions concerning diagnostic tests
1. Which disease (or illness) can you detect through the diagnostic test proposed? What are the probabilities you will not get a false-positive or false-negative result?
2. Is the disease (or illness) you can detect curable? And what are the probabilities of success?

general discussion among the clinical staff, with a reconsideration of the available options, ultimately leading to a much less invasive intervention.

CONCLUSION

We believe that in the near future, especially dealing with predictive medicine, priority setting, and implicit or explicit rationing in health care, it will be essential to have a global strategy to involve consumers in more informed decisions and choices. Consumer empowerment is a necessary buttress against the uncertainty in medical science. It should not be seen as an erosion of the physician’s authority by the public, but rather as the foundation of a new partnership to which physicians should be enthusiastic contributors.

Consumer empowerment leads to more autonomy and freedom for the individual, be that individual in perceived good or bad health. Furthermore, consumer empowerment is in the best interest of health professionals because it can reduce the practitioners’ frustration in communicating with the patient; help the patient to make sound choices, thus sharing the responsibility of choice with the practitioner; and finally, bring the patient’s views and experiences with illness back to the center of medical attention (9:11).

Finally, we believe that a broad community program aimed at consumer empowerment would keep the medical profession under healthy pressure regarding scientifically proven health promotion and evidence-based prescription practices. This pressure could also lead to increased motivation for physicians to keep abreast of current knowledge, as well as move them from the position of demigod to partner when faced with a more active, better informed consumer/patient.

REFERENCES


