are tough requirements, but they are likely to ensure greater rigour and relevance for future research.

Heather Goodare *consumer representative, BMJ editorial board*

Horsham, West Sussex RH13 6DF

Sue Lockwood *chair*

Breast Cancer Action Group, PO Box 281, Fairfield, Victoria 3078, Australia

HG chairs BREAST UK (Breast Cancer Research Ethics and Advocacy Strategy).

1 Goodare H, Smith R. The rights of patients in research. *BMJ* 1995;310:1277-8.
2 Herxheimer A, Goodare H. Who are you, and who are we? Looking through some key words. *Health Expectations* 1999;2:3-6.
3 Neuberger J. Let's do away with "patients." *BMJ* 1999;318:1756-7.
4 Chalmers I. What do I want from health research and researchers when I am a patient? *BMJ* 1995;310:1315-8.
5 Bradburn J, Maher J, Adewuyi-Dalton R, Grunfeld E, Lancaster T, Mant D. Developing clinical trial protocols; the use of patient focus groups. *Psycho-Oncology* 1995;4:107-12.
6 Hanley B on behalf of the Standing Group on Consumers in NHS Research. *Involvement works: the second report of the Standing Group on Consumers in NHS Research*. London: Department of Health, 1999.
7 Liberati A. Consumer participation in research and health care. *BMJ* 1997;315:499.
8 National Coordinating Centre for Health Technology Assessment. *Annual report of the NHS Health Technology Assessment Programme 1998*. London: Department of Health, 1999.
9 Macaulay AC, Commanda LE, Freeman WL, Gibson N, McCabe ML, Robbins CM, et al. Participatory research with communities and lay involvement. *BMJ* 1999;319:774-8.
10 US Department of the Army. *Congressionally directed medical research programs, fiscal year 1998. Status report*. Fort Detrick, MD: US Army Medical Research and Materiel Command, 1998:25.
11 Standing Group on Consumers in NHS Research. *Strategic Alliances workshop 27 January 1999: workshop report*. Winchester: Help for Health Trust, 1999.
12 Herxheimer A. The rights of the patient in clinical research. *Lancet* 1988;ii:1128-30.
13 General Medical Council. *Seeking patients' consent: the ethical considerations*. London: GMC, 1999.

Shared decision making in a publicly funded health care system

Policies exist to reduce the risk of conflict between individual and society

Imagine you are a general practitioner. A middle aged male patient of yours has taken a cholesterol test at a pharmacy which showed raised concentrations and wants to discuss his treatment options. Following sound evidence[1] and national guidelines,[2] you tell him that, because he has no other risk factors, medical intervention is not warranted. However, the patient knows that recent trial evidence shows that statins can reduce cardiac events even in populations with mildly raised total cholesterol concentrations.[3] You know that such use could greatly increase the cost of such drugs—to as much as £3.5bn in England,[4] from £113m in 1997.[1]

You support shared decision making with patients,[5 6] but you recognise the dilemma here: should you see yourself as the agent of the patient, focusing on the effectiveness of treatments, or of the healthcare system and the population it serves, focusing on affordability?

If you choose the system perspective there is more scope for conflict between you and the patient about the treatment of choice. In some cases conflict can arise because the patient's choice is likely to affect negatively the health of others. For example, the efficacy of some forms of immunisation requires high utilisation to ensure herd immunity, but individuals focusing on its costs and benefits to them may decide not to have immunisation. Similarly, a patient requesting antibiotics for a simple viral infection may be reluctant to recognise the dangers to population health of inappropriate antibiotic use.

In most cases the treatment chosen by the individual patient does not so directly impact on the health of others, yet it will still have an opportunity cost. Resources used to treat one individual will be unavailable for other patients covered by the same health system. This situation applies to all collectively funded systems, including those based on private insurance.[7] Moreover, when patients do not personally bear the costs of treatment there is little incentive for them to constrain their pursuit of maximum health gain. If, together with the patient, you decide to prescribe statins because it will slightly reduce his risk of a cardiac event, regardless of the cost of this form of management, the patient's extra benefit will be at the expense of others in the system who are unable to have their preferred—and possibly more effective—treatment. If the objective of the system is to maximise total health benefits from available resources then, within a collectively funded system, the individual doctor-patient partnership may not be able to make an unconstrained choice.

If shared decision making is an important policy objective how can the risk of conflict be reduced? One approach is to augment the clinical evidence with information about costs of treatment.[8] You and your patient would then be expected to weigh up all the attributes of treatment, including costs. To be consistent with the system's goal, the final decision needs to strike a balance between the likely benefits to your patient and the benefits forgone to other patients. Healthy individuals may behave altruistically in health care—blood donation is one example. Nevertheless, it is an important research question whether, when the implications of limited resources are explained to them, ill patients are willing to agree to decisions which result in less chance of health gain for themselves but improved aggregate outcomes.

An alternative to relying on the individual patient's altruism is for the doctor to filter the information and tell patients only about treatments the health system is willing to fund. However, as more sources of information become available to the patient, for doctors to discuss only cost effective treatment options would threaten the trust that has to underlie a successful partnership.

BMJ 1999;319:725–6

A more promising approach to lessening the conflict between the doctor and patient is to make a clear distinction between clinical guidelines, which inform doctors (and, through them, their patients) about the health related attributes of treatments, and system guidelines, which indicate which treatments the system will fund.[9] Telling the patient about all available treatments while also indicating which ones the system will fund will not, of course, remove the conflict. Rather, it shifts it away from the consulting room towards the policymakers who decide what the system will fund. But this is the most appropriate place for systemwide funding decisions if the process is transparent, based on good analytical methods and explicit system objectives, and, ideally, has high levels of political accountability. In some countries systemwide statements are provided about whether particular healthcare interventions will be funded from public resources—for example, in the case of new pharmaceutical products in Australia[10] and Ontario.[11] The National Institute for Clinical Excellence in England represents an opportunity for the NHS to provide clear statements about whether or not it will fund particular interventions and, if so, for which patients.

Thus you would be able to share all relevant information with your patient about the clinical implications of statins, perhaps emphasising the very small changes in cardiac risk they would generate, but you could also tell him that the health service had ruled out funding these drugs for people like him.

But what if your patient continues to want statins? In many countries he could fund the treatment himself. The extent to which private funding is permitted, either through private insurance or payments at the point of consumption, is ultimately a political decision, reflecting, among other things, society's beliefs about equity in and access to health care. Therefore the conflict between the individual and society reaches its ultimate manifestation in political choices about a preferred healthcare system.

Mark J Sculpher *senior research fellow, Centre for Health Economics*

Ian Watt *professor of primary and community care*

University of York, York, YO10 5DD
(mjs23@york.ac.uk)

Amiram Gafni *professor*

Centre for Health Economics and Policy Analysis, Department of Clinical Epidemiology and Biostatistics at McMaster University, Hamilton, Ontario, Canada

1 NHS Centre for Reviews and Dissemination. Cholesterol and coronary heart disease: screening and treatment. *Effective Health Care* 1998;4.
2 Standing Medical Advisory Committee. *The use of statins.* London: Department of Health, 1997.
3 Downs JR, Clearfield, Weis S, Whitney E, Shapiro DR, Beere PA, et al. Primary prevention of acute coronary events with Lovastatin in men and women with average cholesterol levels. *JAMA* 1998;279:1615-22.
4 Pickin DM, Payne JN, Haq IU, McCabe CJ, Ward SE, Jackson PR, et al. *Statin therapy/HMG Co-A recuctase inhibitor treatment in the prevention of coronary heart disease.* Sheffield: Trent Institute for Health Servies Research, 1996.
5 Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). *Soc Sci Med* 1997;44:681-92.
6 Charles C, Gafni A, Whelan T. Decision making in the physician-patient encounter: re-visiting the shared treatment decision model. *Soc Sci Med* 1999;49:651-61.
7 Eddy DM. The individual v society. Is there a conflict? *JAMA* 1991;265:1446-50.
8 Freemantle N, Mason J. Not playing with a full DEC: why development and evaluation committee methods for appraising new drugs may be inadequate. *BMJ* 1999;318:1480-2.
9 Browman GP, Levine MN, Mohide EA, Hayward RSA, Pritchard KI, Gafni A, et al. The practice guidelines development cycle: a conceptual tool for practice guidelines development and implementation. *J Clin Oncol* 1995;13:502-12.
10 Commonwealth of Australia. *Guidelines for the pharmaceutical industry on preparation of submissions to the Pharmaceutical Benefits Advisory Committee: including major submissions involving economic analyses.* Canberra: AGPS, 1995.
11 Ministry of Health. *Ontario guidelines for economic analysis of pharmaceutical products.* Ontario: Ministry of Health, 1994.

We ask all editorial writers to sign a declaration of competing interests (www.bmj.com/guides/confli.shtml#aut). We print the interests only when there are some. When none are shown, the authors have ticked the "None declared" box.