MEDICAL PRACTICE

Conference Report

First consensus development conference in United Kingdom: on coronary artery bypass grafting

I Views of audience, panel, and speakers

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Last November the King's Fund organised the first consensus development conference in the United Kingdom, with coronary artery bypass grafting the topic selected for this experiment. The conference generated considerable discussion, as much concerning the consensus process as about the conclusions on coronary artery bypass grafting. After the conference consensus panel members and speakers were sent a letter requesting their views on several issues, and members of the audience were sent a questionnaire. This paper summarises the response to these inquiries.

Background

Consensus development conferences, as initiated in the United States of America by the Office of Medical Applications of Research at the National Institutes of Health, take a specific medical technology or procedure and assess its application in health care. The unique features of the process are that the discussion takes place in public, and there is a consensus panel, from a broad range of backgrounds, that listens to the evidence presented by experts and prepares answers to a set of questions about the technology or procedure. The Office of Medical Applications of Research recently held its 49th conference; Sweden, Denmark, the Netherlands, and more recently Norway and Finland have also experimented with the approach. Because the consensus conference of the King's Fund was the first of its kind in the United Kingdom it was decided that it should closely follow the American model before making any necessary modifications for subsequent conferences in the United Kingdom. Organisational arrangements, including timing of discussion and the all night sitting of the panel, were therefore similar to those in the United States.

There were, however, two important differences. Firstly, panel members in the United States represent a range of interests, including the consumer perspective, and have no known bias, but all are knowledgeable about the subject. The panel in the United Kingdom consisted (apart from two specialists) of people who were not experts on coronary artery bypass grafting; half of them were not medical. The American conferences therefore lean more heavily towards scientific peer review, while the panel in the United Kingdom is nearer to the judicial model. In part this reflects differences between the Office of Medical Applications of Research and the King's Fund. The Office of Medical Applications of Research is the focal point in the National Institutes of Health for assessment and transfer of technology, and one function is to assess procedures resulting from the research activities of the National Institutes of Health. The King's Fund was interested in experimenting with the consensus approach as a way of broadening the debate among a wide range of professionals in health care and with the public about medical technologies, hence the choice of a more independent rather than expert panel.

The second difference was in the questions put and the nature of the evidence presented to the panel. In the United States the questions are restricted to scientific issues, including the need for further research. The nature and constraints of funding in the National Health Service made it seem important to include some reference to costs and to the implications for the service if increased use of coronary artery bypass grafting should be recommended. The main task of the panel, however, was to consider the scientific merits of coronary artery bypass grafting for different types of patients; it heard insufficient evidence to reach conclusions about what priority should be given to coronary artery bypass grafting in comparison with competing demands for resources.

Views of panel members and speakers

Ten of 11 panel members (excluding the chairman) and 13 of the 14 speakers responded to a letter asking about the broad aims of the conference and the process.

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PURPOSE OF THE CONFERENCE

The first question asked whether the two broad aims of the conference had been achieved: to reach conclusions about coronary artery bypass grafting, given a broader range of views than is usual for medical procedures, and to open the subject to public debate. Three panel members said unequivocally that the process had worked well; others that reaching consensus had worked better than the public debate, which was difficult in the face of so many experts with data. One panellist was "not convinced we faced up to ethical and economic questions." All the panel found it a stimulating if exhausting experience and hoped that such conferences would continue.

Among the speakers, most of whom (unlike members of the panel) specialised in cardiac care, two had doubts. One said "I am pleased you did the experiment but a lot of my scepticism remains . . . (*a*) when the facts are available in the medical literature the consensus is usually arrived at by the right people writing leaders in the right journals and (*b*) when the facts are not known there is little point in arriving at a consensus except on the need for further research." Other speakers were much more positive though critical of specific aspects. For example: "worked well but composition of witnesses and panel determined outcome," "good idea but speakers failed to educate the audience sufficiently," and "comments from the floor caused misgivings to medical presenters but panel clearly had little difficulty in distinguishing valuable evidence from uninformed comment."

THE EVIDENCE

Most of the panel felt that the technical data were adequate. Suggestions included: that a senior registrar in community medicine should have been asked to pull together the epidemiological data in advance, and that, as with the medical issues, alternative economic views were needed. Several commented on insufficient time for discussion by the audience; one said that it would have been helpful to have the opportunity to recall speakers and another that there was not enough input from outsiders to the "coronary artery bypass grafting establishment." Several speakers complained of too little time for the panel to cross examine the experts.

Of the 10 speakers, eight considered that the data were adequate, but several said that too much time was spent on clinical trials. Several speakers commented that it was difficult to know at what level to pitch the presentation, and some thought that a meeting of the speakers some time before the conference would have been useful, but one warned that "in view of the comments about bias, a prior meeting would be perhaps an undesirable feature."

PANEL MEMBERSHIP AND PREPARATION OF STATEMENT

The panel and most speakers thought that the panel membership and mixture of people were good and well balanced. Two speakers said there were too many doctors, and one suggested adding a politician. All members of the panel thought it would have helped to meet some time before the conference, particularly to define aspects for which they needed information so as to be able to cross examine the experts better.

All members of the panel thought that writing the report overnight had been unpleasant but differed whether it could be improved. Most thought there should have been more time to prepare the statement, preferably during the day, though they recognised that this risked losing the audience as it would lengthen the gap between the end of the presentations and the presentation of the statement. Several commented on the importance of keeping the panel together until the statement was written.

The speakers, who did not experience it, were less sceptical about the overnight sitting than the panel, but four said that this was not an acceptable way to write the statement. Six speakers were satisfied with the statement ("a useful and realistic document"); two were unhappy about it ("too superficial to rate as a serious analysis of the problem"); and others considered that it went too far in certain aspects.

Views of the audience

Apart from the speakers and panellists 194 people attended the consensus conference; of the questionnaires sent out, 136 (70%) were returned. The following analysis excludes responses from four people who attended for half a day or less. The response rate and the degree of detail given in the answers to questions, together with the many accompanying letters, are evidence of the considerable interest that this conference generated.

Table I shows the background of participants at the consensus conference, including those who completed questionnaires and those who did not. The 11 who ticked more than one box were assigned a category according to their place of work or their reason for attendance. Sixteen overseas participants were from Denmark, Finland, France, Germany, Holland, Ireland, Sweden, Switzerland, and the United States. Nine were from national policy making bodies, including those running consensus development conferences, and the seven others were from the participating specialties, from academic or industrial organisations. The reasons why people attended the conference showed that some were more interested in the consensus process and others in coronary artery bypass grafting itself (table I). Several community physicians were interested in planning and resource allocation.

EVIDENCE AND DISCUSSION

Table II shows that most attendees agreed that technical aspects—that is, medical and scientific—were covered adequately and in a way that could be understood, although the group that specialised in cardiology was more divided. Some thought that there was insufficient coverage of complications, regional variations in facilities, time until vessel stenosis, alternative medical treatments, and rehabilitation. Community physicians expressed concern about the poor epidemiological data and that coronary artery bypass grafting was not presented in the whole context of the prevention and treatment of coronary heart disease; some also said that there was a bias towards coronary artery bypass grafting. All five people who took part in the organisation of consensus conferences in other countries felt that not only the technical but also the economic and social issues were covered adequately.

Concerning these broader issues, several members of the audience said that the patients' perspective, especially their views on the quality of life and ethical aspects of coronary artery bypass grafting, were not covered adequately. Many people said that coverage of economic aspects was inadequate. Specialists in community medicine in particular complained that the conference had not considered the priority that should be given to coronary artery bypass grafting in the face of competing demands for resources in the "high tech" specialties and also in comparison with other types of services (the elderly, mentally ill, and so on).

TABLE I—*Reasons given for attendance by responders*

Background of participants	To learn about coronary artery bypass grafting and coronary heart disease	Working in subject (practice or research) and wanted to join in debate	For planning resource allocation, etc	Consensus process	Both consensus process and coronary artery bypass grafting	Concern about lack of facilities for coronary artery bypass grafting	No response	No of responders	No of non-responders*	No of attenders
Cardiologist or cardiac surgeon	4	10	3	5	1	5	1	29	13	42
Doctor in community medicine	2	1	13	9	1			26	4	30
Representative of national or international organisation	2	2	2		6		3	15	1	16
Other practising doctor	6	4	1		2			13	6	19
Other health or health related professional (nurse, social worker, etc)	5	2	3	1			1	12	8	20
Industry	7	1	1	2				11	8	19
Academic (not included above)		5	3				2	10	2	12
Community Health Council or other consumer representative	6							6	2	8
Patient or relative of patient	5							5	5	10
Medical writer	1			1		1	2	5	2	7
Unknown									11	11
Total								132	62	194

*Includes four whose responses were not used.

TABLE II—*Opinions on presentation of technical and other issues*

Background of participants	Technical issues covered adequately			Technical issues presented comprehensibly			Other issues covered adequately		
	Yes	No	No response	Yes	No	No response	Yes	No	No response
Cardiologist or cardiac surgeon	17	12		23	6		12	17	
Doctor in community medicine	18	8		18	6	2	3	22	1
Representative of national or international organisation	12	2	1	10	3	2	5	8	2
Other practising doctor	10	2	1	9	3	1	7	5	1
Other health or health related professional (nurse, social worker, etc)	12			10	2		5	6	1
Industry	10	1		10	1		5	5	1
Academic (not included above)	8	2		9	1		3	7	
Community Health Council or other consumer representative	5	1		5	1		4	2	
Patient or relative of patient	3	2		5			2	3	
Medical writer	4	1		5			2	3	

TABLE III—*Opinion about quality and influence of final statement*

Background of participants	Quality of statement				Influence of statement*						
					Policy makers		Health authorities		Practising doctors		
	Good	Adequate	Poor	No response	Yes	No	Yes	No	Yes	No	No response
Cardiologist or cardiac surgeon	10	17	2		9	11	8	12	13	8	7
Doctor in community medicine	3	15	7	1	16	4	14	6	16	5	5
Representative of national or international organisation	7	6	1	1	6	5	8	3	6	4	3
Other practising doctor	4	5	3	1	7	3	6	5	8	3	2
Other health or health related professional (nurse, social worker, etc)	6	4	1	1	1	8	4	4	6	3	3
Industry	4	6	1		3	5	6	3	6	3	2
Academic (not included above)	2	6	2		2	5	4	3	2	4	2
Community Health Council or other consumer representative	3	3			3	1	3	1	3	1	2
Patient or relative of patient	2	3			1	4	2	3	3	2	
Medical writer	4		1		1	3	2	2	2	2	1

*Some participants answered "yes" or "no" to only one or two categories and therefore the totals differ.

TABLE IV—*Comments on medical bias of conference*

Background of participants	Was conference biased too strongly towards medical specialties concerned?		
	Yes	No	No response
Cardiologist or cardiac surgeon	7	22	
Doctor in community medicine	23	2	1
Representative of national or international organisation	9	5	1
Other practising doctor	6	6	1
Other health or health related professional (nurse, social worker, etc)	6	5	1
Industry	7	4	
Academic (not included above)	5	4	1
Community Health Council or other consumer representative	3	3	
Patient or relative of patient	2	3	
Medical writer	3	2	

Most people from all backgrounds felt that the time for discussion by the audience was inadequate especially at the time of the presentation of the consensus statement.

THE CONSENSUS STATEMENT

Table III shows opinions about the final statement and whether it would influence national policy makers, local health authorities, and practising doctors. Most people thought that the statement was good or adequate, including the specialties concerned, but a few community physicians thought it was poor. The views on what influence it would have were variable; some hoped that it would be influential but doubted its impact in the current economic state. Practising doctors in the specialties concerned and others thought the statement would influence practice, though they were less sanguine about its influence on decision making organisations. Community physicians, however, thought that it would influence these organisations as well as practising doctors.

THE QUESTION OF BIAS

Members of the specialties concerned were confident that the conference was not too biased towards them, though one or two who answered "yes" said this was inevitable as they were the group who had the data (table IV). Similar comments were made by those who answered positively from various backgrounds. The community physicians were sure, not just in numbers but in the detailed comments that they made, that there was a bias towards both the medical profession as a whole and particularly the specialties concerned. The other groups were more evenly divided on this question, but only one of the five people concerned with running consensus conferences overseas thought there was a bias.

Of those who were critical, many said the problem was that there were not enough speakers against coronary artery bypass grafting and some that the panel, though not biased in itself, could not have concluded differently given the weight of the evidence that was presented.

GENERAL COMMENTS ON THE CONFERENCE

Despite reservations, especially from doctors in community medicine, that the specialties concerned had been given undue weight and that the priority for coronary artery bypass grafting in health care had been inadequately considered, there was overwhelming agreement that the consensus conference had been fascinating, that this experiment was important in opening up debate, and that such conferences should continue. One medical writer said: "your conference was a model forum for a debate on a contentious issue"; a potential patient said: "I paid my own way on a small pension and unemployment benefit. It was well worth the expense"; and a community physician said: "I am sure the great majority of those present would answer that the consensus conference was of value in this country. It proved a very satisfactory mechanism for setting out an important and complex problem which was within well defined limits. . . . There is no way that I have come across which could obtain such a clear statement of policy and need."

A few members of the audience were disappointed or felt that such conferences might be dangerous. A cardiologist commented: "I found the exercise superficial and thus potentially dangerous—better if statement had been more authoritative," and a community physician said: "If some of the money is to be found from reallocation then it must pay to get in fast a series of consensus conferences."

Discussion

The overall impression of those who came was that the consensus conference had been an important event. Overwhelming support for continuing the conference was shown, but with some modifications. The comments and suggestions made by the audience, panellists, and speakers will be taken into account when future conferences are planned. For example, clearly the amount of time allowed for discussion was not adequate for an audience in the United Kingdom. This was exactly the same as allowed in American consensus conferences but an audience in the United Kingdom seems to have much more to say. I was recently present at an American conference with 600 participants, and yet with only minor overruns everyone who wished to speak seemed to have an opportunity to do so.

A more difficult issue is that concerning bias. Almost everyone felt that the panel was unbiased (so much so that some thought their statement could not be authoritative enough). There was concern, however, that the cardiac specialties played too large a part and that there were too few speakers against coronary artery bypass grafting. (The views of the cardiac specialists, however, provided an interesting contrast with those of the community medicine specialists on this point.) Less concern about bias might have been shown if there had been more speakers from other backgrounds and more time for discussion by the audience, if the conferences had been more widely known to the public, and if there had been more cross questioning of the speakers by the panel. But whatever is done experts concerned with a topic will inevitably be in the majority. As one speaker, not from the "cardiac club," commented: "The weakness that will be evident in all such meetings is that they are dominated by those with a close interest in the question. In principle I think you went a long way in the prior planning of the meeting to lean as far as you could in the other direction."

The future of consensus conferences in this country may be different from that overseas, where discussion has been limited to scientific and medical aspects of individual procedures and conditions. The comments from the audience suggest a need to expose broader issues (ethics, economics, and so on), though it could be difficult for much to be covered in the time available. Such an approach might also push the panel into making more value judgments, whereas the American technique for consensus conferences is restricted to weighing up the scientific evidence. The most serious difficulty perhaps is whether the priority for a particular procedure can be discussed in relation to needs for other resources in the National Health Service. In plans for future conferences consideration will be given to whether this issue could feasibly be built into this particular type of conference. The King's Fund will be sponsoring further consensus conferences and reviewing each one before deciding whether to proceed with the next. This will provide an opportunity to make modifications based on what is learnt from each conference and may lead away from the American model towards experimentation with the approach of the consensus conference for setting priorities and influencing national policy. The next conference is planned for early 1986. The organisers are grateful for the interest shown in the process by participants at the first conference, which will certainly influence future conferences.

II Commentary by chairman of conference

BRYAN JENNETT

The amount, vigour, and variety of published, canvassed, and private comment evoked by the consensus development conference on coronary artery bypass grafting (CABG) held in November 1984 augurs well for the future of such conferences as a genre in Britain. It is hoped that after this pilot conference a format may evolve that will allow fruitful discussion of a wide variety of topics in the future. Efforts were made to discover how the conference on coronary artery bypass grafting struck those who attended by an invitation for detailed comment[1]; in addition, two assessors (a paediatrician who is also a dean, and a policy analyst) were asked to attend the whole conference and to submit a written commentary. There have also been published editorials in the *BMJ*[2] and in the *THS Health Summary*,[3] eight letters in the *BMJ*,[4-11] and three personal accounts —from a regional medical officer who was a member of the panel,[12] a cardiologist who was a speaker,[13] and a district hospital physician.[14]

These published comments were mostly about how this particular conference was conducted and the statement that was published,[15] but some were directed at the tone of the article in the *BMJ*.[2] This was applauded by physicians in community medicine and resented by cardiological physicians and surgeons—for example, "can never undo the harm done by the *BMJ* leader," "it was superficial, cynical, and in extremely poor taste." This reflected the dichotomy between these two groups about whether or not the conference and the final statement had been too much influenced by the cardiac doctors, who were regarded by the specialists in community medicine as champions of increased coronary artery bypass grafting. Indeed, one community physician considered that the whole conference had been invalidated by having even one cardiac expert on the panel. But several cardiac experts were equally uneasy at having to defend themselves against those who they regarded as ill informed bystanders.

Based on his participation in the conference on coronary artery bypass grafting in the United Kingdom and also in the American conference on preventing heart disease by lowering cholesterol concentrations, one cardiologist questioned the value of consensus conferences as a way of debating controversial issues and advising policy makers.[13] His preferred alternatives were expert committees of the World Health Organisation or small national expert panels, in either case meeting over much longer periods of time. These, however, do not provide an opportunity for debate with medical opinion outside the specialty or for exposure of issues to non-medical experts and the public. With the American consensus programme so well established and several European countries committed to programmes it is important to consider whether Britain can usefully adopt and adapt this approach. We need not accept without modification either the American model or the variations already evolving in Europe. Nevertheless, the essence of this type of conference must be preserved—its essential difference from the traditional meeting of experts. It seeks not to replace such meetings but to provide an opportunity for exposing to a more broadly based group of people issues on which there is some disagreement among the experts immediately concerned.

Choosing the topic and questions

For a topic to be ripe for a consensus conference there must be enough data to discuss and enough controversy to justify debate; and the matter must be sufficiently important in terms of policy, principles, or priorities to

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