- 14 Beasley CM Jr, Dornseif BE, Bosomworth JC, Saylor ME, Rampey AH, Heiligenstein JH. Fluoxetine and suicide: a meta-analysis of controlled trials of treatment for depression. *BMJ* 1991;303:685-92.
- 15 Khan A, Khan S, Kolts R, Brown WA. Suicide rates in clinical trials of SSRIs, other antidepressants, and placebo: analysis of FDA reports. *Am J Psychiatry* 2003;160:790-2.
- 16 Jick SS, Dean AD, Jick H. Antidepressants and suicide. *BMJ* 1995;310:215-8.
- 17 Oravec R, Czigler B, Leskosek E. Correlation between suicide rate and antidepressant use in Slovenia. *Arch Suicide Res* 2003;7:279-85.
- 18 Helgason T, Tomasson H, Zoega T. Antidepressants and public health in Iceland. Time series analysis of national data. *Br J Psychiatry* 2004;184:157-62.
- 19 Gunnell D, Middleton N, Whitley E, Dorling D, Frankel S. Why are suicide rates rising in young men but falling in the elderly?—a time-series analysis of trends in England and Wales 1950-1998. *Soc Sci Med* 2003;57:595-611.
- 20 Amos T, Appleby L, Kiernan K. Changes in rates of suicide by car exhaust asphyxiation in England and Wales. *Psychol Med* 2001;31:935-9.
- 21 Shah R, Uren Z, Baker A, Majeed A. Deaths from antidepressants in England and Wales 1993-1997: analysis of a new national database. *Psychol Med* 2001;31:1203-10.
- 22 Freemantle N, House A, Song F, Mason JM, Sheldon TA. Prescribing selective serotonin reuptake inhibitors as strategy for prevention of suicide. *BMJ* 1994;309:249-53.
- 23 Teicher MH, Glod C, Cole JO. Emergence of intense suicidal preoccupation during fluoxetine treatment. *Am J Psychiatry* 1990;147:207-10.
- 24 Masand P, Gupta S, Dewan M. Suicidal ideation related to fluoxetine treatment. *N Engl J Med* 1991;324:420.
- 25 Als-Nielsen B, Chen W, Glud C, Kjaergard LL. Association of funding and conclusions in randomized drug trials. *JAMA* 2003;290:921-6.
- 26 Medicines and Healthcare Products Regulatory Agency. Selective serotonin reuptake inhibitors (SSRIs): overview of regulatory status and CSM advice relating to major depressive disorder (MDD) in children and adolescents including a summary of available safety and efficacy data. http://medicines.mhra.gov.uk/ourwork/monitorsafequalmed/safetymessages/ssrioverview_101203.htm (accessed 16 May 2004).
- 27 Nutt D. Death and dependence: current controversies over the selective serotonin reuptake inhibitors. *J Psychopharmacol* 2003;17:355-64.
- 28 MacKay FR, Dunn NR, Martin RM, Pearce GL, Freemantle SN, Mann RD. Newer antidepressants: a comparison of tolerability in general practice. *Br J Gen Pract* 1999;49:892-6.
- 29 McClure GMG. Suicide in children and adolescents in England and Wales 1970-1998. *Br J Psychiatry* 2001;178:469-74.
- 30 Hawton K, Hall S, Simkin S, Bale L, Bond A, Codd S, et al. Deliberate self-harm in adolescents: a study of characteristics and trends in Oxford, 1990-2000. *J Child Psychol Psychiatry* 2003;44:1191-8.
- 31 Donoghue JM, Tylee A. The treatment of depression: prescribing patterns of antidepressants in primary care in the UK. *Br J Psychiatry* 1996;168:164-8.
- 32 Paykel ES, Priest RG. Recognition and management of depression in general practice: consensus statement. *BMJ* 1992;305:1198-202.
- 33 Harris EC, Barraclough B. Excess mortality of mental disorder. *Br J Psychiatry* 1998;173:11-53.

(Accepted 11 June 2004)

Interactive case report

A 64 year old woman with knee pain: case outcome

Peter Tugwell, Annette M O'Connor, Nancy A Santesso

Department of
Medicine,
University of
Ottawa, 202-1
Stewart Street,
Ottawa, Canada
K1N 6N5

Peter Tugwell
professor of medicine

Ottawa Health
Research Institute,
Ottawa Hospital,
1053 Carling
Avenue, Ottawa,
Canada, K1Y 4E9
Annette M
O'Connor
senior scientist,
clinical epidemiology

Cochrane
Musculoskeletal
Review Group,
University of
Ottawa

Nancy A Santesso
knowledge translation
specialist

Correspondence to:
ptugwell@uottawa.ca

This is the final part
of a three part case
report, which
describes the
outcome and
summarises the
comments made by
readers during the
case presentation

BMJ 2004;329:38-40

Four weeks ago (5 June, p 1362) we presented the case of Mrs Patell, who visited her doctor after reading a newspaper article about the risks of chronic use of paracetamol with alcohol intake. Although she needed the pain relief, she was reluctant to give up alcohol. Her general practitioner discussed the benefits and harms of paracetamol versus non-steroidal anti-inflammatories and gave her a decision aid to help her clarify her decision (12 June, p 1425).

After discussing her completed decision aid with her general practitioner, Mrs Patell decided to continue the paracetamol up to 4000 mg/day. She has reduced her alcohol intake but feels that the small increase in her risk of liver disease associated with alcohol is still preferable to the even greater risk of

This case is fictional but was developed from several real cases. It was commissioned to contribute to this special issue on harms.

bleeding with non-steroidal anti-inflammatories. Mrs Patell is confident in her decision and feels that she was given enough information and guidance to allow her to make an informed, value based decision.

In this case, the doctor could not clearly recommend a treatment option to the patient. The evidence of benefits and harms was not clear, and the value the patient placed on the benefits and harms was not known. The doctor recognised that Mrs Patell was uncertain about what to do but wanted to be involved in the decision making process and used a decision aid. A Cochrane systematic review of over 30 randomised trials of decision aids provides clear answers about the efficacy of decision aids.¹ Compared to usual care, decision aids improve patients' knowledge of options, create realistic perceptions of the probabilities of benefits and harms, clarify personal values, enhance participation in decision making without affecting anxiety, reduce decisional conflict about the best course of action, and improve the match between what patients' value and what they choose.

We thank George Wells and Joan Peterson for help with the calculations.

Competing interests: PT received travel and research support from pharmaceutical companies. AOC receives an unrestricted research grant from the Foundation for Informed Medical Decision Making, which has a licensing agreement with Health Dialog, a company that markets decision aids.

1 O'Connor AM, Stacey D, Entwistle V, Llewellyn-Thomas H, Rovner D, Holmes-Rovner M, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2003;(2):CD001431.

Decision aids can benefit patients and doctors

Commentary: Is evidence based patient choice feasible?

Peter Cantillon

What could be more ordinary and humdrum (for a clinician) than a case of a woman with osteoarthritis of the knee? Yet a doctor's potential responses to her uncertainty about whether to take a non-steroidal anti-inflammatory drug (NSAID) or paracetamol has stimulated an interesting debate. Tugwell and colleagues have used this case to demonstrate the use of a decision aid as a tool in helping a patient to make an informed choice. The decision aid is clearly very patient centred. It asks the patient to consider exactly what needs to be decided and the pros and cons of different options using visual representations of risk and benefit. It also encourages the patient to decide who should have what role in making the decision. It is clear that such a tool could be of enormous benefit in helping patients make decisions where the balance of the relative benefits and risks of competing options is not obvious.¹

There are, however, clear sources of potential bias in the construction of decision aids. Are all the potential risks considered (in this case gastrointestinal bleeding was the only risk assessed for NSAIDs)? Were all the relevant sources of evidence appraised, and is the representation of the synthesised findings appropriate? Should decision aids aim to be more comprehensive? For example, should Mrs Patell be told about alternative therapies and about the other risks associated with taking NSAIDs? If a decision aid becomes more comprehensive will it be too

complicated for patients to interpret? Does a partial consideration of the benefits and risks constitute informed choice? Is there not an element of "framing" involved in selecting what to put into a decision aid and what to leave out?

I can see a clear value in using decision aids as tools for teaching students about the concepts of contextual complexity, shared decision making, informed choice, and the explanation of risk. They represent an excellent vehicle for explaining the relevance of numbers needed to treat, numbers needed to harm, etc. If doctors are to use such tools in practice, decision aids need to be readily available (internet or desktop reference), sufficiently flexible to meet different idiosyncratic patient values, and appropriately comprehensive to cover the main risks and benefits that a patient needs to consider. To interpret and explain a decision aid, doctors need to be statistically numerate,² and other visual means of communicating risk should be considered.³ Above all, doctors need to value the time required to help patients to make informed choices.

Competing interests: None declared.

- 1 O'Connor AM, Légaré F, Stacey D. Risk communication in practice: the contribution of decision aids. *BMJ* 2003;327:736-40.
- 2 Gigerenzer G, Edwards A. Simple tools for understanding risks: from innumeracy to insight. *BMJ* 2003;327:741-4.
- 3 Paling J. Strategies to help patients understand risks. *BMJ* 2003;327:745-8.

Department of
General Practice,
National University
of Ireland, Galway,
Ireland

Peter Cantillon
senior lecturer

peter.cantillon@
nuigalway.ie

Commentary: Decision aids in clinical practice

A Cranney

Decision aids can be a useful format to communicate evidence based information on harms and benefits of therapies to individual patients. When used as an adjunct to the consultation, decision aids can change the format of the consultation process; decision aids are designed to enhance communication and interaction between patient and practitioner—not to replace it. Decision aids are not indicated for each clinical decision or scenario and they may not appeal to all physicians. But trials evaluating decision aids in the United Kingdom concluded that they helped patients use information to clarify their values and preferences.¹⁻³

I have had the opportunity to use a decision aid in the clinical setting. This decision aid incorporates detailed information about self care and multiple therapies and has recently been adapted for use in a UK research project. I have found that exposing patients to the current evidence on efficacy, benefits, and harms enhances the consultation by focusing the discussion and ensures that consistent information is given to each patient.

Many respondents on bmj.com questioned the availability of such tools that include evidence based data and the plausibility of their use in everyday practice. New initiatives are making decision aids available on the web, which can be reviewed by patients in their own time or discussed with a nurse educator. If easily accessible and used correctly, decision aids can save time during the consultation. By helping determine the patient's preferred role for participating in the decision—for example, "doctor, what should I do?" or "I want to decide"—decision aids can help practitioners judge whether they can move quickly from facilitating the decision making process to planning treatment.

When introduced at the point of care, decision aids can be used to develop individual risk factor profiles. Treatment options can then be tailored according to the individual's risk. In this case, the physician knew that Mrs Patell had responded well to a non-steroidal anti-inflammatory drug; there was no question that Mrs Patell could be one of 94 who do not benefit.

Ottawa Hospital,
1053 Carling
Avenue, Ottawa
ON, Canada,
K1Y 4E9
A Cranney
rheumatologist
ancranney@ohri.ca