

From evidence to action

Sharing decisions with patients



Reproduced from cover page of JAMA, Users' Guide to the Medical Literature, 3rd ed.

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Disclosures

I have no financial conflict of interest in relation to this presentation.

My intellectual conflicts of interests:

- Member of the **GRADE** Working Group
- Board member **MAGIC** Foundation
- Co-founded and steering the **BMJ Rapid Recs**
- Deputy editor ACP journal club – McMaster PLUS Evidence Alerts

What is shared decision making?



When? When not? How? How much?

Patient centered care



Personalized medicine

Shared decision making



Barry et al. Shared decision making - pinnacle of patient-centered care. *NEJM* 2012;366:780-1.

Stiggelbout et al. Shared decision making: really putting patients at the centre of healthcare. *BMJ* 2012;344:e256.

Djulgovic B et al. Evidence-based practice is not synonymous with delivery of uniform health care. *JAMA* 2014;312:1293-4.

Shared Decision Making is a process by which

a **patient** and a **clinician**

work together,

have a **conversation**,

partner with each other

to identify the **best course of action**,

the best treatment or test

at this point in time.

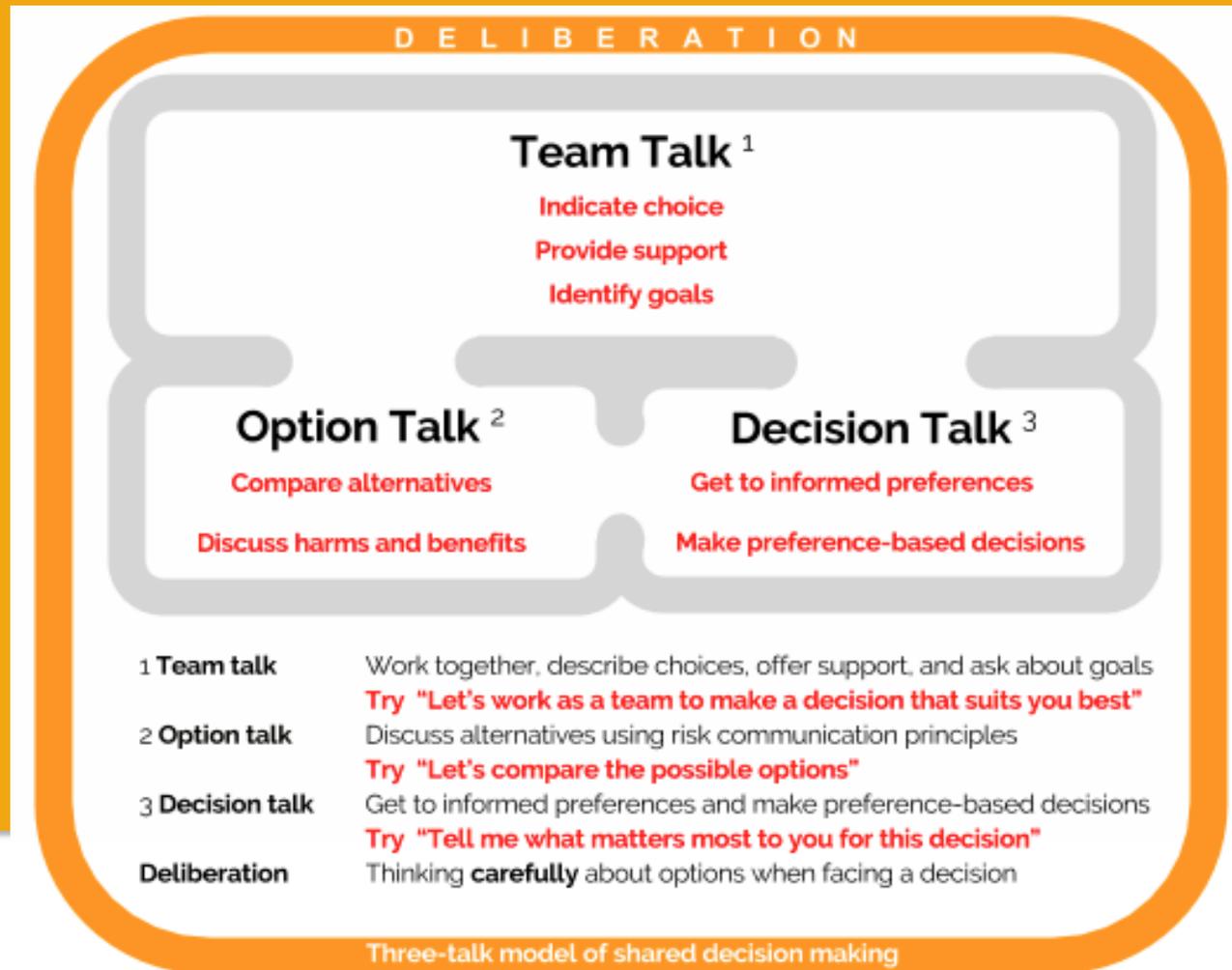
It is about **sharing what matters**

Clinicians share information about the alternatives, benefits, harms

Patients share prior experience, goals, expectations, values.

Victor Montori

Collaborative Deliberation



Elwyn G et al. Shared decision making: a model for clinical practice. J Gen Intern Med. 2012 Oct;27(10):1361-7.

SDM: Common beliefs and objections

- "Patients do not really want it"
 - 70-90% prefer SDM (European survey on >8000 patients)
 - Time trend (they were 50% before year 2000)
 - >50% unsatisfied with information given and implication
- "Clinical encounters would take more time"
 - No systematic increase (3 systematic reviews)
- "Too complicated for patients, many (most) are not capable"
 - Several studies among vulnerable, sick or with low literacy
 - Less a question of if.. but rather how...
- "We are already doing it ! "
 - Not quite... "perception-reality gap"
 - Average of 23/100 on OPTION scale (33 international studies)

Clinical practice is made of a myriad of decisions

Need for SDM ?

- When should I consult? [Patient]
- When should we admit/discharge this patient? [Physician]
- When should I call the resident? [Nurse]

- Which diagnostic test to perform/offer?
- What should we screen for and when?

- **What are the reasonable options for therapy?**
- What type/frequency of follow-up?
- What are the practical aspects to put in place in one's daily life?

+ many therapeutic interactions that are not decisions

→ Potential field of knowledge

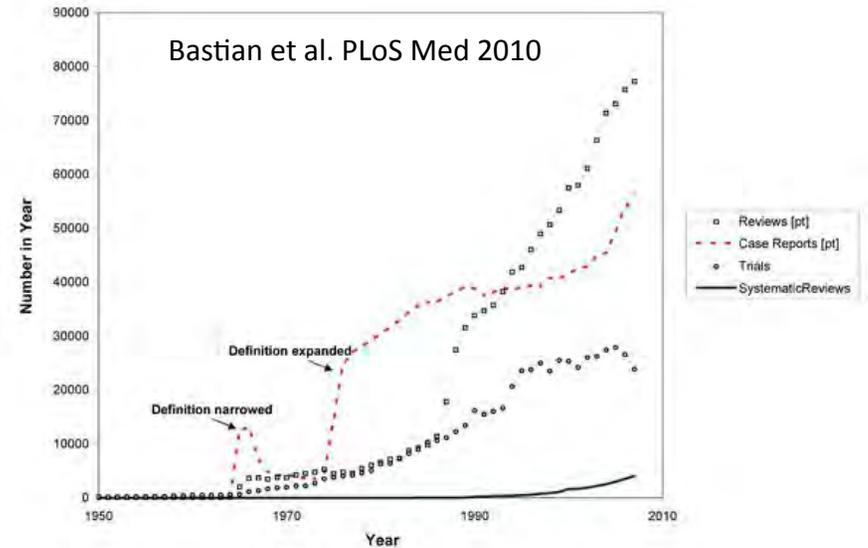


Volume of health evidence every day

➤ 3000-4000 publications

- 100 Randomized trials
- 20 systematic reviews

Retrieving the evidence
Signal vs. Noise ?



Staying up-to-date ?



- **Agoritsas** et al. Increasing the quantity and quality of searching for current best evidence to answer clinical questions. *Implement Sci* 2014;9:125.
- **Agoritsas** et al. Sensitivity and predictive value of 15 PubMed search strategies to answer clinical questions rated against full systematic reviews. *J Med Internet Res* 2012;14:e85.
- **Agoritsas** et al. Finding Current Best Evidence, in *JAMA Users' Guides to the Medical Literature*. McGraw-Hill Medical, 2015.

Clinical practice guidelines: The good, the bad and the ugly

ORIGINAL INVESTIGATION

ONLINE FIRST | HEALTH CARE REFORM

Failure of Clinical Practice Guidelines to Meet Institute of Medicine Standards

Two More Decades of Little, If Any, Progress

Justin Kung, MD; Ram R. Miller, MD; Philip A. Mackowiak, MD

Background: In March 2011, the Institute of Medicine (IOM) issued a new set of standards for clinical practice guidelines intended to enhance the quality of guidelines being produced. To our knowledge, no systematic view of adherence to such standards has been undertaken since one published over a decade ago.

Methods: Two reviewers independently screened 130 guidelines selected at random from the National Guideline Clearinghouse (NGC) website for compliance with 18 of 25 IOM standards.

Results: The overall median number (percentage) of IOM standards satisfied (out of 18) was 8 (44.4%), with an interquartile range of 6.5 (36.1%) to 9.5 (52.8%). Fewer than half of the guidelines surveyed met more than 50% of the IOM standards. Barely a third of the guidelines produced by subspecialty societies satisfied more than 50% of the IOM standards surveyed. Information on conflicts of interest (COIs) was given in fewer than half of the guidelines surveyed. Of those guidelines including such information, COIs were present in over two-thirds of committee chairpersons (71.4%) and 90.5% of co-

INVITED COMMENTARY

ONLINE FIRST

In Guidelines We Cannot Trust

The Institute of Medicine (IOM) recently updated its standards for guideline development.¹ If adhered to, trustworthy guidelines should follow. Trustworthiness connotes integrity, dependability, and reliability. Unfortunately, in guidelines we cannot trust.

In the late 1990s, 2 colleagues and I critically appraised a broad set of published guidelines and found that guidelines adhered to less than half of the methodological standards for guideline development.² We opined that developers would adhere to recommended standards of guideline development. As demonstrated by Kung et al³ in this issue of the Archives, guidelines are still not following guidelines.

Kung et al³ scrutinized 114 guidelines published in the National Guidelines Clearinghouse against 18 of the standards recently set forth by the IOM.¹ Despite some methodological shortcomings, Kung et al³ found that the overall percentage of standards satisfied was only 8 of 18 (44.4%).

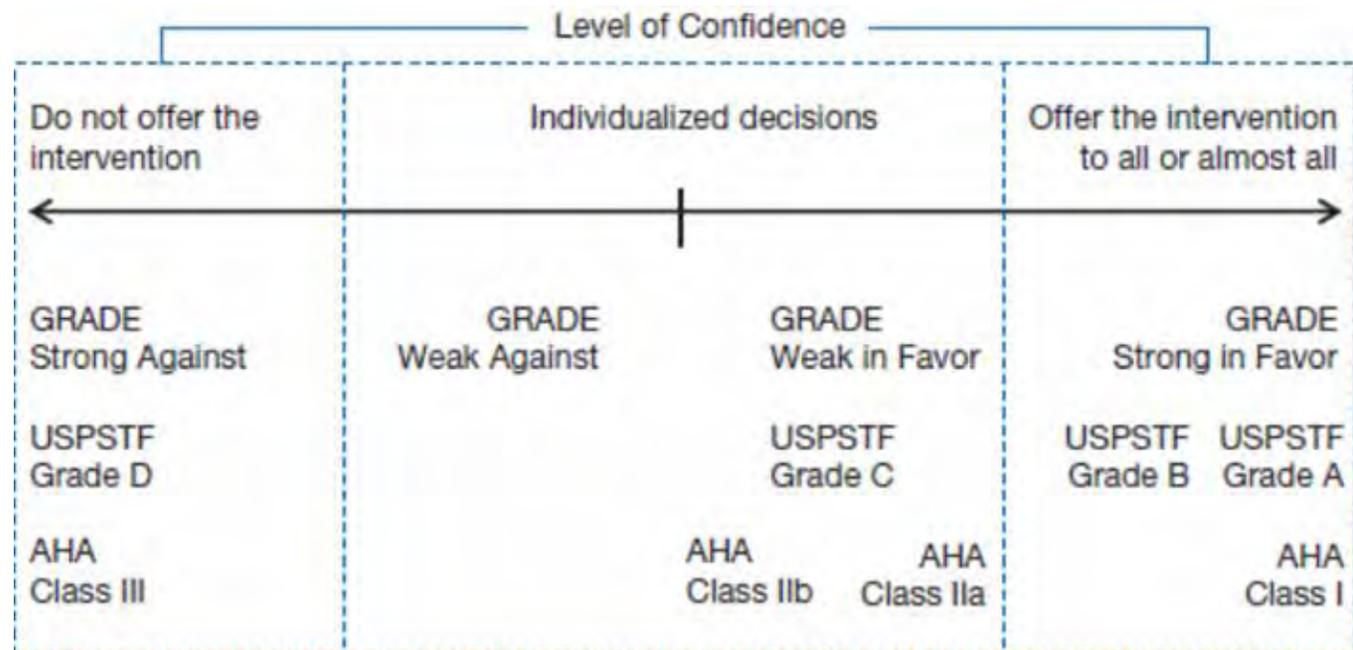
While I laud this ideal we have little evidence regarding the impact on guideline quality and the resulting recommendations by policies prohibiting relations with industry, and there is the potential cost of the loss of subject expertise on guideline panels. Disclosure alone is insufficient to protect against COIs. I favor an approach championed by the American College of Chest Physicians' Antithrombotic Guidelines,⁴ which panel members with significant COIs do not participate in discussions or voting on recommendations which they have COIs but may offer written input so that their clinical and research expertise is maintained.⁵

A closely related topic that limits guideline trustworthiness is the often single subspecialty panel composition. Members of a clinical specialty are likely to recommend interventions for which their specialty serves. One needs to look no further than prostate cancer guidelines for evidence of this. Groups with multidisciplinary membership tend to develop more recommendations that are not evidence based.⁶ Guideline development is complex, as is patient care. Expectations in both clinical and nonclinical disciplines

Niveau d'évidence & recommandations???

From: How to Use a Patient Management Recommendation: Clinical Practice Guidelines and Decision Analyses
Users' Guides to the Medical Literature, 2014

Class Ia?
Grade A
Class IIIb?



Legend:

Direction and Strength of Recommendations in Different Grading Systems

Abbreviations: AHA, American Heart Association; GRADE, Grading of Recommendations Assessment, Development and Evaluation; USPSTF, US Preventive Services Task Force.

<http://www.gradeworkinggroup.org/index.htm>

ANALYSIS

GRADE

RATING QUALITY OF EVIDENCE AND STRENGTH OF RECOMMENDATIONS

GRADE: an emerging consensus on rating quality of evidence and strength of recommendations

Guidelines are inconsistent in how they rate the quality of evidence and the strength of recommendations. This article explores the advantages of the GRADE system, which is increasingly being adopted by organisations worldwide

Guideline developers around the world are inconsistent in how they rate quality of evidence and grade strength of recommendations. As a result, guideline users face challenges in understanding the messages that grading systems try to communicate. Since 2006 the *BMJ* has requested in its "Instructions for Authors" on bmj.com that authors should use the Grading of Recommendations Assessment and Evaluation (GRADE) system when submitting a clinical guidelines article. What was behind this decision?

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Andrew D Oxman researcher,

advantages and disadvantages but also by their confidence in these estimates. The cartoon depicting the weather forecaster's uncertainty captures the difference between an assessment of the likelihood of an outcome and the confidence in that assessment (figure). The use of intervention that estimate. As those offering recommendations have often erred as a result of not taking sufficient account of the quality of evidence.² For a decade, organisations recommended

→ BMJ 2004, BMJ 2008, JCE 2010-present
→ continued evolution

GRADE

Strong recommendations

1. Clear balance 
 - benefits clearly outweigh risks/hassle/cost
 - risk/hassle/cost clearly outweighs benefits

2. Sufficient certainty in estimates (high or moderate) 

3. Patients values & preferences:
 - almost all **same** choice



Weak recommendations

1. Close balance 
 - Close call between benefits and risks/hassle/cost
 - Therefore more preference-sensitive

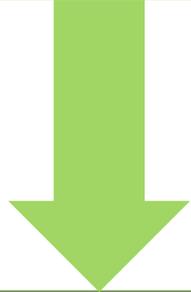
2. Lower certainty in estimates 

3. Patients values & preferences:
 - choice **varies** appreciably (or is very uncertain)



GRADE

Strong recommendations



Just do it



Weak recommendations



*Shared
decision making*



Most important decisions in health care are not clear cut

Strength of recommendations in UpToDate (n=9451)

	All Recommendations
	N (%)
Low confidence	4701 (49.7%)
Moderate confidence	3759 (39.8%)
High confidence	991 (10.5%)
Total	9451 (100%)

Most important decisions in health care are not clear cut

Strength of recommendations in UpToDate (n=9451)

	Weak Recommendations	Strong Recommendations	All Recommendations
	N (%)	N (%)	N (%)
Low confidence	4335 (66.7%)	366 (12.4%)	4701 (49.7%)
Moderate confidence	2019 (31.1%)	1740 (59.0%)	3759 (39.8%)
High confidence	147 (2.3%)	844 (28.6%)	991 (10.5%)
Total	6501 (68.8% of all rec)	2950 (31.2% of all rec)	9451 (100%)

Most important decisions in health care are not clear cut

Strength of recommendations in UpToDate (n=9451)



	Weak Recommendations	Strong Recommendations	All Recommendations
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	2019 (31.1%)	1740 (59.0%)	3759 (39.8%)
	147 (2.3%)	844 (28.6%)	991 (10.5%)
	6501	2950	9451
	(68.8% of all rec)	(31.2% of all rec)	(100%)



VIEWPOINT

Evidence-Based Practice Is Not Synonymous With Delivery of Uniform Health Care

Benjamin Djulbegovic, MD, PhD

Division of Evidence-Based Medicine, Department of Internal Medicine, Morsani College of Medicine, University of South Florida, Tampa; and H. Lee Moffitt Cancer Center and Research Institute, Tampa, Florida.

Gordon H. Guyatt, MD, MSc

Department of Clinical Epidemiology, McMaster University, Hamilton, Ontario, Canada.

Current clinical practice is characterized by substantial variation in delivery of health care for the same conditions.¹ In turn, clinical variation is considered one of the major drivers of ever-increasing health care costs¹ contributing to the estimated 30% of inappropriate or wasteful health care.² Perhaps as a natural response to this unsatisfactory situation, a widespread and influential school of thought has emerged contending that greater uniformity of clinical practice is desirable.^{1,3} Advocates maintain that by achieving uniformity in care, practice variation can be decreased, in turn leading to large cost reductions. **The suggested mechanism to achieve uniformity in part involves clinician adherence to practice guidelines, which is seen as synonymous with evidence-based practice.³ In this Viewpoint, we explain that this position is based on a misunderstanding of trustworthy guidelines⁴ and that striving for uniformity of practice as an end is misguided.**

The first limitation in the drive for uniformity is a failure to appreciate the need for guidelines that achieve a

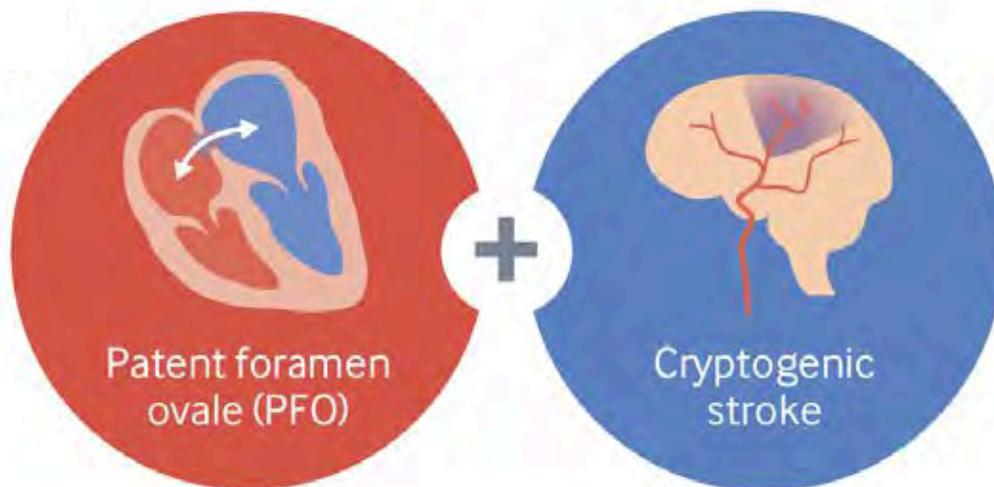
terms of benefits, harms, and costs.⁶ Studies directly addressing the relevant questions may not have been undertaken, or if they have, they may be small, poorly designed or implemented, show inconsistent results, be limited by publication bias, or have enrolled idiosyncratic populations of questionable applicability. In these cases, the confidence in the estimate of effects will often be low or very low. In addition, if values and preferences differ widely across patients (which is often if not uniformly the case), the right decision for one patient may be the wrong decision for another. For example, Montori et al⁷ illustrated how recent guidelines by the American College of Cardiology and the American Heart Association for the use of statins for primary prevention of heart disease do not mandate uniform practice—some patients informed about cardiovascular disease risk reduction will choose the recommended course of action and use statins, but others will not.

Organizations that produce guidelines should distinguish between situations in which confidence in



John, 60 years old

- Teacher secondary school, considering early retirement
- Treated for hypertension
- Minor stroke (NIHSS 3)
 - No persistent disabling neurological deficit
 - Patent Foramen Ovale (PFO)
 - Cryptogenic



No atrial fibrillation
No aortic disease
No left sided heart disease
No cerebrovascular disease

What does John and his doctors need to make a decision about what do do next?

Options ?
The menu



Benefits and harms

The Balance 

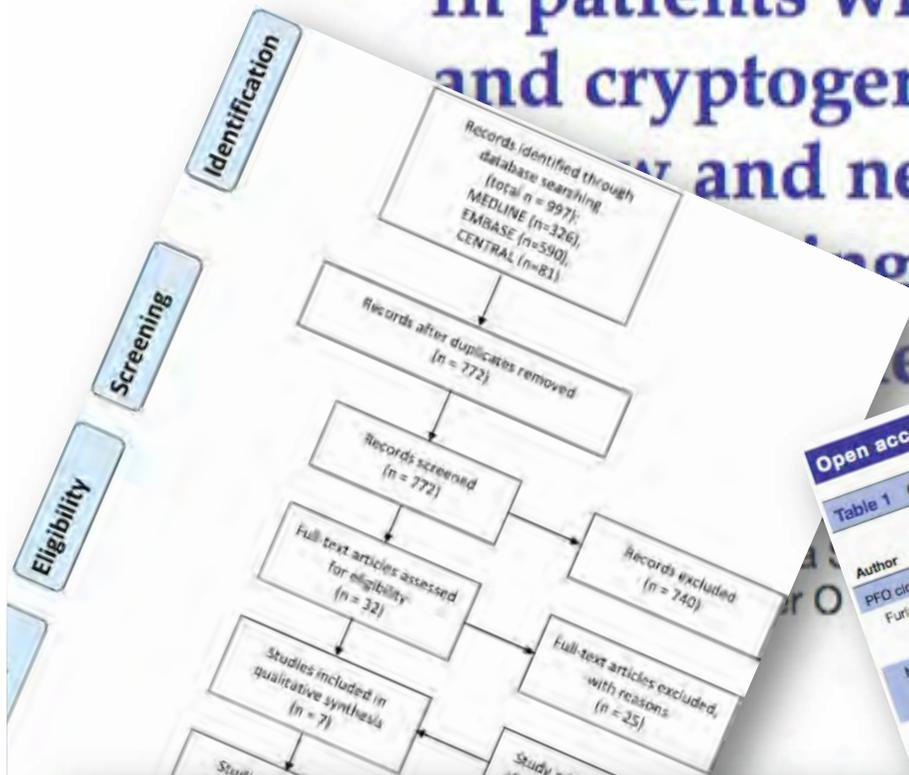
Certainty

In the evidence 

Practical Issues



BMJ Open Patent foramen ovale closure, antiplatelet therapy or anticoagulation in patients with patent foramen ovale and cryptogenic stroke: a systematic review and network meta-analysis

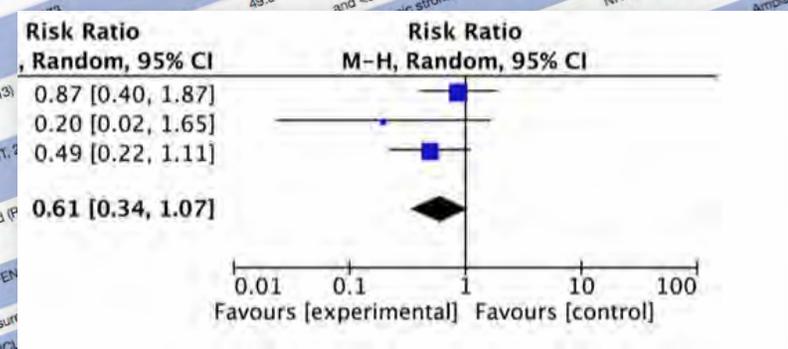


Open access

Table 1 Characteristics of patients in eligible studies

Author	n randomised	Mean age	% Male	Inclusion criteria	Moderate or higher shunt (%)*	Atrial septal aneurysm >10mm (%)†	Most common device used for closure
Furlan (CLOSURE 1, 2012)	909	46.0	51.8	Cryptogenic stroke, PFO, >18 years and <60 years	52.8‡	37.8	STARFlex 100%
Mas (CLOSE, 2017)		43.4	59.0	Cryptogenic stroke, PFO, >18 years and <60 years	92.5§	31.8	Amplatzer 52%¶
Meier (PC Trial, 2013)		49.8		Cryptogenic stroke, PFO, >18 years and <60 years	65.6**	23.7††	Amplatzer 100%
Saver (RESPECT, 2017)				Cryptogenic stroke, PFO, >18 years and <60 years	48.8†††	35.7***	Amplatzer 100%
Sondergaard (PFO closure, 2017)							Cardioform 61%‡‡
Lee (DEFENSE, 2017)							Amplatzer 100%
PFO closure							
Mas (CLOSURE 1, 2012)							
Anticoagulation vs antiplatelet therapy	203 (88 with cryptogenic stroke)	44.2	57.0	Cryptogenic stroke, PFO, >18 years			
Homma (PICSS, 2002)	361	61.4	63.6	Cryptogenic stroke, PFO, >18 years			

CLOSURE 1	+	+	?	?	-	+	+
PC Trial	+	+	?	+	-	+	+
RESPECT	?	-	?	+	-	+	+

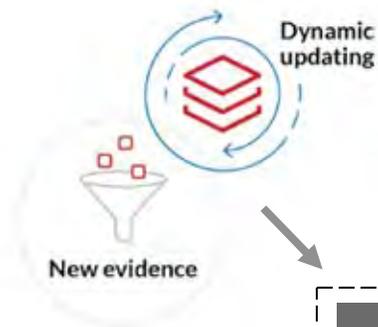


Our Lab = MAGIC app

38 000
Users

49 active
Organisations
(and many more testing)

140
Public guidelines



**Guideline panel
Systematic Reviewers**
Using MAGICapp

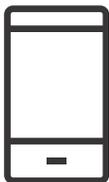


Database
Structured and
tagged content

AUTHORING

PUBLICATION

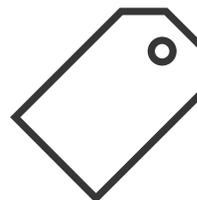
Multilayered formats
For all devices



**Integration in
the EMR**



Adaptation
National and local
or EBM textbooks



Decision aids



SHARE-IT

ANALYSIS

SPOTLIGHT: PATIENT CENTRED CARE

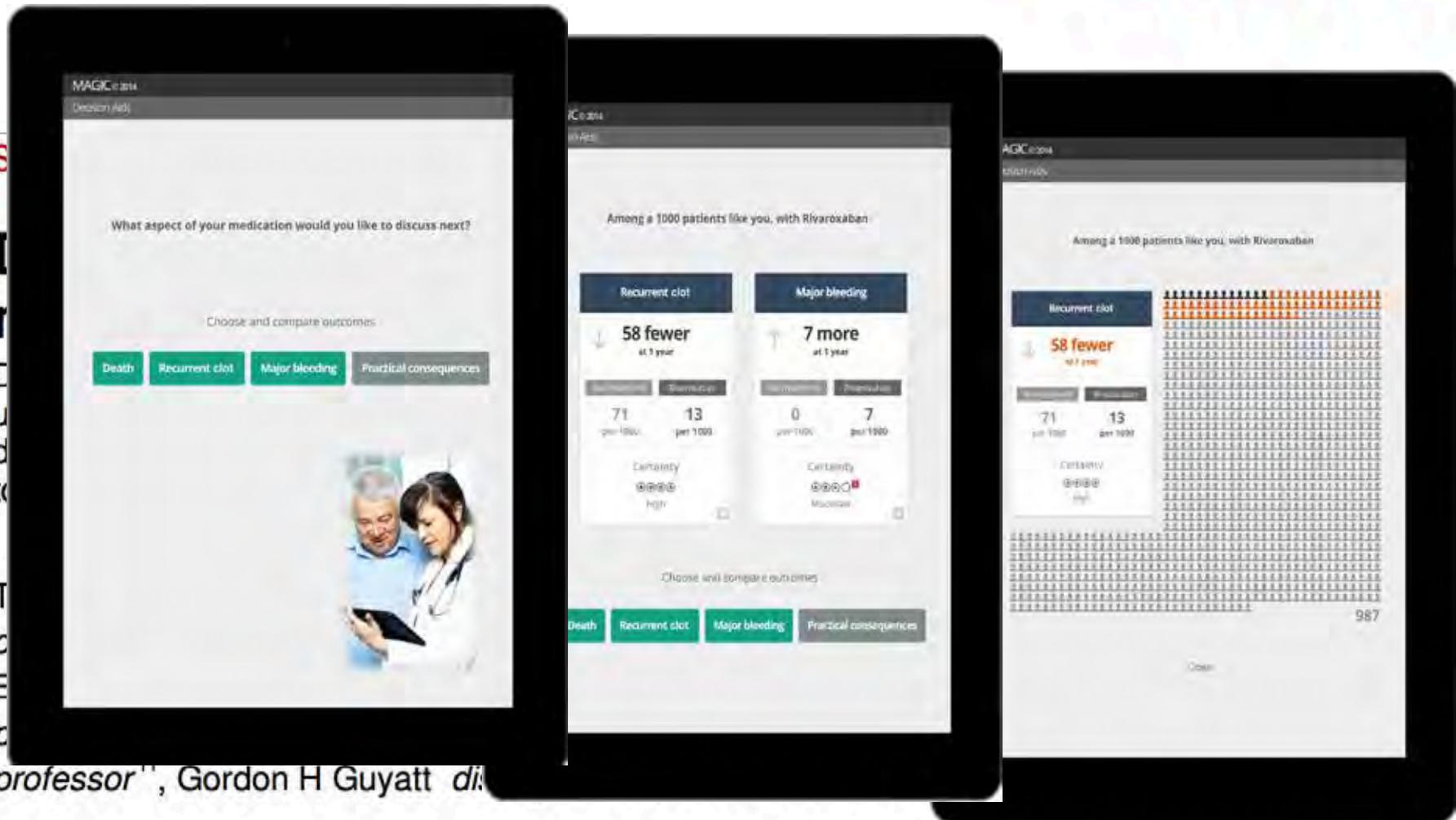
Decision aids that really promote shared decision making: the pace quickens

Decision aids can help shared decision making, but most have been hard to produce, onerous to update, and are not being used widely. **Thomas Agoritsas and colleagues** explore why and describe a new electronic model that holds promise of being more useful for clinicians and patients to use together at the point of care

Thomas Agoritsas *research fellow*^{1,2}, Anja Fog Heen *doctoral candidate*^{3,4}, Linn Brandt *doctoral candidate*^{3,4}, Pablo Alonso-Coello *associate researcher*^{1,5}, Annette Kristiansen *doctoral candidate*^{3,4}, Elie A Akl *associate professor*^{1,6}, Ignacio Neumann *assistant professor*^{1,7}, Kari AO Tikkinen *adjunct professor*^{1,8}, Trudy van der Weijden *professor*⁹, Glyn Elwyn *professor*¹⁰, Victor M Montori *professor*¹¹, Gordon H Guyatt *distinguished professor*¹, Per Olav Vandvik *associate professor*^{3,4}

SHARE-IT

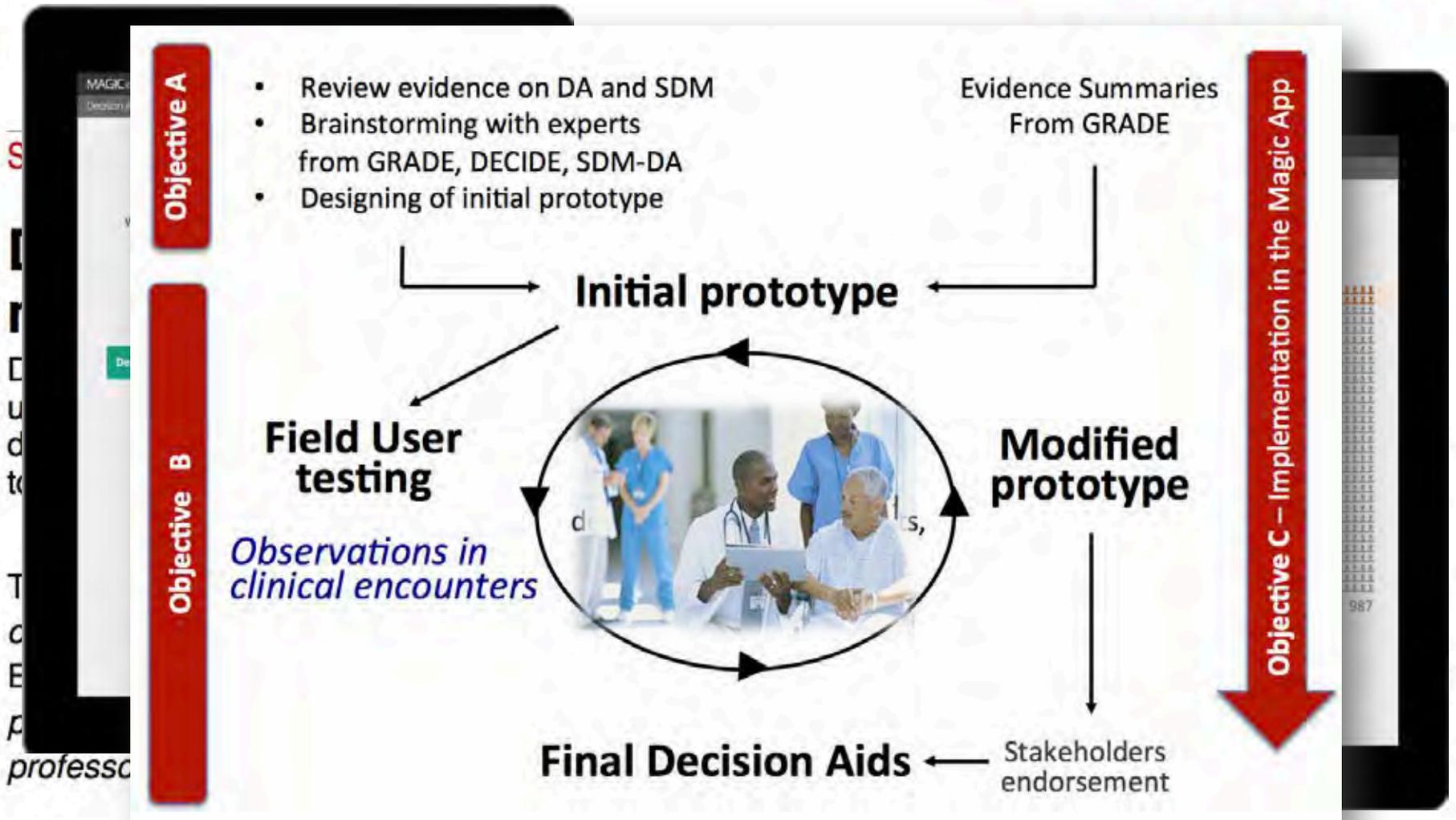
ANALYSIS



professor", Gordon H Guyatt *dis*

SHARE-IT

ANALYSIS





thebmj

Research ▾

Education ▾

News & Views ▾

Campaigns

BMJ 2016 ; 354 doi: <http://dx.doi.org/10.1136/bmj.i5191> (Published 28 September 2016)

Cite this as: *BMJ* 2016;354:i5191

Reed A Siemieniuk, methodologist^{1 2}, Thomas Agoritsas, assistant professor^{1 3}, Helen Macdonald, acting head of education section⁴, Gordon H Guyatt, distinguished professor^{1 5}, Linn Brandt, methodologist⁶, Per O Vandvik, associate professor^{6 7}

UiO : University of Oslo



HOW WE MAKE A **RAPID REC**



New BMJ collaboration accelerates evidence into practice to answer the questions that matter quickly and transparently through trustworthy recommendations

Siemieniuk, **Agoritsas** et al. Introduction to BMJ Rapid Recommendations. *BMJ* 2016;354:i5191.
Agoritsas et al. The BMJ Rapid Recommendations. *Rev Med Suisse* 2019;15:149-55.



thebmj

Research ▾

Education ▾

News & Views ▾

Campaigns

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HOW WE MAKE A **RAPID REC**

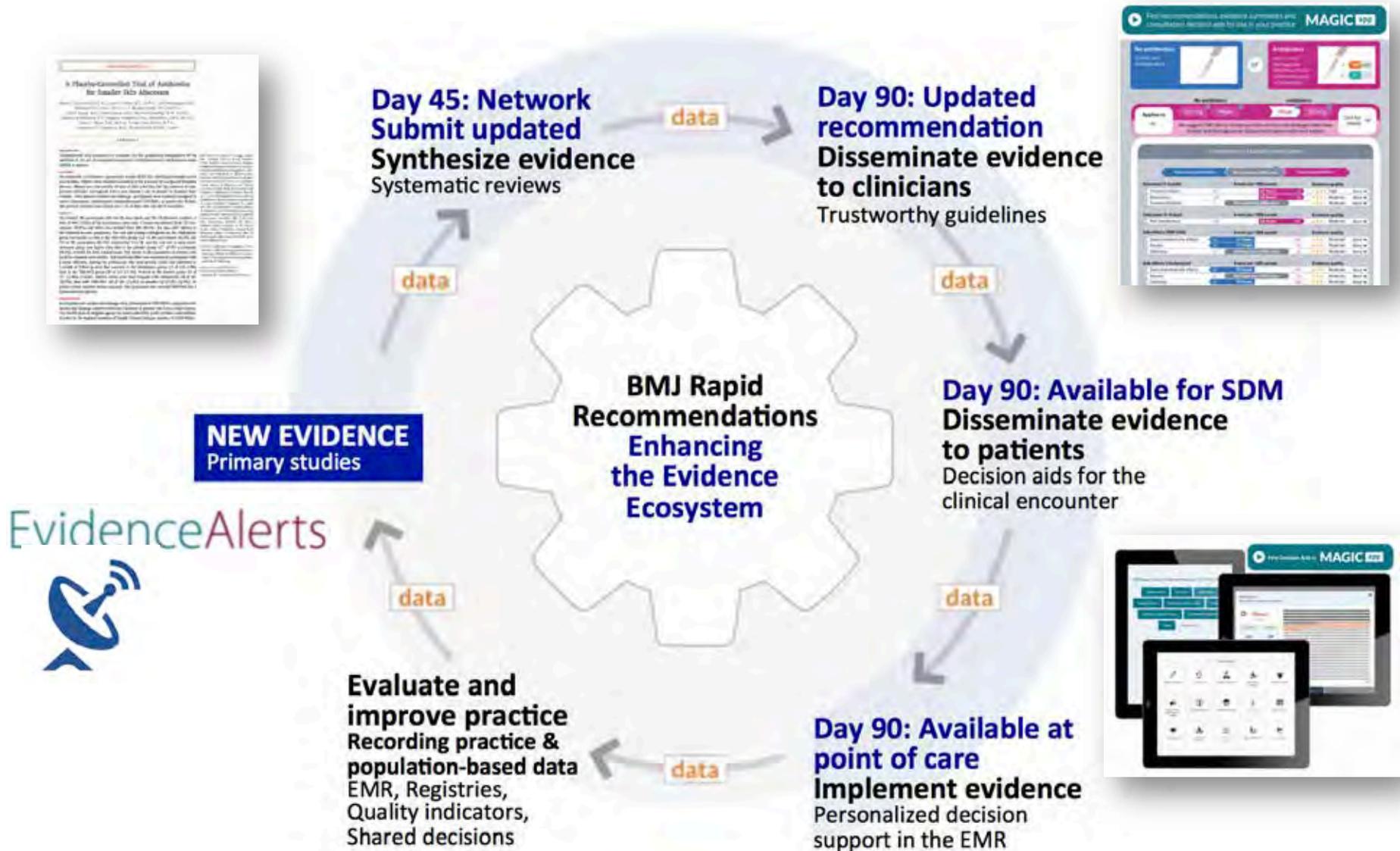
✓ Trustworthy

✓ Timely

✓ Actionable

Siemieniuk, **Agoritsas** et al. Introduction to BMJ Rapid Recommendations. *BMJ* 2016;354:i5191.
Agoritsas et al. The BMJ Rapid Recommendations. *Rev Med Suisse* 2019;15:149-55.

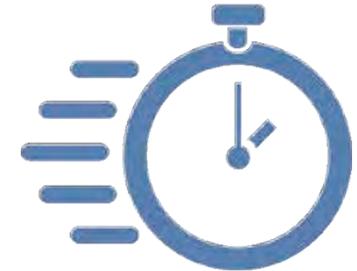
BMJ RapidRecs : 90-100 day objective



thebmj Rapid Recommendations (Rapid Recs)



Patient partners



WARNING!



GRADE

M Authoring & Publication Platform

Infographics
Decision Aids

Prostate cancer screening

Screening

www.bmj.com/rapid-recommendations

Corticosteroids for treatment of sore throat

n=14 guidelines in 3 years

n=25 recs

n=18 SR

Primary Care

Antibiotics for uncomplicated skin abscesses

Antiretroviral therapy in pregnant women living with HIV

Altmetric *



Drugs
Acute care

Dual vs single antiplatelet therapy

Corticosteroid therapy for sepsis

Thyroid hormones treatment for subclinical hypothyroidism

Strong Recs Against

Oxygen therapy for acutely ill medical patients



Low intensity pulsed ultrasound (LIPUS) for bone healing

Subacromial decompression surgery for adults with shoulder pain

De-implementation

Arthroscopic surgery for degenerative knee arthritis and meniscal tears *

Atraumatic (pencil-point) versus conventional needles for lumbar puncture

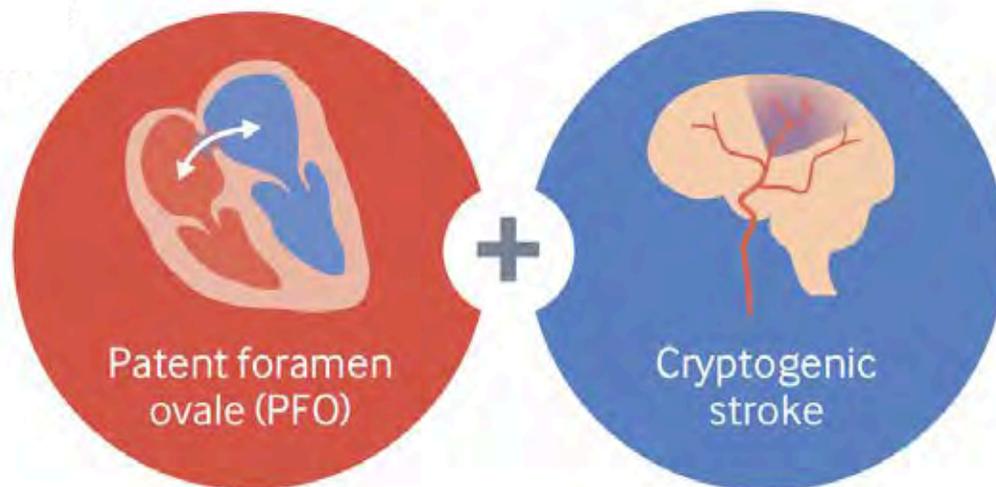
Devices

Transcatheter versus surgical aortic valve replacement

Patent foramen ovale closure or drug therapy for management of cryptogenic stroke

John, 60 years old

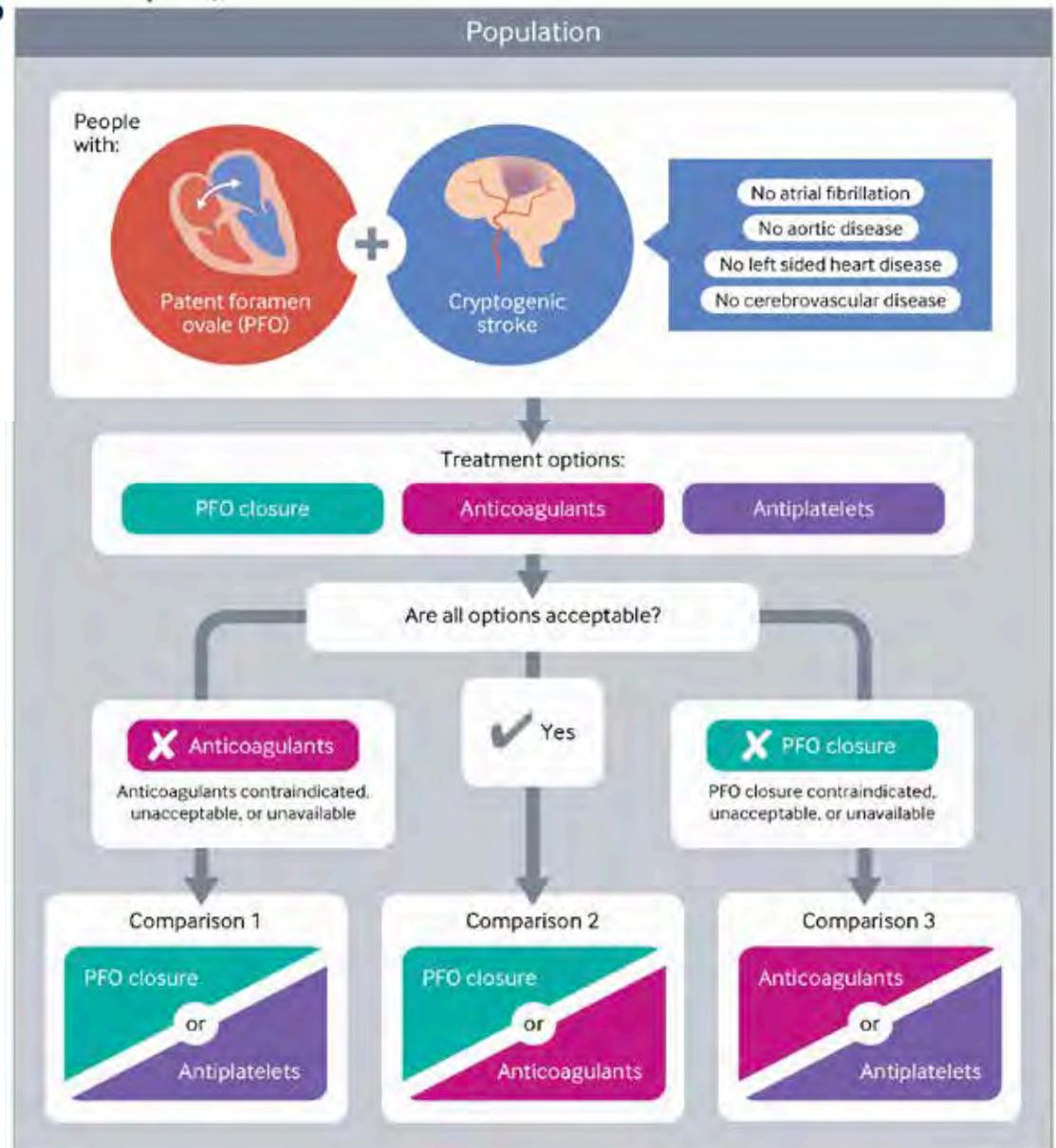
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Patent foramen ovale closure, antiplatelet therapy or anticoagulation therapy alone for management of cryptogenic stroke? A clinical practice guideline

Ton Kuijpers,¹ Frederick A Spencer,² Reed A C Siemieniuk,^{3,4} Per O Vandvik,^{5,6} Catherine M Otto,⁷ Lyubov Lytvyn,² Hassan Mir,² Albert Y Jin,⁸ Veena Manja,⁹ Ganesan Karthikeyan,¹⁰ Elke Hoendermis,¹¹ Janet Martin,¹² Sebastian Carballo,¹³ Martin O'Donnell,¹⁴ Trond Vartdal,¹⁵ Christine Baxter,¹⁶ Bray Patrick-Lake,¹⁷ Joanie Scott,¹⁸ Thomas Agoritsas,^{3,19} Gordon Guyatt^{2,3}



Comparison 1

PFO closure

Percutaneous closure of PFO followed by antiplatelet therapy



or

Antiplatelets

Antiplatelet therapy alone



PFO closure

Antiplatelets

Strong

Weak

Weak

Strong

More details

We recommend PFO closure followed by antiplatelet therapy over antiplatelet therapy alone.

Comparison of benefits and harms

Favours PFO closure

No important difference

Favours antiplatelets

Within 5 years

	Events per 1000 people		Evidence quality
Ischaemic stroke	13	87 fewer	★★★★ Moderate More
Death	9	No important difference	★★★★ Moderate More
Major bleeding	7	No important difference	★★★★ Moderate More

Within 1 year

	Events per 1000 people		Evidence quality
Persistent AF flutter	23	18 fewer	★★★★ Moderate More
Device-related adverse events	36	36 fewer	★★★★ High More

See all outcomes **MAGIC app**

See patient decision aids **MAGIC app**

Comparison 2

PFO closure

Percutaneous closure of PFO followed by antiplatelet therapy



or

Anticoagulants

Anticoagulation therapy



PFO closure

Strong

Weak

Anticoagulants

Weak

Strong

More details

We suggest PFO closure followed by antiplatelet therapy over anticoagulation therapy. Discuss both options with each patient.

Comparison of benefits and harms

Favours PFO closure

No important difference

Favours anticoagulants

Within 5 years

	Events per 1000 people		Evidence quality
Ischaemic stroke	13	No important difference 29	★☆☆ Low More
Death	9	No important difference 13	★★★★ Moderate More
Major bleeding	7	20 fewer 27	★★★★ Moderate More

Within 1 year

	Events per 1000 people		Evidence quality
Persistent AF flutter	23	18 fewer 5	★★★★ Moderate More
Device-related adverse events	36	36 fewer 0	★★★★ High More

See all outcomes

MAGIC app

See patient decision aids

MAGIC app

Comparison 3

Anticoagulants

Anticoagulation therapy



or

Antiplatelets

Antiplatelet therapy



Anticoagulants

Strong

Weak

Antiplatelets

Weak

Strong

More details

We suggest anticoagulation over antiplatelet therapy.
Discuss both options with each patient.

Comparison of benefits and harms

Favours anticoagulants

No important difference

Favours antiplatelets

Within 5 years

Events per 1000 people

Evidence quality

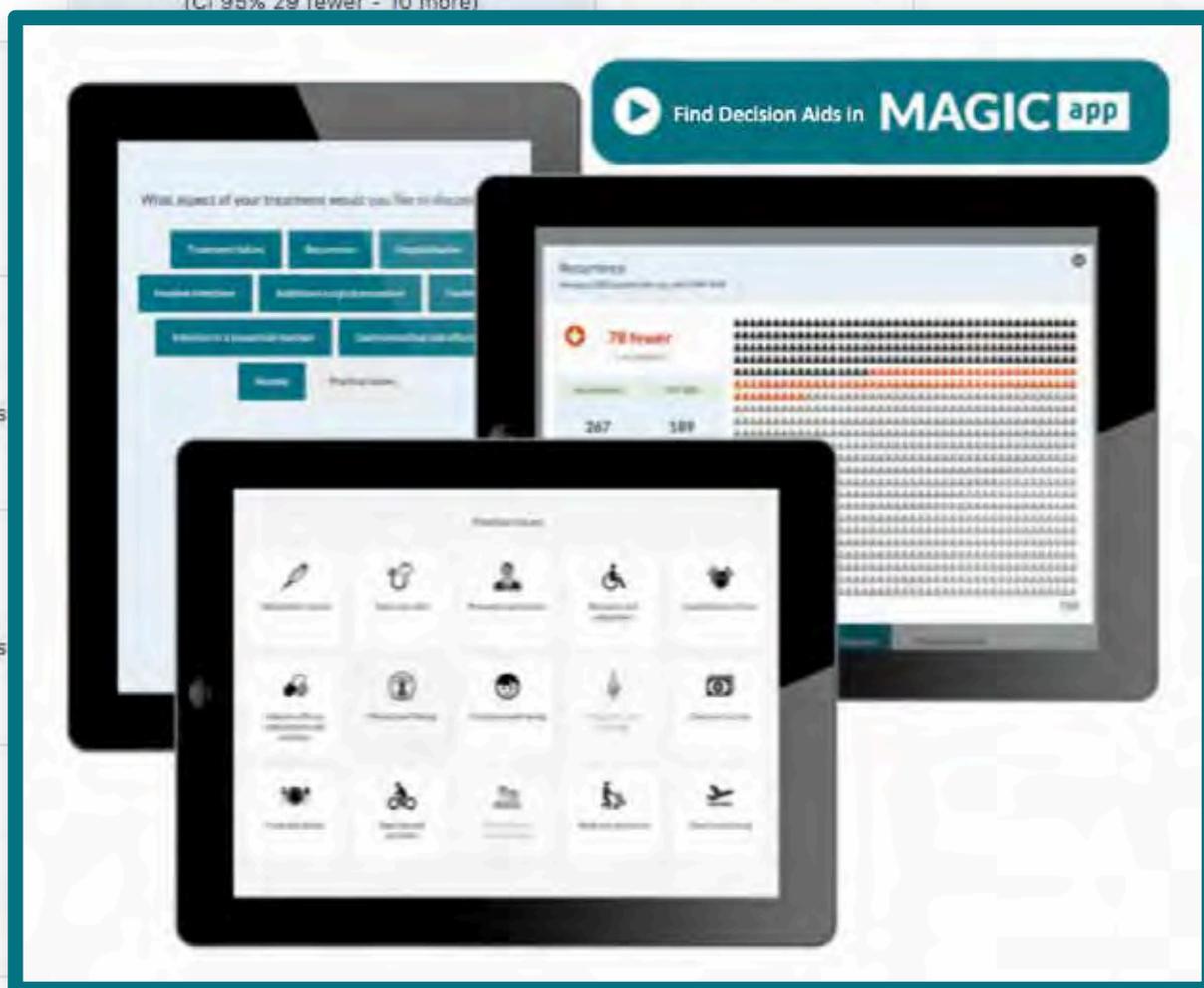
Outcome	Anticoagulants	Antiplatelets	Events per 1000 people	Evidence quality	More
Ischaemic stroke	29	100	71 fewer	Low	More
Death	13	3	No important difference	Low	More
Major bleeding	26	14	12 fewer	Moderate	More
Pulmonary embolism	1	5	No important difference	Moderate	More

See all outcomes **MAGIC app**

See patient decision aids **MAGIC app**

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Anticoagulation	PFO closure plus antiplatelet therapy		
Ischaemic stroke Standardized to 5 years 8 Critical	Odds Ratio 0.44 (CI 95% 0.08 - 3.83) Based on data from 353 patients in 1 study Follow up: 5.3 years.	29 per 1000 Difference: 16 fewer per 1000 (CI 95% 29 fewer - 10 more)	13 per 1000	Low Due to very serious imprecision	There may be little or no difference in ischaemic stroke
Ischaemic stroke (modelling data from VTE literature) Standardized to 5 years 8 Critical	Odds Ratio 0.93 (CI 95% 0.31 - 2.76)	29 per 1000 Difference: 2 fewer per 1000 (CI 95% 20 fewer - 47 more)	27 per 1000	Low Due to serious imprecision and serious indirectness	There may be little or no difference in ischaemic stroke
Death Standardized to 5 years 9 Critical	Relative risk 0.69 (CI 95% 0.02 - 32.36) Based on data from 353 patients in 1 study Follow up: 5.3 years.	13 per 1000 Difference: 4 fewer per 1000 (CI 95% 13 fewer - 9 more)	9 per 1000	Moderate Due to serious imprecision	There is probably little or no difference in death
Major bleeding Standardized to 5 years 7 Critical	Odds Ratio 0.26 (CI 95% 0.07 - 0.82) Based on data from 353 patients in 1 study Follow up: 5.3 years.	27 per 1000 Difference: 20 fewer per 1000 (CI 95% 27 fewer - 2 fewer)	7 per 1000	Moderate Due to serious imprecision	PFO closure plus antiplatelet therapy probably decreases major bleeding
Major bleeding (modelling data from VTE literature) Standardized to 5 years 7 Critical	Odds Ratio 0.28 (CI 95% 0.13 - 0.55)	24 per 1000 Difference: 17 fewer per 1000 (CI 95% 21 fewer - 11 fewer)	7 per 1000	Moderate Due to serious indirectness	PFO closure plus antiplatelet therapy probably decreases major bleeding

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Anticoagulation	PFO closure plus antiplatelet therapy		
Ischaemic stroke Standardized to 5 years 8 Critical	Odds Ratio 0.44 (CI 95% 0.08 - 3.83) Based on data from 353 patients in 1 study Follow up: 5.3 years.	29 per 1000 Difference: 16 fewer per 1000 (CI 95% 29 fewer - 10 more)	13 per 1000	Low Due to very serious imprecision	There may be little or no difference in ischaemic stroke
Ischaemic stroke (modelling data from VTE literature) Standardized to 5 years 8 Critical	Odds Ratio 0.93 (CI 95% 0.31 - 2.76)				
Death Standardized to 5 years 9 Critical	Relative risk 0.69 (CI 95% 0.02 - 32.36) Based on data from 353 patients study Follow up: 5.3 years.				
Major bleeding Standardized to 5 years 7 Critical	Odds Ratio 0.26 (CI 95% 0.07 - 0.82) Based on data from 353 patients study Follow up: 5.3 years.				
Major bleeding (modelling data from VTE literature) Standardized to 5 years 7 Critical	Odds Ratio 0.28 (CI 95% 0.13 - 0.55)				



What aspect of your treatment would you like to discuss next?

Ischaemic stroke

Death

Major bleeding

Persistent atrial fibrillation or flutter

Transient atrial fibrillation or flutter

Device or procedure related adverse event

Transient ischaemic attack

Pulmonary embolism

Systemic embolism

Practical issues





Ischaemic stroke



Among a 1000 patients like you, with PFO closure plus antiplatelet therapy



16 fewer

Standardized to 5 years

Anticoagulation

PFO closure plus
antiplatelet
therapy

29

per 1000

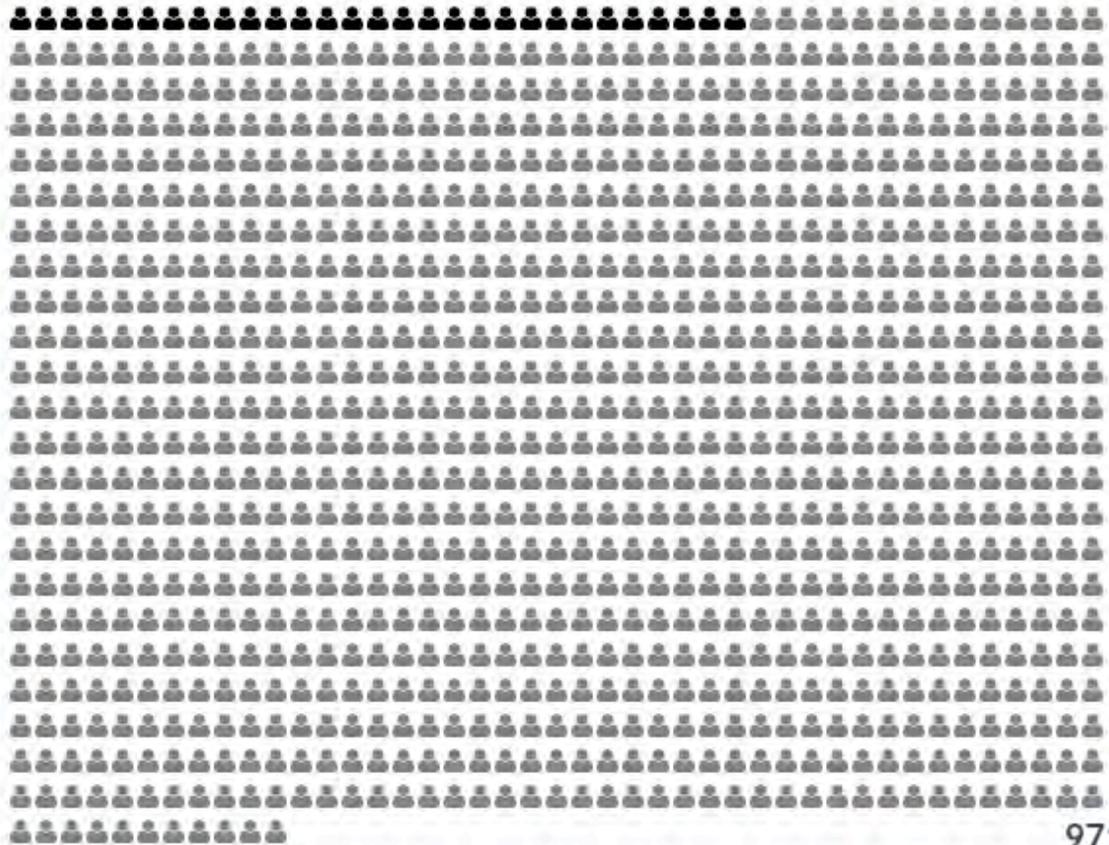
13

per 1000

Certainty



LOW



971

Transient atrial fibrillation or flutter

Device or procedure related adverse event



Ischaemic stroke



Among a 1000 patients like you, with PFO closure plus antiplatelet therapy



16 fewer

Standardized to 5 years

Anticoagulation

PFO closure plus
antiplatelet
therapy

29

per 1000

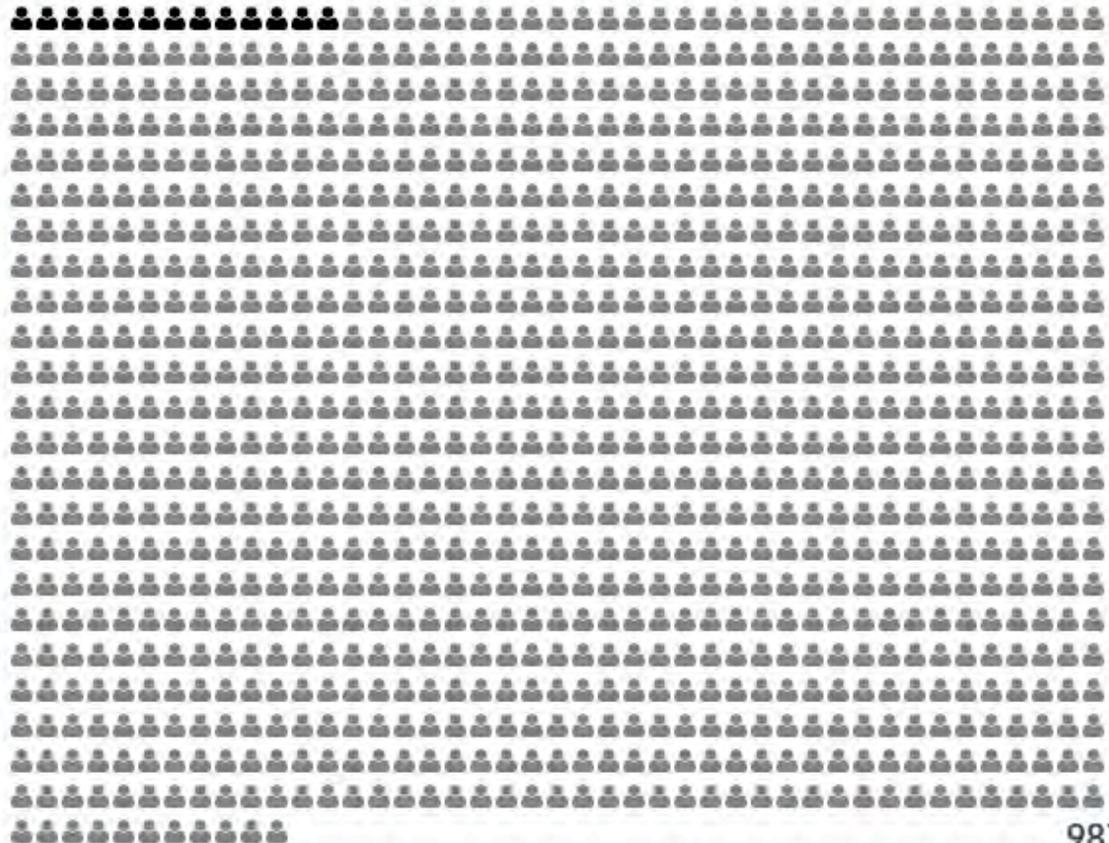
13

per 1000

Certainty



LOW



987

Transient atrial fibrillation or flutter

Device or procedure related adverse event



Ischaemic stroke



Among a 1000 patients like you, with PFO closure plus antiplatelet therapy



16 fewer

Standardized to 5 years

Anticoagulation

PFO closure plus antiplatelet therapy

29

per 1000

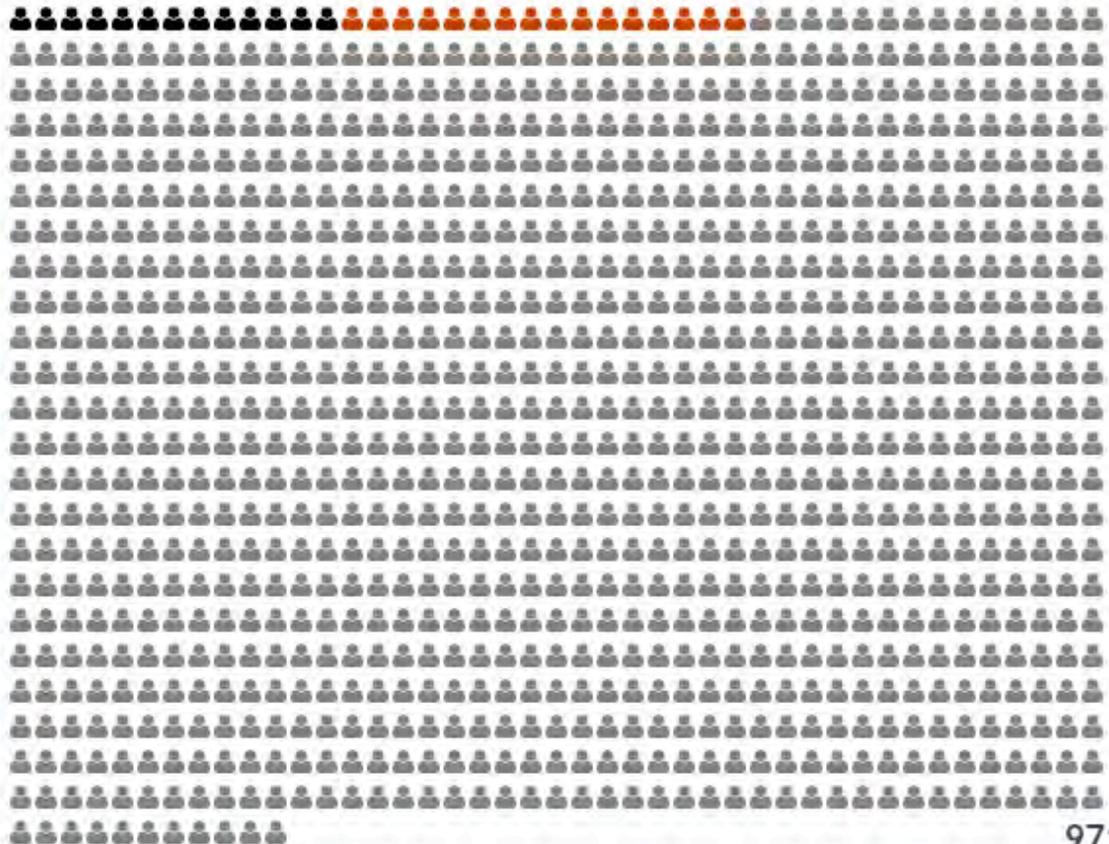
13

per 1000

Certainty



LOW



971

Transient atrial fibrillation or flutter

Device or procedure related adverse event

What aspect of your treatment would you like to discuss next?

Ischaemic stroke

Death

Major bleeding

Persistent atrial fibrillation or flutter

Transient atrial fibrillation or flutter

Device or procedure related adverse event

Transient ischaemic attack

Pulmonary embolism

Systemic embolism

Practical issues





Major bleeding



Among a 1000 patients like you, with PFO closure plus antiplatelet therapy



20 fewer

Standardized to 5 years

Anticoagulation

PFO closure plus
antiplatelet therapy

27

per 1000

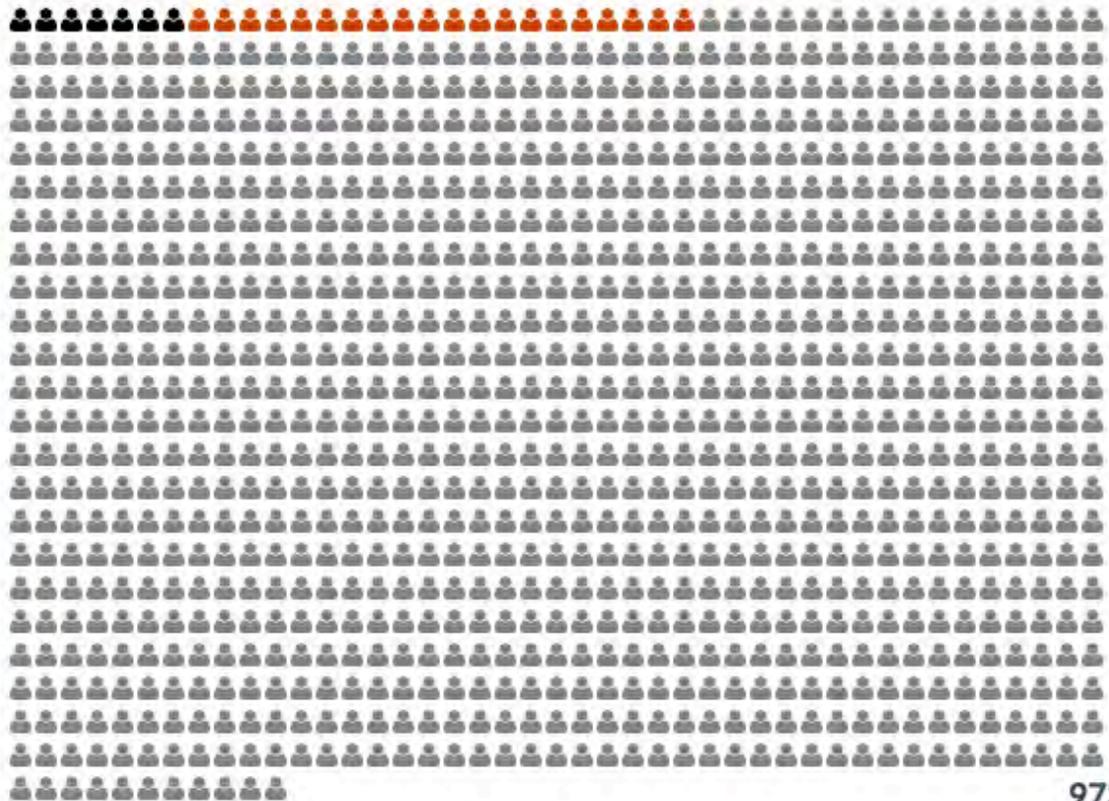
7

per 1000

Certainty



MODERATE



973

Ischaemic stroke

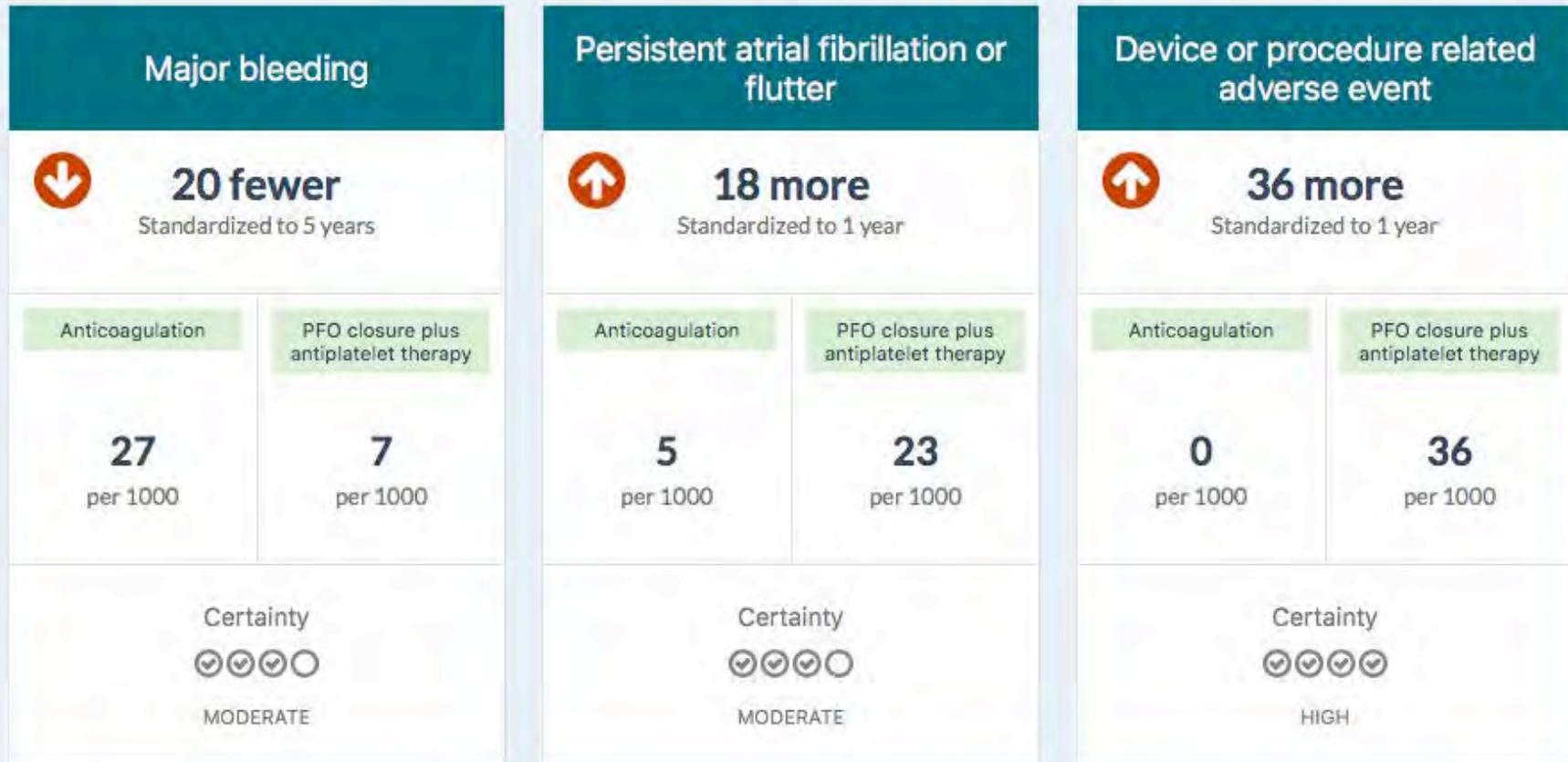
Ischaemic stroke (modelling data from VTE literature)

Death

Major bleeding (modelling data from VTE literature)

Transient atrial fibrillation or flutter

Among a 1000 patients like you, on average with PFO closure plus antiplatelet therapy



Ischaemic stroke

Ischaemic stroke (modelling data from VTE literature)

Death

Major bleeding (modelling data from VTE literature)

Transient atrial fibrillation or flutter

What aspect of your treatment would you like to discuss next?

Ischaemic stroke

Death

Major bleeding

Persistent atrial fibrillation or flutter

Transient atrial fibrillation or flutter

Device or procedure related adverse event

Transient ischaemic attack

Pulmonary embolism

Systemic embolism

Practical issues



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▶ Categories

▶ Young people

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Home

Health Professionals

Patients' experiences shared on film.

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PEOPLE'S EXPERIENCES OF HEALTH

LEARNING & TEACHING

HEALTH PROFESSIONALS

YOUNG PEOPLE

Practical issues



Medication
routine



Tests and visits



Procedure and
device



Recovery and
adaptation



Coordination of
care



Adverse effects,
interactions and
antidote



Physical well-being



Emotional well-
being



Pregnancy and
nursing



Costs and access



Food and drinks



Exercise and
activities



Social life and
relationships



Work and
education



Travel and driving



Tests and visits



with PFO closure plus antiplatelet therapy

May include 1 or 2 visits to the cardiologist in the first 6 months followed by an appointment every 1-2 years.

with Anticoagulation

Initial frequent testing required to achieve appropriate dose. Periodic testing required while taking medication.



Medication routine



Coordination of care



Adverse effects, interactions and antidote



Physical well-being



Emotional well-being



Pregnancy and nursing



Costs and access



Food and drinks



Exercise and activities



Social life and relationships



Work and education



Travel and driving



Procedure and device



with PFO closure plus antiplatelet therapy

The PFO device will be implanted using a catheter (long, thin, flexible, hollow tube), inserted through a small cut made at the inner thigh (groin), with local anaesthesia and moderate sedation or under general anaesthesia.

The procedure takes under 2 hours. In-hospital stay is usually one day.



Medication
routine



Coordination of
care



Adverse effects,
interactions and
antidote



Physical well-being



Emotional well-
being



Pregnancy and
nursing



Costs and access



Food and drinks



Exercise and
activities



Social life and
relationships

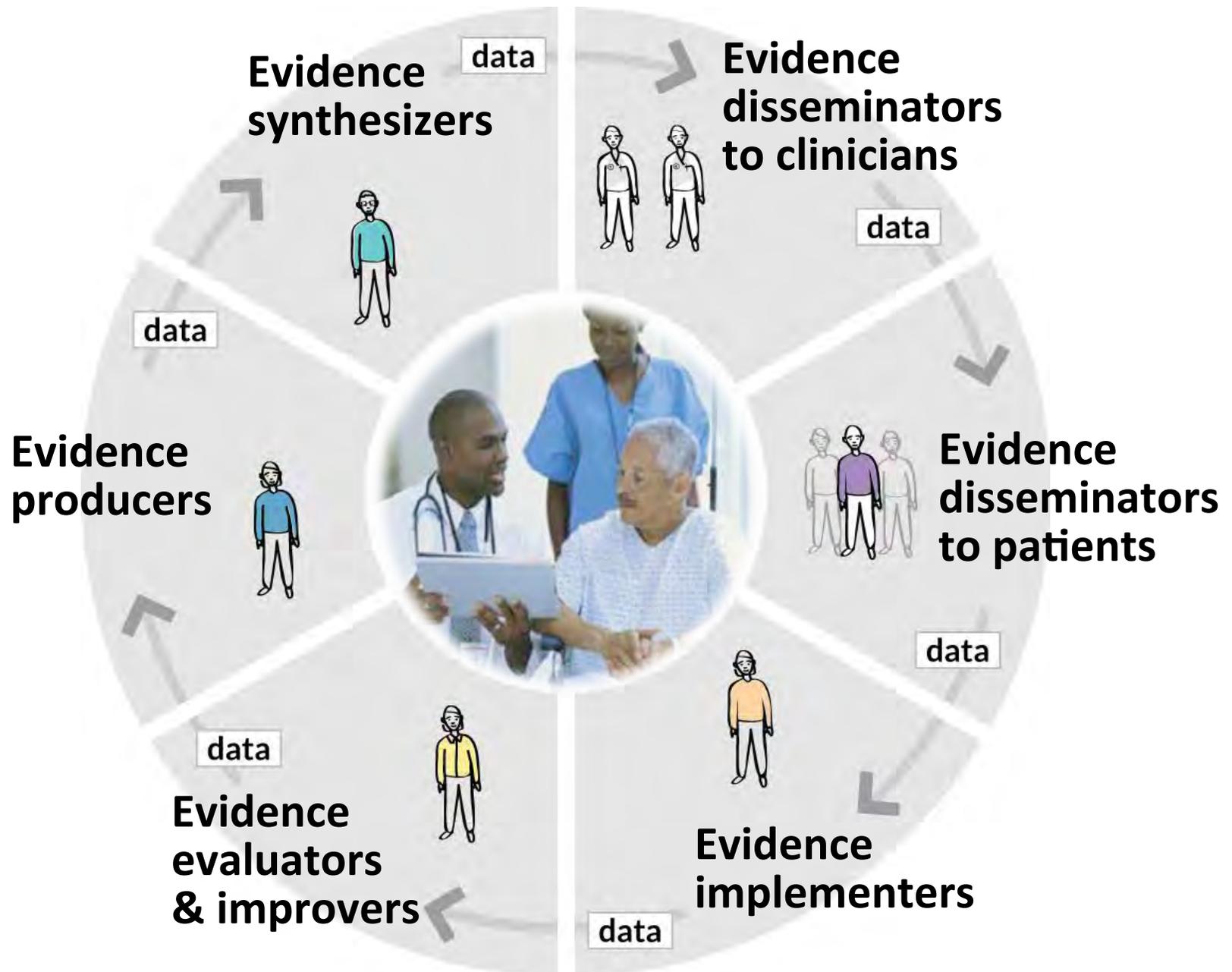


Work and
education



Travel and driving

The Evidence Ecosystem



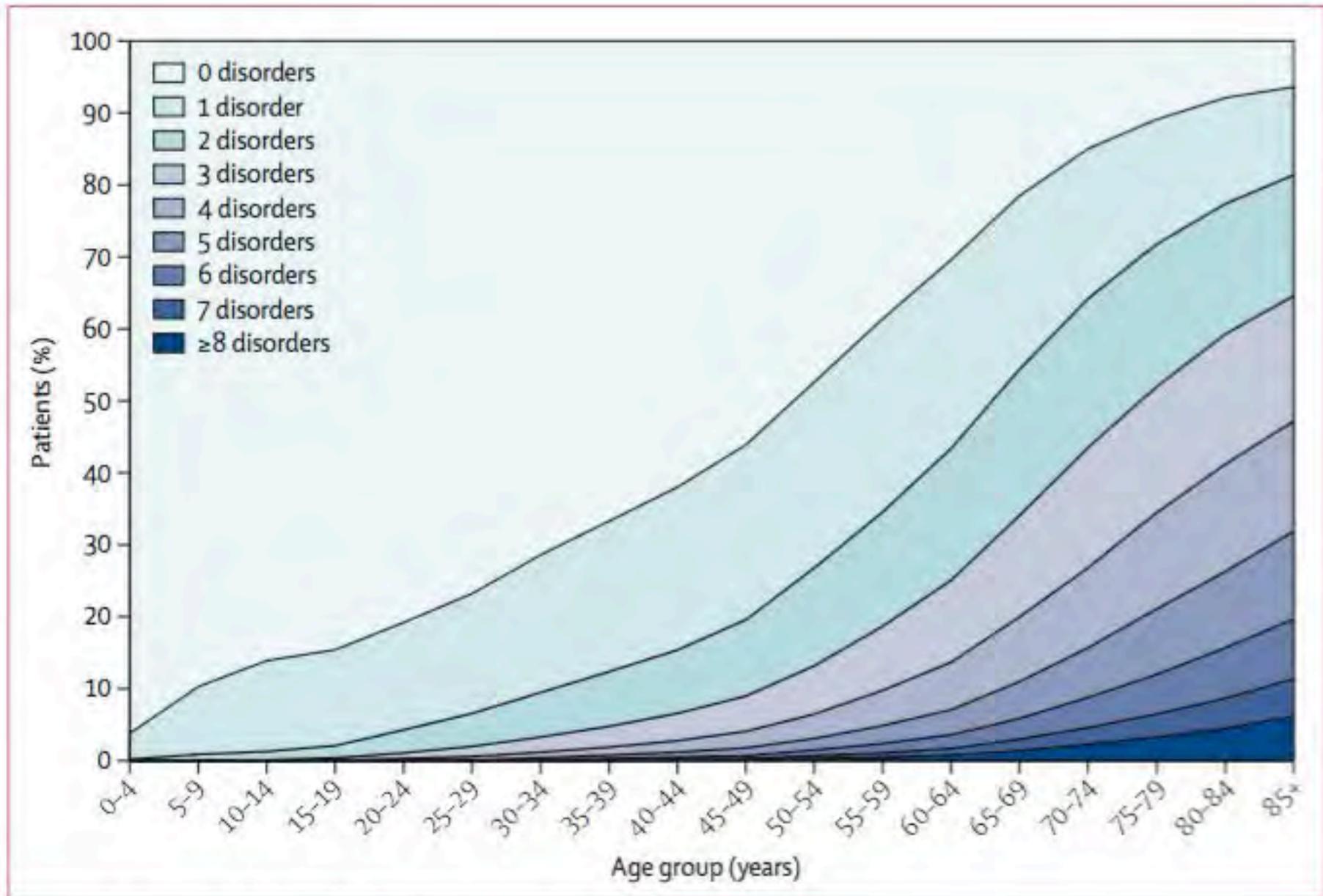


Figure 1: Number of chronic disorders by age-group

The “work” of the patient

Burden



Figure 1. The cumulative complexity model.

Capacity



More time for patients project



Darbellay Farhoumand P, Le Du S, Perrier A,
Agoritsas T. *Rev Med Suisse* 2018;14:1550-5.

Sophie Le Du & team
Prof Arnaud Perrier

All hospital teams that
are implementing it

VIEWPOINT

JAMA July 2, 2019

Shared Decision Making and the Importance of Time

Time can be considered an organizing tool
that controls what happens and when.

Changing attitudes alone will not create time for shared decision making. Because the science of allocating time for care is in its infancy, medicine must innovate. New scheduling algorithms

Priorités de mise en œuvre

Protéger le temps patient et répondre en temps réel à ses besoins.

Activer la collaboration médico-patient-soignante autour du plan de prise en charge et du tableau patient. Fluidifier l'information et la communication en augmentant la visibilité pour répondre aux besoins des patients. Toutes les activités possibles sont délivrées au patient ou auprès du patient. Les autres activités sont réduites au minimum.

Avoir les bonnes informations en un coup d'œil.

Anticiper et standardiser de manière intelligente afin de réduire la complexité. Il est facile et rapide d'avoir les informations nécessaires et mises à jour en tout temps et sans avoir à demander.

Impliquer le patient à chaque étape, décider ensemble.

Prise en compte des décisions et priorités du patient, lui donner confiance permet de l'intégrer comme partenaire de son processus de soin.

La bonne chose au bon endroit au bon moment par la bonne personne.

Grâce à des processus simplifiés, les collaborateurs ont plus de temps pour s'occuper des patients et commettent moins d'erreurs.

Priorisation: Vers un **systeme** de solutions

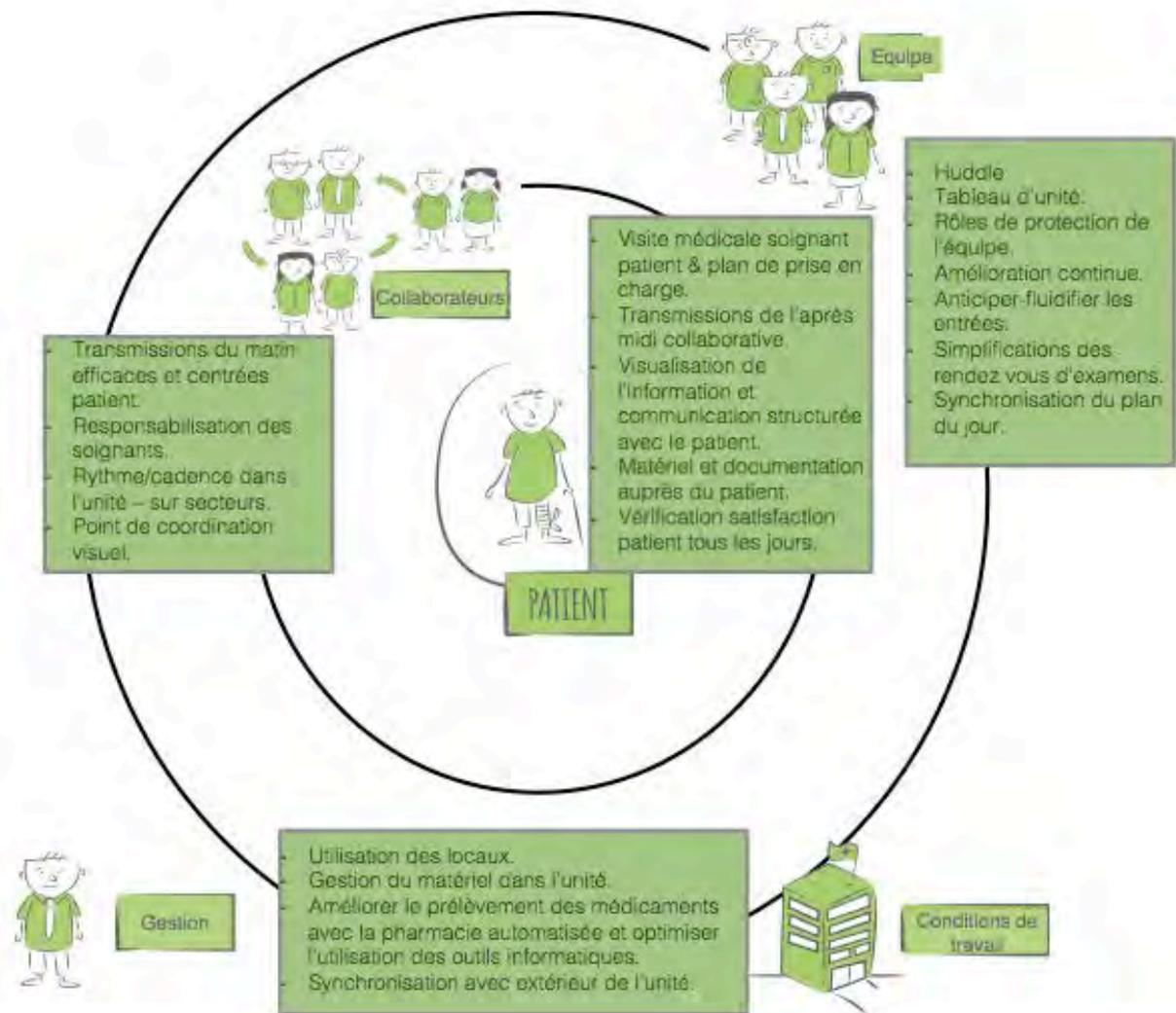


Tableau patient et plan de prise en charge

MON HOSPITALISATION	
1.	<i>Infection du poumon</i>
2.	<i>Masse dans le foie ?</i>
3.	<i>Moral</i>
SORTIE	
<i>14 décembre ?</i>	

HUG Hôpitaux Universitaires Genève	
médi-co-soignante dès 9h30	
Alimentation	<input type="checkbox"/> Normal <input type="checkbox"/> A jeun <input type="checkbox"/> Autre: _____
Hydratation	<input type="checkbox"/> Libre <input type="checkbox"/> Autre: _____
Mobilisation	<input type="checkbox"/> Libre <input type="checkbox"/> Autre: _____
Ce qui est important pour vous aujourd'hui?	
Patient-e / proches Préoccupations, vos questions, etc.	
Plan de prise en charge	



Est-ce qu'on a **écouté** ce qui compte pour vous?



Est-ce qu'on vous a aidé à **comprendre** vos problèmes de santé?



Est-ce qu'on prend **ensemble** les **décisions** qui vous concernent ?



Etes-vous **satisfait(e)** de vos soins **aujourd'hui**?



Que pourrait-on encore améliorer ?

Patient partnership project



Sylvie Touveneau & team

Sandra Merkli

All hospital teams that are implementing it

Promoting patient partnership at all levels of the institution. Changing culture.

Since March 2016 :

- **523 patient partners**
- **748 partnership**

www.hug-ge.ch/patients-partenaires/decouvrez-partenariat-aux-hug



Levels of partnership

Individual

1. Partnership for one's own care
→ *eg. shared decision making*
2. Partnership for the improvement of quality of care & research
→ *eg. projects, teaching, research...*
3. Partnership in institutional leadership
4. Health care policy

Community

Looking for synergies beyond silos



**Feasible care
CAN**

*EBM in JAMA, 1992
ACP J Club 1991*



**Appropriate care
NEED**



**Desirable care
WANT**

Thank you!

 **@ThomasAgoritsas**