

Decision analysis in patients' care

Sir—We strongly believe that behaviour described by Glyn Elwyn and colleagues (Aug 18, p 571)¹ about decision analysis in patients' care is also important for children affected with severe diseases.

Our suggestion is that the process of obtaining informed consent should always be managed as negotiated shared consent. The evolutive characteristics of cognitive processes in children and adolescents, the ego defence mechanisms, the coping behaviour activated in the relation among the child patient, his or her family, and the physicians must all be taken into account.

Many parents have told us that the informed consent procedure was useful, although commonly confusing. They found that discussions were more helpful than the information they read in the consent forms. Satisfaction was not related to ethnic origin or level of education. We believe that paediatricians must be trained in this topic in addition to their technical studies. They need to acquire an adequate knowledge on communication, relational features, and ethics. Our goal is for paediatricians to become competent even in the family system health model,² theory of social representation,³ problem-based learning,⁴ and in communication skills.⁵

*Ezio F Casari, Luisa M E Massimo

Clinical Psychology Unit, University of Genova, "G Gaslini" Research Children's Hospital, 16147 Genova, Italy

- 1 Elwyn G, Edwards A, Eccles M, Rovner D. Decision analysis in patient care. *Lancet* 2001; **358**: 571–74.
- 2 Rolland J. Toward a psychosocial typology of chronic and life-threatening illness. *Family Sys Med* 1984; **2**: 245–62.
- 3 Moscovici S, Duveen G. Social representations: studies in social psychology. Oxford: Blackwell Publishers, 2000.
- 4 Guilbert JJ. Educational handbook for health personnel, 6th edn. Geneva: WHO; 1987.
- 5 Curry RH, Makoul G. An active learning approach to basic clinical skills. *Acad Med* 1996; **71**: 41–44.

Sir—How could we decide whether a decision is right or not? How could we pass a judgment on a judgment? Are the rules or criteria used at level 1 (the decision) still relevant at level 2 (the decision on the decision, or meta-decision)? Since ethics may be defined, as the way decisions (behaviours) should be taken, moral theories could help to answer these questions.

According to Glyn Elwyn and colleagues' decision analysis,¹ a decision is the right one if its expected consequences are the most desirable.

From a moral point of view, this is a consequentialist model.² The shape of decision analysis, looking mainly towards the outcomes explicitly exhibit this end-oriented (teleological) thought.

However, competitive models do exist. With a deontological (rule-based) frame, a good decision is a decision applying a principle, irrespective of the consequences, but different principles may lead to different best decisions. For example, a decision is the right one if the person who takes it is entitled to do it. In our western society, under the paradigm of autonomy, a patient's decision is, merely by itself, the right decision subject to, among other criteria,³ the prerequisite of information. With another pattern, a decision may be known to be right because it comes from a formal consensus statement. The decision is the right one because the right process had been followed, the right people involved, the right timing provided.

When facing a situation with few or inconclusive data on the probability of outcome (clinical research) or outcome with a wide range of value (eg, prophylactic mastectomy) or with merely the kind of outcome unknown (preliminary research), consequentialism is even weaker and the alternative decision patterns rather favoured. Currently we are living under three models related to three key questions: an end-oriented model that answers the question "why this decision"; a model based on autonomy that answers the question "who takes it"; and one centered on the process that answers the question "how was it done".

Complex interactions,⁴ combinations, or conflicts⁵ result from that coexistence, without dominance, of these models.

François Eisinger

Institut Paoli-Calmettes INSERM U379-E9939, 13009 Marseille, France (e-mail: eisinger@marseille.inserm.fr)

- 1 Elwyn G, Edwards A, Eccles M, Rovner D. Decision analysis in patient care. *Lancet* 2001; **358**: 571–74.
- 2 Brody BA. Moral theory and moral judgments in biomedical ethics. In: Brody BA, ed. Moral theory and moral judgments in biomedical ethics. Dordrecht: Kluwer Academic Publishers, 1988: 1–12.
- 3 Muramoto O. Bioethics of the refusal of blood by Jehovah's Witnesses, part 3: a proposal for a don't-ask-don't-tell policy. *J Med Ethics* 1999; **25**: 463–68.
- 4 Eisinger F, Geller G, Burke W, Holtzman N. Cultural basis for differences between US and French clinical recommendations for women at increased risk of breast and ovarian cancer. *Lancet* 1999; **353**: 919–20.
- 5 Glick SM. Unlimited human autonomy: a cultural bias? *N Engl J Med* 1997; **336**: 954–56.

The teaching of appropriate use of antimicrobials

Sir—The reports of the House of Lords Select Committee on Science and Technology, *Resistance to Antibiotics and other Antimicrobial Agents*,¹ and the UK Standing Medical Advisory Committee, *The Path of Least Resistance*,² emphasise the importance of teaching concerned with the appropriate use of antimicrobials at undergraduate level.

We did a postal survey of UK medical schools and the University of St Andrews, which offers a 3-year preclinical course, on teaching and learning on this topic. We received replies from 17 (71%) of 24 institutions. The contact times allocated to teaching about the rational use of antimicrobials (as opposed to pharmacology, mode of action, &c) varied greatly (range 0.5–22.0 h). Although many respondents commented that students might receive information on the use and misuse of antimicrobials during teaching time devoted to other topics and while undertaking clinical placements, none was able to quantify this time. All institutions that responded, except one, reported that lectures, generally in years 2 and 3 were the main method of teaching, but in some cases, lectures were supplemented with tutorials or problem-based learning exercises (individually or in groups). One medical school stated that students learned the principles and practice of antimicrobial use through a self-directed learning module throughout the undergraduate course.

In hospitals, antimicrobials are frequently prescribed by inexperienced junior medical staff with insufficient guidance from more senior colleagues.³ This situation underscores the importance of teaching medical undergraduates about good antimicrobial prescribing. However, our results suggest that teaching methods and time devoted to this topic vary widely across medical schools.

The threat to public health posed by antimicrobial resistance is such that national guidelines to help dental and medical schools establish core curricula for teaching the appropriate use of antimicrobials, and the potential consequences of misuse, at undergraduate level should be developed. However, chronic under-resourcing of academic units should be addressed if this teaching is to be delivered effectively. One report concludes that UK "[academic] medical microbiology