tients is whether it facilitates informed, value-concordant decisions. Physicians can facilitate informed, value-concordant decisions in at least 3 ways. First, physicians can frame information in ways that foster accurate beliefs about important outcomes. For example, as the authors noted, it is generally better to frame outcome risk information in terms of absolute risk rather than relative risk because evidence suggests that this approach leads to more accurate outcomes expectations.3

Second, communications with patients can shift the focus or emphasis that patients place on different types of outcomes. In doing so, physicians can increase the likelihood that the weights the patients assign to outcomes are consistent with the patients’ underlying values. Shaw and Elger’s description of a physician shifting a patient’s focus from fear of surgery to fear of death is an example of this strategy. The authors argued that this strategy is appropriate because it reduces a patient’s bias for avoiding short-term, negative outcomes. However, we contend that the appropriateness of this technique should be judged by whether the resulting weights placed on short- and long-term outcomes are consistent with a patient’s underlying values.

A third strategy of physicians involves priming heuristics that help patients reach value-concordant decisions. We believe that recommendations made by physicians affect the decisions made by patients primarily because they prime a physician-knows-best heuristic. Shaw and Elger argued that it is usually appropriate for physicians to offer a recommendation. Although we do not disagree with this assertion, we believe the most appropriate recommendations are those that are made with sensitivity to how patients value the potential outcomes of the final decision.

Adam A. Powell, PhD, MBA
Melissa R. Partin, PhD

Author Affiliations: Minneapolis Veterans Affairs Health Care System, Minneapolis, Minnesota (Powell, Partin).

Corresponding Author: Adam A. Powell, PhD, MBA, Minneapolis Veterans Affairs Health Care System, One Veterans Drive, 111-0, Minneapolis, MN 55406 (adam.powell@va.gov).

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.


In Reply It appears that we are not in disagreement with Drs Powell and Partin, who state that instead of focusing on bias reduction, a better litmus test of the appropriateness of communica-

tion is whether it facilitates informed, value-concordant decisions by patients. Similarly, we stated in our Viewpoint that the aim of our model of persuasion is precisely to help patients make autonomous decisions in line with their basic beliefs; bias reduction is merely the first step in achieving this objective.

Powell and Partin also claim that the appropriateness of bias reduction should be judged according to whether the resulting weights placed on short- and long-term outcomes are consistent with a patient’s underlying values. Once again, we believe the aim of removing bias in such cases is not necessarily to prevent patients from fulfilling their wish to avoid short-term harm but to make sure that they are aware of the potential long-term costs of doing so. If the results of bias reduction were a new bias against a patient’s deeply held beliefs, the attempt at persuasion would indeed have failed.

In addition, Powell and Partin believe the most appropriate recommendations are those that are made with sensitivity to how patients value the potential outcomes of the final decision. This is precisely the objective of our model of persuasion: to provide patients with evidence-based information about the different options available to them while also removing any biases that might distort their interpretation of this evidence, thereby enabling them to make autonomous choices that are in accordance with their core values.

David Shaw, PhD
Bernice Elger, MD

Author Affiliations: Institute for Biomedical Ethics, University of Basel, Basel, Switzerland (Shaw); Université de Genève, Geneva, Switzerland (Elger).

Corresponding Author: David Shaw, PhD, University of Basel, Institute for Biomedical Ethics, Bernoullistrasse 28, Basel-Stadt 4055, Switzerland (davidmartinshaw@gmail.com).

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Elger reported receiving travel and meeting expenses from the Swiss Federal Commission on Genetic Testing. Dr Shaw reported no disclosures.

CORRECTION

Clarification of Data: In the Clinical Review entitled “Sublingual Immunotherapy for the Treatment of Allergic Rhinoconjunctivitis and Asthma: A Systematic Review,” published in the March 27, 2013, issue of JAMA (2013;309[10]:1022-1029. doi:10.1001/jama.2013.2049), a clarification should be made in 2 places. On page 1281, under the heading “Rhinitis,” the third sentence should read “The majority of studies (94%) demonstrated greater improvement in the sublingual immunotherapy group vs placebo.” In Table 1, second row, “Rhinitis or rhinoconjunctivitis symptoms scores,” in column 7, “Findings,” should read “The majority of studies showed greater improvement in symptoms in the sublingual immunotherapy group vs placebo.” This article has been corrected online.

Labels Switched in Figure: In the Original Contribution entitled “Association Between Bleeding Events and In-hospital Mortality After Percutaneous Coronary Intervention” published in the March 13, 2013, issue of JAMA (2013;309[10]:1022-1029. doi:10.1001/jama.2013.1556), 2 variable labels were reversed. In Figure 2, the “Access-site bleed” variable labels were switched. This article has been corrected online.