Much of these experts' work has gone into the development of decision aids which are available to physicians and interested patients could access it themselves. Such resources (commonly called patient decision aids) that enable patients to learn more about their risk profile without a visit to the doctor can take the form of picture boards, videos or booklets, can prepare patients for a conversation about their risks and options, a big benefit for time-pressed physicians.

“Patients in the study, which was published in the Archives of Internal Medicine, were told their cardiovascular age (current age minus calculated change in life expectancy based on cardiovascular risk factors) and offered advice on lifestyle changes and pharmacotherapy to treat dyslipidemia. Controls were not told their cardiovascular age.

Although overall the study recorded fairly modest impact on the patients’ achievement of lipid targets, the patients with the greatest difference between their real age and cardiovascular age had significantly larger drops in cholesterol levels than those with the lowest difference. Conversely, those patients whose cardiovascular age was lower than their chronologic age were less likely to get to targets than those receiving usual care, which indicated that risk assessment also served to reassure low-risk individuals, noted Dr. Grover.

For some people, a visual representation of some kind is very helpful,” he said. “People clearly understand when their risk factors are high enough that their cardiovascular age is higher than their chronological age, and when they’ve done something to bring that cardiovascular age down, they know they are going in the right direction,” he added.

**Decision aids**

After his study was complete, Dr. Grover put the cardiovascular age tool on the Internet at www.chiprehab.com so that interested patients could access it themselves. Such resources (commonly called decision aids) that enable patients to learn more about their risk profile without a visit to the doctor can be key to helping patients make good decisions, experts said.

Evidence-based decision aids, which can take the form of picture boards, videos or booklets, can prepare patients for a conversation about their risks and options, a big benefit for time-pressed physicians.

“The doctors don’t have to spend as much time. They can spend time answering questions,” said Dr. Sheridan.

Time and office space could be used even more efficiently if decision aids turn down the need for home assignments for patients. Dominick L. Frosch, PhD, assistant professor in the UCLA department of medicine, has studied video decision aids used in the office, and someday plans to examine what would happen if physicians prescribed the aids.

“There are a lot of open questions, such as ‘After the physician prescribes it, will the patient actually watch it home? After the patient watches the program, will the patient return to the doctor?’” he said.

The entire field of research on patient understanding of risk will have many big, open questions for some time to come, noted Dr. Mulley. Even if a method is found to make all patients perfectly understand the risks of an intervention, they would still have dramatically different perspectives on the statistics.

“If there is a 3% risk of death from a procedure, that 3% might be acceptable to some people, but not to others,” he said. “Often medical decisions depend more on those subjective attitudes that a patient brings to a decision than they do on what they learn from the clinical research.”