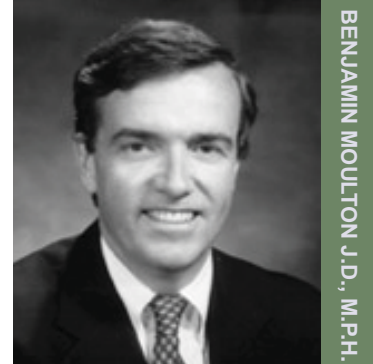


## Ask the Experts

*Benjamin Moulton J.D., M.P.H.*

Mr. Moulton is the co-author of the 2006 article, “Rethinking Informed Consent: the Case for Shared Decision Making,” published in *The American Journal of Law & Medicine*. Recently he was asked to highlight key discussion points in the article and provide an overview on the topic of shared decision-making. Disclaimer: this interview should not be considered by the reader to be legal advice or used as a substitute for professional legal advice for a particular situation.



**Q: Shared decision making (SDM) has been widely advocated as an effective means for patients and their care providers to reach agreement on the best strategy for treatment. What are the advantages of SDM for patients? For care providers?**

**A:** I believe there are significant advantages for both patients and providers.

The SDM process would facilitate a more thorough exchange of treatment information and would supplement the current process of informed consent. SDM is a better means of disseminating information to the patient than a rushed clinical encounter in which the patient is unprepared to ask questions that are specific to his or her treatment and preferences. Currently there are two types of informed consent laws in the United States: patient-centered and physician-centered. In states with physician-centered informed consent, providers are required to present to patients prior to treatment the information that the average qualified practitioner would provide to the patient under like or similar circumstances. In states with patient-centered legislation, the provider is required to present information that the average, objective patient would want to know. Studies have shown that patients vary widely in their individual preferences regarding treatment and thus identifying “an average patient” is a challenging if not impossible task. Whether the physician has complied with the legal informed consent requirements is a jury question that usually involves expert medical testimony.

In states with provider-centered informed consent, health care providers must present to the patient the treatment-related information that an average qualified provider would present. The disadvantage of this type of informed consent is that it discourages active patient participation and encourages providers to render treatment decisions without engaging patients. Studies also have shown that there is no “average qualified” physician, with evidence of significant physician practice variation both between and within states. Thus, both types of informed consent laws have drawbacks.

In contrast, SDM offers patients the opportunity to receive the treatment and information they truly want, and thus participate in a thorough and engaged patient treatment choice. SDM offers providers the opportunity to participate in a robust informed consent process with the patient that is specific to that patient’s needs, values, and lifestyle. SDM also offers a chance for providers to strengthen the therapeutic alliance with their patients.

In addition, research has shown that patients who are well informed about their treatment options are happier with their treatment choice. Well-informed patients also tend to treatment regimens more faithfully and may also achieve better clinical outcomes. In addition, physicians who have implemented SDM with their patients may have a greater degree of protection from litigation if an adverse event occurs during treatment, because of the detailed information about risks and benefits disclosed during the SDM process.

**Q: Is SDM more effective than traditional informed consent for preference-sensitive care?**

**A:** Yes. Actually, the strongest argument in support of SDM is in the area of preference-sensitive care—the treatment of conditions for which two or more valid treatment choices are available for most patients. Chronic back pain, early-stage breast cancer, early stage prostate cancer, and benign prostatic hypertrophy are considered preference-sensitive conditions. Treatment choices for these conditions should be made by well-informed patients who base their decisions on the best available evidence, as well as their personal values and preferences. The treatment choice should be personalized and individualized. SDM advances this goal.

**Q: Shortly after the article was published, Washington state adopted legislation that addresses SDM. What is the significance of the Washington state legislation regarding SDM? What are the potential benefits of the legislation for patients and physicians?**

**A:** The legislation signed into law on May 2, 2007 in Washington state is unique and very forward thinking in that it formally acknowledges the importance of SDM and encourages its use. The legislation also promotes a pilot project, which is currently ongoing, to assess the logistics of implementing SDM in clinical practice and gather data on a number of different outcomes. In addition, the legislation confers a degree of protection to physicians; if they use shared decision making as described in the statute, it is presumed that the informed consent process was used—a presumption that can only be negated with clear and convincing evidence to the contrary. Thus, the legislation requires a higher standard of proof to overcome the rebuttable presumption that the provider engaged in the informed consent process and provides a higher degree of protection from malpractice litigation than prior law, because the plaintiff will need to show clear and convincing evidence that the informed consent process did not occur. Proponents hope that the legislation will encourage physicians to engage in SDM.

**Q: What were the key ingredients to successful passage of the SDM legislation in Washington?**

**A:** I believe that many ingredients came into alignment to facilitate passage of the legislation. The state has a medical community that is well educated on the principles of SDM and a very engaged proactive state medical society. The Washington State Medical Society testified in support of the legislation. Group Health Cooperative is a nonprofit health plan that provides care for over 580,000 individuals, of whom more than 80,000 are state employees. Medical leadership at the vertically integrated plan immediately saw the potential benefits of SDM for patient quality and safety, as well as the potential cost savings and strongly supported the legislation, agreeing to serve as the pilot site for the demonstration project required in the statute. In addition, the legislation had strong bipartisan support because of the clear advantage to patients.



## Q: How can providers be encouraged to use SDM?

**A:** Care providers can be encouraged to use SDM by highlighting the benefits specific to them. These benefits include the opportunity to strengthen the therapeutic alliance with the patient and possible litigation defense protection. Providers may be hesitant to support SDM out of concerns about increased time requirements. However, centers across the country have implemented effective SDM programs that minimize the additional clinical time required from providers. For example, standing orders at Dartmouth Hitchcock Medical Center Comprehensive Breast Program ensure that patients who have recently received a breast cancer diagnosis receive educational materials and decision aids prior to their first meeting with a surgeon. Patients also complete both a written and a computerized assessment of treatment preferences, which is forwarded to the surgeon, streamlining the SDM process and ensuring that real-time clinical and decision process data are available for use during the consultation. In addition, the patient is better informed about the condition and treatment options, and the discussion between the patient and the care provider can be more nuanced and directed to the patient's individual issues and concerns. SDM has the potential to create a win/win situation for both patient and physician.

### Reference:

Rethinking Informed Consent: the Case for Shared Decision Making. *The American Journal of Law & Medicine*. 2006;32(4): 429-501

