



Ask the Experts

Michael J. Barry M.D.

Dr. Barry is Medical Director of the John D. Stoeckle Center for Primary Care Innovation of the General Medicine Unit at Massachusetts General Hospital and Professor of Medicine at Harvard Medical School. In addition, Dr. Barry is past President of the Society for Medical Decision-Making (SMDM). We asked him to describe informed decision making from the health provider's perspective.



Q: What is the status of medical decision-making in the United States today?

A: When I discuss shared decision-making, I'm often asked by physicians, "Aren't we already providing informed consent for medical decisions?" My response is that we have evidence of significant problems in the process of medical decision-making in this country.

A Foundation-sponsored research project called the National Survey of Medical Decisions (the DECISIONS Survey) is investigating how medical decisions are made in the United States. For more information on the DECISION Survey, click here. [link to <http://www.informedmedicaldecisions.org/survey.htm>]

University of Michigan researchers interviewed 3000 adult Americans age 40 and older and asked whether they had made any of ten common medical decisions in the past two years. They found that 56% had discussed starting or stopping meds for hypertension, high cholesterol, or depression; 72% had discussed a screening test for prostate, colorectal, or breast cancer; and 16% had discussed either back surgery, knee replacement, hip replacement, or cataract surgery. These are medical decisions that all have room for patient input.

The survey results showed that patients perceived that their physician recommended the medication, test, or surgery the majority of the time and that they queried the patient about their opinion in less than half the cases. In addition, patients felt that physicians discussed the advantages of the interventions a great deal and the disadvantages to a much lesser degree. These results suggest that providers tend to be fairly aggressive in recommending that patients choose the more aggressive or interventional option.

Finally, when asked basic questions about information related to the medical condition and the health decision they faced, such as common side effects of medications or surgery, fewer than half the patients could answer more than one of the 4 to 5 key knowledge questions correctly. If patients cannot answer the most basic questions about the decisions they're making, how can we consider this truly informed consent?



The DECISION survey results show a lot of room for improvement in decision quality. As health care providers, we need to involve patients more actively in decision making, elicit their opinion about options, conduct a balanced discussion about the advantages and disadvantages of all options, and ensure that patients have the information they need to make truly informed decisions.

Q: Does the published literature support the use of patient decision aids?

A: Yes. Evidence from clinical trials shows that the use of shared decision-making and patient decision aids can improve the quality of medical decisions.

Patient decision aids are tools that help patients participate actively in decisions about their health care. They present information on the treatment or testing options and help patients communicate their personal values about the options.

By providing specific information, decision aids help prepare patients for a higher-level discussion with their health care provider about the treatment or test. For example, a patient decision aid about PSA testing would provide basic information about the prostate and prostate specific antigen (PSA), so the provider could focus his or her discussion on the pros and cons of testing.

A number of clinical trials have documented the effectiveness of decision aids. A 2007 review of 55 such trials found that use of decision aids was associated with:

- Greater knowledge
- More realistic expectations
- Lower decisional conflict
- Greater participation in decision-making
- Fewer people remaining undecided

A review of 18 trials of patient decision aids focused on PSA testing found that use of a video-based decision aid resulted in: [Volk 2007]

- Improved patient knowledge
- More confidence in testing decisions
- Decreased interest in screening and screening behavior among patients in routine care settings
- Increased interest in watchful waiting as a treatment option if diagnosed with prostate cancer

In the case of the PSA test, use of a decision aid resulted in more informed patients and less interest in screening.

Q: Providers may order screening tests, such as serum PSA levels, without discussing the matter with their patients because they feel that this may be seen as an “error of omission,” which would put them at medical-legal risk. What can you tell providers who have such concerns?

A: I’m commonly asked about this concern, especially in light of the Merenstein case, that was the subject of an article in the Journal of the American Medical Association. Daniel Merenstein was a resident whose residency program was successfully sued for \$1 million for his not performing a PSA test, despite documenting a discussion of the risks and benefits. A patient with whom he discussed the pros and cons of PSA testing declined the test and subsequently developed advanced prostate cancer.



Screening guidelines from the American Cancer Society state: "Information should be provided to all men about what is known and what is uncertain about the benefits, limitations, and harms of early detection and treatment of prostate cancer so they can make an informed decision about testing." [ACS 2008] In the case, four physicians testified that they simply order the test without discussion for male patients over age 50. Thus, although Dr. Merenstein followed national guidelines, the plaintiff alleged that he had not practiced the standard of care.

In 2007, some researchers and I held a series of mock trials to determine whether the verdict in the Merenstein case reflected the typical thinking of potential jurors. We convened six focus groups with a total of 47 potential jurors recruited through an ad in a Boston newspaper. Participants heard three different scenarios loosely based on the Merenstein case.

In the first scenario, the discussion about PSA testing was not documented in the medical record. In the second, the discussion is documented in the record. In the third, the provider used a patient decision aid and documented its use in the record. After each scenario was presented, we asked participants whether the physician had met the standard of care, and if not, whether harm resulted. A "yes" answer on both questions is necessary for a doctor to be found guilty of malpractice.

What we found was that a majority (83%) felt the standard of care was not met in the scenario in which there was no note in the record. Of these participants, 74% felt that harm had resulted. In the scenario in which a note in the record described the discussion, 28% felt the standard of care was not met; of these participants 85% felt harm had resulted. In the scenario in which decision aid use was documented, the minority (6%) felt the standard of care had not been met. Of these participants, 67% voted that harm had resulted.

Better documentation that a patient made an informed decision to decline a PSA test appeared to provide greater medical-legal protection for a physician following national guidelines, with the greatest protection coming from the use of a PSA decision aid.

Some physicians may decide to order PSA testing to be safer legally, but it is important to understand that there are disadvantages to testing (such as the need for further evaluation of false positives). Patients should be made aware of these disadvantages. Use of a decision aid helps to clearly document the content of a discussion with a patient, which health care providers may see as an added benefit of their use.

References:

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