Group Health’s Participation In A Shared Decision-Making Demonstration Yielded Lessons, Such As Role Of Culture Change

ABSTRACT In 2007 Washington State became the first state to enact legislation encouraging the use of shared decision making and decision aids to address deficiencies in the informed-consent process. Group Health volunteered to fulfill a legislated mandate to study the costs and benefits of integrating these shared decision-making processes into clinical practice across a range of conditions for which multiple treatment options are available. The Group Health Demonstration Project, conducted during 2009–11, yielded five key lessons for successful implementation, including the synergy between efforts to reduce practice variation and increase shared decision making; the need to support modifications in practice with changes in physician training and culture; and the value of identifying best implementation methods through constant evaluation and iterative improvement. These lessons, and the legislated provisions that supported successful implementation, can guide other states and health care institutions moving toward informed patient choice as the standard of care for medical decision making.

I
n January 2009 Group Health, a non-profit health system based in Seattle, Washington, began participating in the first systemwide integration of shared decision making into clinical practice in the United States. The proposal for the shared decision-making pilot was one feature of Gov. Chris Gregoire’s Healthy Washington Initiative. Passed by the Washington State legislature in 2007, the initiative was the first legislation in the United States to encourage the use of shared decision making and patient decision aids to address deficits in existing informed-consent methods.

Five health systems participated in the pilot: Group Health, Virginia Mason Medical Center, Everett Clinic, Multicare Medical Group, and the Carol Milgard Breast Center. This article examines the lessons learned from Group Health’s endeavor, which proved to be the most successful integration effort.

Group Health, a consumer-governed health system that integrates care and coverage for more than 660,000 patients in Washington State and Idaho, distributed 27,000 decision aids in three years to patients considering treatment for twelve preference-sensitive surgical conditions. Preference-sensitive conditions have multiple treatment options for which the risks and benefits are in clinical equipoise, or balance—meaning that the risks and benefits of the options are roughly equivalent, and therefore patients’ preferences should play a determinative role in which option is to be selected.

The Group Health Shared Decision-Making Demonstration Project proved successful on a variety of fronts. First, the demonstration project proved that Group Health could successfully and systematically integrate the distribution and use of decision aids into its clinical practice. Second, use of decision aids by Group Health patients led to highly favorable patient
satisfaction reports across all conditions in the demonstration project (Exhibit 1).

Third, Group Health found decision aids and shared decision making cost-effective overall, and for some conditions, they resulted in a reduction in costs. Finally, the strength of the evidence that large-scale distribution of patient decision aids, accompanied by shared decision making, is both economically and clinically feasible was such that Group Health decided to purchase decision aids for the twelve conditions studied in the demonstration project and stated its intent to integrate shared decision making for all preference-sensitive conditions. In effect, Group Health committed to continuing the work of perfecting and broadening implementation, even after the demonstration project ended.

This article explores five key lessons learned from the demonstration project. We offer these to help guide other states, health policy makers, and health care institutions that aspire to integrate shared decision making into clinical care to promote patient-centered care and transition from traditional informed consent to informed patient choice, a model that incorporates patient values and preferences into medical decision making.

Informed Consent And Shared Decision Making

Starting in the 1950s and accelerating through the 1980s, all states adopted the legal doctrine of informed consent. As envisioned, the doctrine requires a process of communication between the provider and patient that articulates the material risks, benefits, and alternatives to inform patient decision making about a given treatment. But the process of communication envisioned by the judges and legislators in creating the legal doctrine of informed consent has, in practice, largely been reduced to acquiring a signature on a form.

The current method in the United States of obtaining informed consent by providing patients with a long form, which describes a particular treatment and provides a list of its risks and benefits, is ineffective. Modern consent forms often have limited educational value, and patients frequently do not read them. As a result, patients often make medical decisions in the face of avoidable ignorance.

Providers often focus on obtaining a signature without ensuring that the patient comprehends the risks of treatment. This neglect of attention to patient comprehension is particularly problematic in cases of preference-sensitive care, when patient values and preferences for certain risks or benefits should guide the treatment choice. In short, traditional informed-consent methods produce consents that are neither informed nor consensual. These concerns have led to numerous calls for reform.

Shared decision making is a process in which the physician shares with the patient all relevant risk and benefit information on all treatment alternatives and the patient shares with the physician all relevant personal information that might make one treatment or side effect more or less tolerable than others. It was first suggested as an alternative to modern informed consent in 1982 by the President’s Commission on the Ethical and Legal Implications of Informed Consent.

<table>
<thead>
<tr>
<th>Exhibit 1</th>
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**Group Health Patient Satisfaction Survey Results On Decision Aids**

<table>
<thead>
<tr>
<th>Please rate how well the decision aid:</th>
<th>Excellent/very good</th>
<th>Good</th>
<th>Fair/poor</th>
<th>Total responses per question (out of 2,223)</th>
<th>% positive ratings out of total responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helped you understand your health condition</td>
<td>1,428</td>
<td>613</td>
<td>112</td>
<td>2,153</td>
<td>94.8</td>
</tr>
<tr>
<td>Helped you understand the treatment choices for your health condition</td>
<td>1,573</td>
<td>499</td>
<td>84</td>
<td>2,156</td>
<td>96.1</td>
</tr>
<tr>
<td>Helped you understand what is most important to you when thinking about treatment choices for your health condition</td>
<td>1,500</td>
<td>536</td>
<td>112</td>
<td>2,148</td>
<td>94.8</td>
</tr>
<tr>
<td>Helped you prepare to talk with your health care provider about treatment choices for your health condition</td>
<td>1,528</td>
<td>508</td>
<td>103</td>
<td>2,139</td>
<td>95.2</td>
</tr>
</tbody>
</table>

SOURCE Group Health Research Institute. NOTES Raw data from 2,223 survey participants, out of 12,263 surveys mailed with decision aids from January 2009 to April 2011. Data provided by Group Health Research Institute and on file with authors. Positive rating means excellent, very good, or good.
According to the Informed Medical Decisions Foundation, there are six steps to shared decision making for providers: inviting the patient to participate, presenting options, providing information on benefits and risks, eliciting patient preferences, facilitating deliberation and decision making, and assisting with implementation. The process of shared decision making often begins with patients viewing a decision aid that provides general information about their condition and treatment choices and encourages them to consider their personal values prior to meeting with physicians to make a treatment decision.

The goal of shared decision making is to make treatment selection more patient centered, so that it is “respectful of and responsive to individual patient preferences, needs and values” while still providing an opportunity for the physician to share his or her expertise and make recommendations. The bilateral process of communication inherent in shared decision making encourages both the patient and provider to participate in the development of the treatment plan.

Over the past thirty years, health services research has demonstrated the clinical benefits of shared decision making. A meta-analysis of eighty-six randomized controlled trials found that patients’ use of decision aids resulted in multiple benefits: increased knowledge of the treatment choices, more accurate expectations of benefits and risks, improved alignment of treatment choice with values, and greater participation in decision making. Yet as of 2007, whether shared decision making could be integrated into patient care in a practical and economically feasible manner remained unknown.

The Washington State legislature set out to answer this question. In addition to the fact that Governor Gregoire’s Healthy Washington Initiative was the first legislation in the country to acknowledge the benefits of shared decision making, the Washington State legislation contained three provisions intended to ease the way toward implementing shared decision making. First, it required the state to develop a means of certifying the accuracy and neutral status of any decision aids used as part of the shared decision-making process.

Second, the legislation granted legal protection to providers who engaged in shared decision making with the use of a certified decision aid by creating a rebuttable presumption that they had obtained an informed consent. This provision ensured that providers would not be exposed to malpractice liability for deviating from traditional norms of informed consent.

Third, the law instructed the Washington State Health Care Authority to undertake a shared decision-making pilot project to examine the feasibility and financial implications of integrating shared decision making into medical care for a variety of conditions. The legislation was designed to reduce potential barriers to integration of shared decision making and provide evidence that might support its future use.

Study Data And Methods

THE DEMONSTRATION PROJECT Group Health, along with the four other health systems, volunteered to conduct the legislatively mandated but unfunded pilot. The demonstration project at Group Health was a three-year study that examined the economic and practical implications of integrating shared decision making and decision aids into patient care. It was conducted within six specialty service lines: orthopedics, gynecology, neurosurgery, urology, general surgery, and cardiology. Decisions for twelve preference-sensitive surgical conditions were evaluated, including knee and hip osteoarthritis, benign prostatic hyperplasia, and early-stage breast cancer.

Patients making treatment decisions for selected conditions were to be mailed video-based decision aids and accompanying written materials, provided free of charge by the Informed Medical Decisions Foundation and Health Dialog, a private company. Patients could also access the decision aids and materials online via Group Health’s member website or a link in the patient’s after-visit summary.

Group Health researchers gathered data on distribution rates to patients scheduled for surgery, on patient satisfaction with the decision aids, and on the economic impact of the program. Clinical leaders received reports every two weeks that showed distribution of the decision aids by individual physician, specialty, and topic.

Group Health surveyed patients regarding their opinions on the usefulness of the decision aids in improving their understanding of their condition, treatment options, and personal values (Exhibit 1). Researchers measured economic impact by comparing annual total health costs among patients with the selected conditions before and after the introduction of decision aids.

The demonstration project’s study design had several limitations. First, it was an observational study that compared overall health care costs and usage among patients with the selected conditions before and after the introduction of decision aids, potentially introducing unidentified bias. Second, the patient satisfaction survey results are subject to response bias because only
18 percent of patients voluntarily responded to the survey.

Third, during the intervention period, decision aids were not distributed to all patients with the selected conditions; in some cases, only one-third of patients with a selected diagnosis received a decision aid. In fact, the primary measure for reporting the distribution of decision aids focused on patients who had been scheduled for surgery, when ideally all patients who were considering treatment options would have received the aid prior to a treatment discussion.

Fourth, the study considered the distribution of decision aids and its cost implications. However, distribution alone does not mean patients viewed the aids and physicians incorporated them into their discussions. Fifth and finally, the cost-effectiveness data comparing overall health care costs for similar patients in the control and intervention groups ideally should have been collected over a longer period of time to account for the possibility that a decision to forgo an invasive procedure simply delayed the need to perform it. Greater longitudinal studies also should be conducted to determine the long-term patient care impact and cost-effectiveness of integrating shared decision making.

**CURRENT ARTICLE** For the current article, a series of semistructured interviews were conducted with key stakeholders in the demonstration project to analyze the study from a variety of vantage points. Policy makers, senior executive leadership, service-line chiefs, practicing physicians, researchers, and other employees integrally involved in facilitating the demonstration project were interviewed.

Interviews were conducted over two days by two researchers, recorded and transcribed, and reviewed for accuracy. The transcripts were then analyzed to identify recurrent themes and the most salient lessons learned. Our interview data is limited by the biases and perspectives of our interviewees as well as the retrospective nature of the interview process itself.

In addition, we reviewed patient satisfaction survey data collected by Group Health from June 2009 through April 2011. Group Health distributed patient satisfaction surveys along with 12,263 decision aids; 2,233 surveys were returned. Despite the low response rate of 18 percent, we present these data as offering insight into the kind of patient satisfaction information that moved providers at Group Health to strengthen their commitment to decision-aid distribution.

Our study also incorporates the limitations of the demonstration project. These design limitations are important to consider in determining the overall effect of the decision aids on health care delivery. However, from a policy and clinical perspective, the value of incorporating shared decision making into practice is most clearly evident in Group Health’s decision to purchase decision aids for the demonstration project conditions and to continue working to integrate shared decision making across all preference-sensitive care.

**Study Results** Five lessons were distilled from the interviews conducted with demonstration project stakeholders. We focus on lessons with potentially high relevance to other institutions, policy makers, and providers interested in integrating shared decision making into clinical practice.

**PATIENTS NEED TO BE INVITED TO PARTICIPATE IN TREATMENT DECISIONS** Health services research has repeatedly demonstrated patient demand for greater involvement in clinical decision making. However, in the context of traditional clinical decision making, many patients still encounter barriers to participation, including the need to avoid being perceived as “difficult.” Sending patients decision aids, encouraging their use, and asking patients to reflect on their preferences invites patients to discuss their treatment and empowers them to voice their opinions, breaking down previously perceived barriers.

This invitation is essential to patient engagement. A recent national survey by the Institute of Medicine found that patients whose providers listened to them, elicited their goals and concerns, and explained their options were three to five times more satisfied with their providers. Likewise, nearly 95 percent of patients who responded to the Group Health survey positively rated the decision aids as helping them to understand their condition, treatment choices, and preferences as well as preparing them to meet with their physician (Exhibit 1).

More than 90 percent of responding patients strongly supported the provision of decision aids for a broader range of conditions and patients. The more physicians committed to integrating shared decision making into practice, the more patients felt comfortable participating in the discussion, voicing their opinions, and acting as partners in treatment decisions.

**SHARED DECISION MAKING CAN AFFECT UNWARRANTED PRACTICE VARIATION** In addition to improving patient experience, Group Health saw shared decision making as a possible route to improving quality of care by reducing unwarranted variation. Inspired by the work of Jack Wennberg and the *Dartmouth Atlas of Health*...
Shared Decision Making

While care, Group Health leaders decided to examine variation within their own system. They found that the significant variation that exists between the practice patterns of health care providers nationwide also existed within Group Health. Variations can indicate systematic undertreatment or overtreatment of patients.

For Michael Soman, president and chief medical executive of Group Health Physicians, seeing data on practice variation throughout Group Health quickly concluded what had been a sixty-year-long debate about whether variation existed at Group Health. “We had the same amount of variation as anybody else,” Soman noted. But fixing the variation would require solving the vexing problem of separating warranted from unwarranted variation.

Warranted variation in treatment of similarly situated patients reflects differences in patient preferences, values, or circumstances. In contrast, unwarranted variation includes those differences that cannot be explained by clinical circumstances or patient preferences. Dividing warranted and unwarranted practice variations requires a serious commitment to patient engagement to identify which treatment decisions result from patient preferences.

From the beginning, Group Health made an important decision to strive for the level of variation that would result from patients’ treatment choices after being fully informed through shared decision making, regardless of the implications for service utilization and care cost. Shared decision making has been shown to have the potential to reduce health care expenditures because fully informed patients often select less invasive health care interventions.\(^1\)

However, the goal of shared decision making can never be to lower costs. Cost reduction must be considered a positive potential side effect of acting in accordance with the ethical and legal imperative that patients have the opportunity to make fully informed decisions about health care.\(^8\) Given that opportunity, some fully informed patients will choose less expensive treatments, and others will choose more expensive ones.

Accepting and understanding this reality should be a precondition for any organization seeking to promote shared decision making. Fortunately, the alignment of shared decision making with Group Health’s patient-centered philosophy, and the process’s potential to improve quality of care by reducing unwarranted variation, inspired leaders at Group Health to pursue the demonstration project.

**Effective Integration Requires Leadership at All Levels** Although administrative commitment is necessary to change physician culture, it is not sufficient to do so. Integrating shared decision making required substantial leadership at all levels of the organization.

Key champions within Group Health, including Karen Merriken, senior policy adviser, and David McCulloch, medical director of clinical improvement, pushed the organization’s leadership to seriously consider the demonstration project and supported the project during all phases. Soman set the general goals but gave service-line chiefs the freedom to try different paths toward attaining them. Soman noted, “What you actually want to do as a leader in this world is create leadership, not followership, in an adaptive environment.”

Toward this end, Soman asked each service-line chief to select a preference-sensitive condition for use in the demonstration project and to design an integration plan. The chief then rallied practicing physicians to incorporate shared decision making and decision aids into their practice. According to Soman, invoking Group Health’s dedication to patient-centered care and continual quality improvement proved particularly effective in convincing physicians to commit to the project.

Initially, shared decision making was more of a natural fit in some service lines than others. Group Health began the demonstration project in service lines with the most receptive physicians and asked them to try distributing the patient decision aids for a few months to identify some of the structural barriers to efficient use. Project leaders then approached less receptive service lines to discuss distribution goals and show them methods used by other service lines. The chief could adopt a model used by another service line or modify it to fit his or her needs.

Then chiefs and other physician leaders garnered participation from the practicing physicians. For example, Charles Jung, a leading orthopedic surgeon, gave a personal testimonial addressing his positive experiences using shared decision making to discuss the differing implications of having knee surgery versus losing thirty pounds. Scott Armstrong, president and CEO of Group Health Cooperative, remembered Jung’s comments as a turning point that “had a really very powerful impact.” In the end, the alignment of Group Health leadership behind shared decision making drove provider behavior change.

**Constant Evaluation and Iterative Improvement Is Necessary** At the time Group Health started the demonstration project, no clear path to broad integration of shared decision making existed. Group Health had to begin its work knowing that mistakes in patient selection and communication would be made.
and that the process would require constant refinement over time.

Soman described his approach as follows: “[Some attempts] will be imperfect and seriously flawed. You will consider that success and not failure. You will check and adjust. You’ll try it again. You’ll see what happens. You will check and readjust. And the only reason we are where we are, which is nowhere near where we need to be, is just because we keep iterating and learning from the iteration and calling that success, but not enough success.”

Following this approach, Group Health provided substantial support to facilitate the varied approaches of its service lines to determine which methods worked best. Tiffany Nelson oversaw the entire integration process, as the director of content of care, a department at Group Health that provides oversight and guidance to Group Health practitioners in their efforts to provide safe, affordable, patient-centered care.

After each chief selected a preference-sensitive condition, all physicians were sent the decision aid for the selected condition to review. Nelson then met with the chief to help him or her troubleshoot distribution, which occurred through a variety of channels: physician order via the electronic health record, patient request through the My Group Health portal, or staff order upon patient referral. The Group Health content of care team headed by Nelson tracked whether each patient undergoing a medical procedure for a targeted condition had been sent a decision aid.

Once distribution data were available, Group Health committed to iterative improvement of its distribution methods. Nelson and her staff followed up with each service line on a monthly basis to report which groups and providers delivered the most decision aids to their targeted population, as well as their relative “defect measures”—that is, the number of patients undergoing procedures for targeted conditions who did not receive a decision aid. “I think these reports provided motivation for some service lines certainly to get on board,” said David Arterburn, an investigator at Group Health Research Institute.

Ideally, distribution to all patients with a specific diagnosis would have been analyzed. Group Health, however, focused on those patients currently considering surgery to avoid presenting surgical options to low-severity patients, or operating on a patient who would not have elected the procedure if he or she had been more fully informed.

Distribution data enabled Nelson to provide physicians with concrete examples of patients who underwent surgery and did not receive the aid. Monthly reports also allowed Nelson’s team to identify ineffective distribution. Matt Handley, medical director for quality and informatics, recalled: “In one geographic area, we had really a lot of [physicians who] weren’t using [the decision aid]. … [I]t was great to have that transparency with their leaders in the room and have very difficult, challenging conversations—with the group ending up saying, ‘Well, this is what we’ve got to do.’”

Monthly reports that included distribution data for all service lines were provided to chiefs for comparison to other service lines. This information helped maintain integration momentum. Defect measure data allowed the distribution improvement process to be iterative and continual, so that a good system could be made closer to perfect.

**Shared Decision Making Should Be Embedded in Physician Training and Culture**

Changing clinical processes alone cannot change clinical culture. Changing culture requires continued education and adaptation. A major challenge facing Group Health was the perception by many providers that shared decision making was duplicative, unnecessary, or unresponsive to individual patients. Many physicians felt that the decision aid would undermine the more nuanced and individualized approach to decision making that they would ordinarily provide. So from the beginning, physicians had to be trained to use decision aids to inform the treatment discussion instead of replacing it.

Once integration began, providing physicians with multiple kinds of data proved essential. First, physicians found their own patients’ opinions about the usefulness of the decision aids especially persuasive (Exhibit 1). According to Arterburn, the strong patient satisfaction results were key to the “continued sustainability” of shared decision making at Group Health. Once Group Health physicians began to realize that the prior research suggesting high patient satisfaction with shared decision making and decision aids applied to their own patients, they committed more fully to integrating those tools into their practices.

A year into the demonstration project, Group Health worked with the Informed Medical Decisions Foundation to develop a half-day continuing medical education training for clinicians to establish that shared decision making was now expected of all specialty physicians at Group Health. The institution and specialty-service-line chiefs placed a high priority on the training, resulting in nearly 90 percent clinician attendance. As one example of the institution’s
commitment, Group Health rearranged its operating room schedule to permit its surgeons to attend a half-day training session. Handley noted that this training shifted the expectation, such that people not engaging in shared decision making "became outliers in an uncomfortable way, defending the old school, when everybody else in the room has moved to saying 'We don't do that here.'"

Efforts to change culture at a systemwide level allowed physicians to see the effect of successful integration in a range of patients and also hold one another accountable. This constant feedback loop helped each service line continuously modify its distribution and slowly change its culture.

Discussion
The success of the demonstration project revealed that what has always been an ethical imperative can also be clinically feasible and cost-effective. Two major questions remain, however. First, how likely are delivery systems with other models of care to achieve similar results? Second, can policy initiatives at the state and federal levels replicate the success realized in Washington State?

Group Health very much differs from the for-profit, fee-for-service, networked health care plans and providers that have come to typify the American health care system. Many of those differences contributed to the demonstration project’s success, which was not achieved as substantially by the other multispecialty group practice pilot sites—as noted above, Virginia Mason Medical Center, Everett Clinic, Multicare Medical Group, and the Carol Milgard Breast Center.

Without question, Group Health’s integrated delivery system permitted its leadership to align across service lines to provide support, resources, and education toward a common goal. The electronic medical records ordering system enabled physicians to send decision aids to patients, track distribution, and monitor patient use via the online patient portal. Paying physicians on salary enabled Group Health to make attending shared decision-making training and taking the time to engage patients in conversations about their treatment options part of a physician’s employment obligations.

Whether shared decision making can be integrated as successfully beyond Group Health’s employed physician base, and into its network of affiliated physicians in private practice, remains to be seen. However, armed with the lessons from the demonstration project, Group Health plans to begin answering this question by working to integrate shared decision making and decision aids into the care of patients who see their 7,000 networked physicians. Outreach is being conducted directly to the patients and also through their primary care physicians. Working to integrate shared decision making into the Group Health network will provide an opportunity to more thoroughly examine the implications of different health system structures and compensation methods for improving quality in patient care.

The demonstration project lessons can also inform both federal and state policy initiatives. The demonstration project suggests that an organization like Group Health—one with an integrated delivery system, salary-based providers, and patient-centered philosophy—can effectively integrate shared decision making to improve the overall quality of patient care. Federal policy makers can encourage similar features in the design and creation of new health care organizations, such as patient-centered medical homes and accountable care organizations.

The Affordable Care Act and the creation of state exchanges also offer a unique opportunity for government entities to give providers the opportunity to experiment with integration methods and physician incentives that will be necessary to effectively integrate shared decision making into clinical practice. Two major sections, 3021 and 3506, of the Affordable Care Act support shared decision making. Section 3021 creates the Center for Medicare and Medicaid Innovation, which offers grants to test innovative methods of delivery and quality improvement initiatives. The act specifically recommends examining decision-support tools designed to “improve applicable individual and caregiver understanding of medical treatment options.” Innovation grants could adopt the flexible and iterative approach of the demonstration project and adapt it to the national level.

Section 3506 aims to facilitate integration of shared decision making into clinical practice. The section calls for the designation of an entity to certify the accuracy and neutrality of decision aids and the establishment of Shared Decision Making Resource Centers to provide technical assistance to providers and “accelerate adoption, implementation, and effective use of patient decision aids and shared decisionmaking.” Again, this provision appears to adopt, at a national level, the type of commitment to physician training and culture change that Group Health and Washington State adopted at the plan and state levels. Unfortunately, funds were not appropriated to implement section 3506.

Without funding, the expense of purchasing decision aids
and educating providers on shared decision making will fall to individual states, health plans, or providers.

State legislation can help promote the changes in physician incentives and culture that the demonstration project suggests are necessary. For example, states can follow Washington State’s incentive-based approach and offer enhanced legal protection for physicians who follow certain shared decision-making procedures. However, this approach assumes that providers have both access to suitable decision aids and knowledge of how to engage patients in shared decision making, which few do.

States could follow Massachusetts’s plan to condition certification of all accountable care organizations or medical homes on an agreement to engage in shared decision making and to make decision aids available via a state-run website, as described in Massachusetts’ recently enacted An Act Improving the Quality of Healthcare and Reducing Costs through Increased Transparency, Efficiency, and Innovation (formerly Senate Bill 2400, section 20), adopted in August 2012. This approach requires substantial capital investment on the state’s part but, if used effectively, would enable all interested physicians and patients in any given state to engage in shared decision making.

Similarly, the federally run or state exchanges could also condition acceptance of a health insurance plan into the exchange on reimbursing providers for the cost of decision aids and time spent engaging patients in shared decision making. Alternatively, state medical licensing boards may adopt practice guidelines that drive culture change and promote shared decision making, as Maine has done.17 Regardless of form, state action promoting shared decision making can provide the key impetus needed to encourage providers to integrate it into practice.

Finally, professional societies, medical educators, and health plans may use the lessons from the demonstration project to implement change in overall provider culture. Group Health found that witnessing the benefits of shared decision making in its own patients encouraged many physicians to strengthen their commitment to integration.

The Association of American Medical Colleges and the Accreditation Council of Graduate Medical Education should incorporate shared decision making into medical school and residency curricula as the optimal decision-making model for preference-sensitive conditions, so that all medical students and residents will have knowledge of the process and will have used it with patients under supervision. Health plans should also collect and distribute data on each physician’s success in sending all appropriate patients decision aids. Keeping the physicians informed of their performance permits iterative improvement.

Finally, creating incentives, such as bonuses and reimbursement codes for engaging in shared decision making, would help entrench it into clinical practice. In combination, these factors could drive dramatic change in medical culture.

Conclusion

Washington State’s Healthy Washington Initiative underscores that state legislatures are able to catalyze meaningful change within the health care system. The demonstration project marks a major step toward transforming shared decision making from a research project into a mainstay of clinical practice.

Clinical decision making must evolve from a perfunctory recitation of facts into a robust bilateral communication between patients and clinicians that includes elicitation of and honoring patients’ preferences. Only by inviting patients into the conversation and providing them with clinical evidence of the risks and benefits of all treatment alternatives can we obtain the type of informed consent envisioned in legal doctrine and embrace informed patient choice.

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NOTES


Shared Decision Making

assert that these lessons can guide course of the project. The authors improvement throughout the constant evaluation and practice variation and the need for the linked to effort store to reduce yield five key lessons, such as making into clinical practice, to integrate shared decision making and decision aids. The demonstration, which sought encouraging the use of shared decision making and decision aids. enactment of legislation Washington State following participation in a demonstration in part of the project. The authors assert that these lessons can guide other states and health care institutions as they embrace informed patient choice as the standard of care.

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