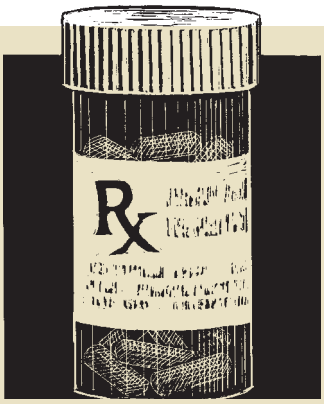
The second expert

By Laura Bozzuto



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In all my years of having routine physicals, I never really thought about how my doctor and I came to decisions about my care. Then, after graduating from college, I spent a year working at the Foundation for Informed Medical Decision Making (FIMDM), an experience that completely changed my outlook on the doctor-patient relationship. Gone was my image of paternalistic doctors who know what's best and of patients who ask, "Well, Doc, what do *you* think I should do?"

I have asked how the risks and benefits of procedures and medications could be presented to patients in a balanced way.

FIMDM is a nonprofit organization that works to ensure that health-care decisions are made with the active participation of fully informed patients. It does this by funding research on medical decision-making and by producing video decision aids that contain both information about various conditions and comments from patients about the decisions they made regarding treatment for those conditions. The organization was founded by Dartmouth's Dr. John Wennberg, a pioneer in the study of the delivery of health care, and Dr. Albert Mulley, now the director of the Dartmouth Center for Health Care Delivery Science.

While working at FIMDM, I learned about shared decision-making—a process in which doctors and patients work together to figure out the best treatment option. I quickly began to think of the patient as the second "expert" in the exam room. Doctors may be the experts when it comes to medical knowledge, but patients are the experts on how medical conditions and treatment decisions affect their lives.

Options: Shared decision-making focuses on decisions that are called "preference-sensitive." These decisions occur in a number of situations. There may be multiple treatment options that are all likely to produce similar results. Or perhaps the available options could lead to very different outcomes or side effects. Or there may be no solid scientific evidence about which option is most effective.

Many factors can influence—often invisibly—the decisions doctors would make in preference-sensitive situations. Things such as the practices of other local doctors, how easy it is to make referrals, and the anecdotal experiences of their other patients can all affect the choices that physicians recommend. Shared decision-making can help patients gain more control over their care.

Whether to get a knee replacement to treat arthritis is an example of a preference-sensitive decision. Arthritis is a progressive disease, and whether a patient has a knee replacement should be driven in large part by how bothersome the pain is for that patient. A complicating factor in the decision is that replacement joints have a limited lifespan, so there is a risk that a second replacement will be needed at some point. These are the kinds of decisions where the patients are the experts on the outcomes they want and the risks they're willing to take.

Preference-sensitive decisions contrast with what is called effective care. These are treatments that are known to have proven benefits that significantly outweigh their risks. An example is giving antibiotics for pneumonia. We know that doing this treats the disease, helps patients get better faster, and has relatively few risks.

At FIMDM, I traveled across the country visiting doctors' offices and hospitals—including DHMC—that are leaders in integrating decision aids and shared decision-making into clinical practice. I researched how patients could learn from these tools and be comfortable with their decisions regarding treatment. I talked with doctors who had seen shared decision-making change the way they practice and had made their patients more active participants in their care.

Strong: The work was inspiring. The shared decision-making community is small but strong—and it is growing. The researchers, doctors, nurses, and administrators developing and using shared decision-making resources believe deeply in what they do. Their work has caught the eyes of policy-makers and was incorporated into the recent federal health-reform legislation.

When I entered medical school, I didn't want to lose the unusual perspective I'd gained. Because of my time at FIMDM, I have questioned medical evidence and asked how the risks and benefits of procedures, medications, and even screening tests could be presented to patients in a balanced way. Even before my first clinical rotation, I knew some of the challenges of doctor-patient interactions. I dug into my classes and attempted to become the "expert" on the physician side of the shared decision-making conversation. Now, as a third-year student, I am beginning to have an opportunity to talk to patients about their decisions. Learning about the implementation of shared decision-making in a practice is challenging, but building it as a personal skill is, I've found, even harder.

I decided to attend DMS in part because of its strong history of involvement in shared decision-making, outcomes research, and patient empowerment in health care. The School has been adding more about these issues to the curriculum every year, in lectures, small-group discussions, and clerkships.

Passion: Helping patients make good decisions about their care has become a passion for me, and I'm sure it will always be an important aspect of my professional life. This interest has inspired me to check out research opportunities, lectures, conferences, and presentations. I am excited to see shared decision-making becoming a part of my fellow students' training and practice as well. It will help us become not just strong physicians, but also leaders in patient care. ■

The Student Notebook essay offers insight or opinion from a Dartmouth student or trainee. Laura Bozzuto graduated from Dartmouth College in 2007 with a degree in sociology and is now a third-year student in the M.D. program at Dartmouth Medical School.