When patient-centred care is worth doing well: informed consent or shared decision-making

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High quality care is patient-centred.1 Efforts to promote patient-centred care in clinical practice should improve quality. Both shared decision-making (SDM) and the process of obtaining informed consent could be expressions of patient-centred care—to the extent that they respond to the advocates’ call for ‘nothing about me without me’. In this issue of BMJ Quality and Safety, Shahu et al2 discuss variations in the quality of informed consent procedures, which could, in their view, fail to support patient-centred care in general, and SDM specifically.

Readers interested in advancing this domain of quality may, therefore, be interested in improving the quality of informed consent procedures and promoting the implementation and routine use of SDM. But are these similar practices? Is informed consent a lesser version of SDM, with SDM the ideal expression of patient autonomy and involvement? Or are these different in purpose, process and outcomes?

Informed consent establishes a minimal legal standard in which (1) clinicians disclose the risks, benefits and alternatives of a proposed treatment or procedure and (2) people accept or reject this procedure that has been identified to be the most relevant for them.3 The patient involvement is limited to accepting or rejecting a proposed path. This ‘choice’ is implemented late in the trajectory of the patient and in the process of making decisions about care. By the time the process becomes recognisable to the parties and formal, often at the time of reviewing and signing an informed consent document, the decision to go forward has been made and is being implemented, perhaps even without active patient involvement.

Why then offer choice in this way to patients? The motivation of informed consent is legal, and its formal procedures reflect legal standards established in local jurisprudence. These standards include the detail with which other options should be presented, the format used and the process used to achieve consent, a process that should conclude with its documentation. In reality, as Shahu and colleagues note, this process, which may sound much like SDM, gets transformed into the collection of a signature on a document in which most often only one option is offered or described in any detail.2 Meeting the standard becomes the goal.

In contrary, SDM represents a more evolved response to the need for patient-centeredness to the extent that it explicitly presents and stimulates to consider more than one option and helps patients and clinicians to deliberate on what is best. In a conversational dance, clinicians and patients work together to think, talk and feel through the situation of the patient and identify sensible ways to address this situation.4 5 The two-way information sharing in SDM,6 7 both by the clinician presenting the relevant options and the patient articulating what matters to him, is relevant for this particular patient and is relevant for comparing different options and choosing one that fits. In contrast, informed consent procedures seem independent of who this patient is and cover topics that are relevant for all people like this patient.5 Unlike the conversational dance in SDM that requires a human connection of careful and kind care, informed consent procedures call for a more technical and mechanical approach, a formal one-way provision of information in which boxes of topics addressed are to be actually or metaphorically ticked for administrative and legal purposes. While SDM seeks an answer to achieve resolution in the
patient situation from several options available, informed consent procedures seek to obtain the ‘go ahead’ to implement one option.

This absence of recognition of more than one sensible way to address the patient’s situation, so-called choice awareness, is a key limitation in the patient centeredness of informed consent procedures. Usually, the existence of other relevant and sensible actions, including foregoing active procedures, is not covered or including only cursorily within informed consent procedures. Shahu et al report that none of the informed consent forms for cardiovascular procedures they analysed offered or described an alternative option.

This problem appears not to arise from the attention to detail that developers place in the construction of informed consent forms. We put forth, rather, that it is a manifestation of the culture of healthcare. In the context of adjuvant radiotherapy treatment, an observational study described the behaviour of radiation oncologists in terms that would suggest that they were applying informed consent principles, without the legal documents. Patients with early-stage rectal cancer could be treated with a number of approaches, including adjuvant radiation. Surgical oncologists would refer patients to discuss this possibility and its relative pros and cons with an expert radiation oncologist. These radiation oncologists reportedly favour an SDM approach and as a group they have endorsed in evidence-based features described in accessible workflows of the practice, are carefully discussed until the best solution for this patient’s situation becomes evident.

We must not confuse SDM with other forms of patient and family involvement in which we seek their consent to proceed with a course of action. We must not confuse SDM with the distribution of decision aids or patient education materials for patients, expecting patients to find the best answer on their own: there is nothing shared about choosing alone from a menu! In SDM, consent with a pre-established expected course is not the goal, as it should also not be the end goal of our efforts to care. Our goal should be to seek the resolution of the patients’ situation in a way that fits with their values, preferences and context. Like other things worth doing, SDM is worth doing well. And when it is done well, it should be recognised as high quality care.

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