the REPORTER

2-HOUR CME: EXPLORING SHARED DECISION-MAKING:

HOW TO PARTNER WITH PATIENTS IN MAKING TREATMENT DECISIONS

CLAIMS BY SPECIALTY: MPL ASSOCIATION'S 2017-2021 NATIONAL CLOSED CLAIM DATA

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Quarter 4, 2023

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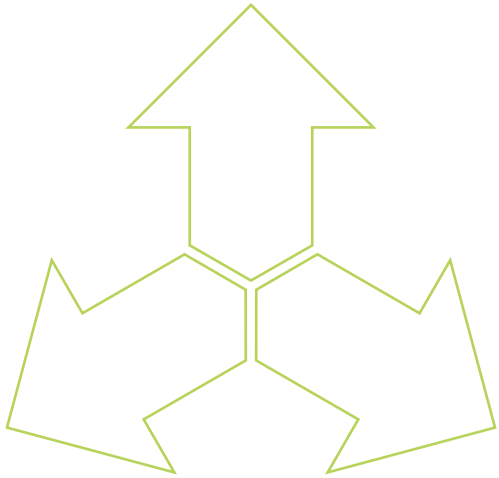
2-HOUR CME: EXPLORING SHARED DECISION-MAKING: HOW TO PARTNER WITH PATIENTS IN MAKING TREATMENT DECISIONS

by Jennifer Nelson



OBJECTIVES

Upon completion of this educational activity, the participant will be able to:

1. explain the advantages of incorporating shared decision-making into patient care;
2. describe how to include patients in shared decision-making;
3. offer examples of how shared decision-making benefits both physicians and patients; and
4. describe how to initiate and promote continued shared decision-making with patients.

COURSE AUTHOR

Jennifer Nelson is a health care writer who has also written for WebMD, New York Life, MSNBC, Fox News, and AARP.

DISCLOSURE

Jennifer Nelson, author of this educational activity, is an independent contractor for Single Care and McKesson. All of the relevant financial relationships listed for Jennifer Nelson have been mitigated. TMLT staff, planners, and reviewers have no relevant financial relationship(s) with any ineligible companies to disclose.

TARGET AUDIENCE

This 2-hour activity is intended for physicians of all specialties who are interested in improving patient outcomes by increasing compliance and satisfaction through shared decision-making.

CME CREDIT STATEMENT

The Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Texas Medical Liability Trust designates this enduring material for a maximum of 2 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ETHICS CREDIT STATEMENT

This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

TEST

To receive credit, physicians should complete the test questions that follow the activity. A passing score of 70% or better earns the physician 2 CME credits.

PRICING

The following fee will be charged when accessing this CME course online at https://lonestara.inreachce.com.

Policyholders: $25
Non-policyholders: $100

INSTRUCTIONS

CME test and evaluation forms must be completed online. After reading the article, go to http://lonestara.inreachce.com. Log in using your myPortal account information to take the course. Follow the online instructions to complete the forms and download your certificate.

RELEASE/REVIEW DATE

This activity is released on November 15, 2023 and will expire on November 15, 2026.

CME DISCOUNT

Lone Star Alliance policyholders who complete this program may earn a 2.5 percent discount that will be applied to their next eligible policy period.

INTRODUCTION

In modern health care, the days of physicians making unliteral decisions for patients have faded into the not-so-distant past. A different approach has risen to the forefront in which physicians, in collaboration with the patients they treat, jointly consider the perspective and preferences of each physician-patient partnership. This collaborative decision-making empowers the patient to take a more active part in their health care to the benefit of both themselves and their providers. Welcome to shared decision-making.

When the U.S. Preventive Services Task Force (USPSTF) was created in 1984 as an independent, volunteer-based panel of national experts in prevention and evidence-based medicine, the task force sought to improve health care nationwide by recommending screenings, counseling, and preventive medication. Physicians were tasked with how best to implement those recommendations for their patient's care.[1]

In 2004, the USPSTF published an article recognizing that patients play a vital role in shared decision-making (SDM) and encouraged physicians to begin a process of SDM with their patients rather than simply prescribing treatment options to them.[2]

In past decades, physicians made treatment decisions for their patients based on their medical training and knowledge. They did so with the understanding that they knew the best course of preventive care choices and clinical treatment for their patients.

In 1982, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research published a report in which they coined the term "shared decision-making." The basis of the report was that informed consent was based on personal well-being and self-determination; to ensure these values were respected, "patients must have all relevant information regarding their condition and alternative treatments, including possible benefits, risks, costs, other consequences, and significant uncertainties. . ."

The report explained that to ascertain ethically valid consent from patients, SDM was a physician's ethical responsibility. Physicians were implored to collaborate with patients based on mutual respect and participation rather than continue a ritual in which physicians recited the treatment(s) they selected for their patients or ticked off choices from the contents of a form and presented it to the patient.[2]

"When I first started my practice, medical professionals dictated treatment plans. Over the last decade, I changed how I interacted with my patients by encouraging open communication, providing comprehensive information about a patient's diagnosis and treatment options, and tailoring care plans to each patient's unique preferences and needs," says Bruce Freedman, M.D., FACS, a former surgeon in hernia and abdominal wall repair and the vice president of clinical development at TELA Bio, a med-tech company focused on advancing the field of soft tissue reconstruction.

TELA BIO conducted a consumer awareness survey in May 2023 of 1,152 participants on hernia repair options, in which the majority of respondents expressed their reliance on primary care physicians and health care professionals for guidance and emphasized the importance of shared decision-making. Survey findings included the following:

- 86.6 percent of all respondents believe in SDM with their physician; and
- 69.8 percent trust that their medical provider will educate them on all available options.[3]

"When patients can voice their concerns, goals, and priorities, medical professionals can appropriately determine the most suitable path forward. This approach not only improves patient satisfaction but also enhances treatment adherence and overall health outcomes," stated Freedman.

In the past, physicians may have been erroneously taught that patients may not have the health care literacy needed to collaborate in joint decisions about their care. Furthermore, patients from socially disadvantaged populations were also deemed to have lower health literacy and numeracy to help make these decisions.[2]

However, systematic reviews of patients from "socially disadvantaged" populations showed that SDM improved patient-clinician communication and reduced decisional conflict. Fewer participants remained undecided about their options after participating in shared decisions. Though not sufficiently detailed – and with too few Black, Indigenous, and Latinx patient participants in the reviews – there were positive reactions and improvements in knowledge across age, sex, and educational level.[2]

Freedman says that as the digital age of health care evolves, patients are more aware, educated, and concerned about their surgical options due to access to information. "This shift has transformed the traditional physician-centered model to a more

collaborative approach that empowers patients to actively participate in their health care decisions."

The goal of this CME is to review the ethical and scientific principles behind SDM; to identify the primary means of incorporating patients into decision-making; to acknowledge that having informed and involved patients is a core value in health care; reaffirm the role of SDM in making patient-centered decisions; and offer practical advice and SDM resources to help physicians.

THE SHARED APPROACH: A MODEL FOR SHARED DECISION-MAKING

What SDM looks like

SDM is defined as "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences."[4]

At its core, SDM is a paradigm in which clinicians agree that self-determination is a desired outcome, and for patients to achieve that outcome, they must choose the opportunity to participate in the decision-making regarding their health care choices.

As part of SDM, physicians support a patient's participation and self-determination by building trust and having a good relationship with the patient. Respecting the patient's competence, no matter their level of health care literacy, is also necessary.

In addition, SDM broadens the tenet of informed consent beyond essential information transfer and expands the concept of respecting a patient's informed choice.

Some patients may hesitate to participate in the SDM process. These patients may claim that they cannot or do not want to make decisions. Patients may feel they lack the health care literacy, judgement, or skills to make such decisions; they may express fear of making a bad or wrong decision; they may be from a demographic in which making such a decision feels inappropriate; or they may be culturally opposed to SDM.[4]

How SDM works

At its core, SDM embodies the belief that physicians should not impose health care decisions on patients but instead engage in a shared dialogue.

To practice SDM, physicians first initiate honest and open communication, present patients with a range of treatment options if they are available, and

discuss the potential benefits, risks, and alternatives associated with each plan. The exchange of information then empowers patients to understand not only their medical condition but the implications and outcomes of the various treatments presented.[5]

During the next phase of SDM, patients are encouraged to express their values, preferences, wishes, and desires as well as their lifestyle, goals, personal beliefs, and even financial limitations. This crucial step in SDM helps acknowledge that treatment plans are not a one-size-fits-all proposition, but rather one in which the physician listens and respects a patient's unique circumstances and assists them with making the best possible treatment decision for their needs.[6]

Finally, during the latter phase of SDM, physicians may employ decision aids, such as brochures, videos, and online tools that can help provide easy-to-understand information about medical conditions, treatment options, and any complexities of these decisions. Decision aids further empower and educate patients to help them align their choices and values with the medical information presented.[6]

How to incorporate SDM

Since SDM is a patient-centric approach, integrating it into medical practice can lead to improved patient satisfaction, enhanced clinical outcomes, reduced health inequities, and better treatment adherence.[7]

1. **Cultivate a patient-centric environment.** Creating a patient-centric practice is the foundation for SDM. Begin with an open and honest communication style with patients. Encourage them to share their values, preferences, and concerns. Listen empathetically and make sure patients feel heard and valued when sharing.[8]

2. **Provide comprehensive information.** Equipping patients with complete, necessary information is at the core of the SDM philosophy. Present all available treatment options, their benefits, risks, and potential outcomes. Encourage questions, address concerns, and inquire about patient preferences. Additionally, use decision aids and educational materials to enhance patient understanding. Emphasize that health care decisions are collaborative, and that the patient's input is critical.[8]

3. **Document and evaluate the SDM process.** Document this process in the patient's medical record, including the treatment options discussed, the patient's preferences, and any agreed-upon treatment or a patient's status regarding decision making ("patient is thinking about treatment" and/or "patient is discussing it with a family member before deciding"). If a treatment or surgical/procedure plan is subject to change based upon a complication or contingency, that should also be documented. Schedule a follow-up appointment to confirm their decision. Documentation helps maintain transparency and ensures everyone on the health care team is advised of the treatment decision and next steps.[9]

Once your SDM process is in place, continually reevaluate it for areas of improvement. Regularly update decision aids and materials to reflect updated medical guidelines and evidence-based information. Also, engage in continued SDM skills training to stay up to date on best practices.

EXAMPLES OF A SHARED APPROACH

Below are examples of a shared approach.

Cancer

When a patient is diagnosed with cancer, the oncologist reviews the test results and diagnosis with the patient and presents various treatment options. These options may include surgery, chemotherapy, radiation therapy, or a combination. The physician then uses decision-making aids such as brochures, videos, and educational materials and information to help clarify the options. The physician will discuss their patient's goals and concerns and listen for what may be inherent in their patient's wishes such as seeing a child graduate from high school or taking more proactive steps to prevent cancer recurrences beyond the current diagnosis. Together, they decide on a cancer treatment plan.

Note with a cancer diagnosis: The emotional repercussions for the patient may inhibit their ability to engage effectively and move forward with a decision because the shock of diagnosis, fear of

side effects, worry of recurrence, and overwhelming nature of the severity may impact their abilities.[8]

Childhood vaccinations
When a parent brings an infant to the pediatrician, they engage in a shared approach to a vaccination schedule. The physician discusses the importance of vaccination and any potential side effects and presents educational materials to help the parent understand the risks and rewards of vaccination.

The parent shares their own beliefs, goals, and concerns with the physician. The parent may have questions regarding negative vaccine stories in the news or ask the physician to dispel myths they've heard from fellow parents. The physician listens empathetically and shares their knowledge with the parent to arrive, via shared approach, on a vaccine schedule they are both comfortable with.

Chronic disease management
Patients with chronic conditions such as diabetes and hypertension work with their physicians to manage their disease as effectively as possible. Physicians educate patients about lifestyle changes, dietary concerns, medication options, monitoring, and regular checkups that contribute to successfully managing the patient's disease. Patients provide input about their daily routine, lifestyle, and dietary choices, and the difficulties they face with their condition or the changes they must make. This shared approach helps lead to a treatment plan that the patient may be more likely to follow.

Surgery
When a patient needs a surgical procedure, surgeons use SDM when recommending procedure choices. They discuss the surgical and nonsurgical options available, including the pros and cons, the prognosis, the risks, and the benefits. Patients ask questions, voice concerns, and consider their fears, lifestyle, and recovery goals. Together, the surgeon and patient decide on a procedure that best fits the patient's individual needs and circumstances.[10]

SDM BENEFITS

A partnership between physician and patient offers the patient numerous benefits, including ensuring that treatment decisions align with their personal values and preferences. Here are some of the key benefits:

Anxiety reduction
Patients undergoing medical care often have a level of anxiety due to fears and concerns about their health, indecision about their treatment options, lack of education or understanding about their condition, and fear of making the wrong treatment decision.

In one study of patients with atrial fibrillation, SDM reduced anxiety and improved adherence to treatment. When comparing the difference in patients' decision-making in treatment selection before and after SDM, the study found those who used SDM experienced a decrease in anxiety from 3.5 points to 2.1 points ($p<0.05$), on a 1-5 scoring method in which 1 was "totally not" and 5 was "relatively much," and was consistent with other studies that show SDM reduces patient anxiety.[11, 12]

Better patient satisfaction
Engaging in SDM fosters a positive physician-patient relationship and encourages patients to trust their physician. Giving patients a voice in the process boosts their sense of control and self-determination about their health care, leaving them with greater satisfaction.

Numerous studies support the conclusion that SDM leaves patients more satisfied with their health care choices and outcomes. A systematic review comprising 115 controlled studies determined that SDM aids help patients feel more engaged. An engaged patient is more likely to:

- acquire sufficient knowledge about their health care condition;
- reduce their decisional conflict;
- increase their role in the SDM process;
- improve their risk perceptions;
- increase the likelihood that their choices will align with their values and preferences; and
- improve the communication, trust, openness, and honesty between themselves and their physician.[13]

Motivated and compliant patients
Research indicates that SDM scenarios in which patients actively participate will result in a more significant commitment and adherence to a selected health care regimen than one chosen by a physician alone. Four key features were noted in the successful SDM models that can improve patient compliance.

They are:

1. share relevant information;
2. express treatment preferences;
3. deliberate options; and
4. agree on a treatment plan to implement.[14]

In one study, the physician-patient relationship was determined to play a positive role in motivating patients and determining their compliance with the treatment plan. In addition, the stronger the physician-patient partnership is, and the more patients participate in their treatment decisions, the higher their compliance with treatment.[15]

Patients' goals and preferences are considered

Giving patients a voice in the SDM process creates a sense of control and self-determination that most patients need and want. Considering each patient's personal goals, values, and belief systems when determining care decisions offers the physician a better understanding of the cultural, economic, and sociodemographic factors of their patient community.

In evidence from 86 randomized trials, the knowledge gained by patients — as well as improved confidence in decisions, more active involvement in their health care journey, and, in many cases, a more conservative treatment option selected — is enough to show that SDM is favorable for patients.[4]

In one study of Portuguese patients, 599 participants were interviewed and given three vignettes of problem-solving decision-making, including scales of morbidity, mortality, and quality of life. Most patients preferred a practitioner-controlled role in life-threatening situations; however, in less serious situations, they were willing to participate in decision-making. Patients who were younger, higher educated, and employed were also more apt to take part in the shared decisions.[6]

Improved outcomes

Emerging evidence also supports that engaging in SDM can improve outcomes for patients. For example, a randomized trial of patients with poorly controlled asthma found that patients who engaged in SDM with their physician experienced better adherence to their treatment plans and achieved better clinical outcomes, including improved asthma symptoms, lung function, and quality of life over a two-year period.[14]

Another study of 212 people with diabetes found that patients who participated in SDM gained better self-

monitoring techniques and improved blood pressure results.[16]

Finally, a study of mental health patients involved in SDM with their physicians showed that these patients were better equipped to reduce their own symptoms of depression over an 18-month period. That study concluded that increasing patient involvement in the treatment of depression may be an important factor in improving a patient's symptoms.[17]

Reduced health care costs

Questions remain about whether health care costs and financial aspects of care should be included in the SDM process, since many physicians may lack information about each patient's individual health care expenses (insurance details, co-pays, and deductibles). However, many believe it should be included in the discussion. While each patient is responsible for paying various costs, from a flat fee to the calendar year deductible of their health care plan, physicians should consider including the cost of care during SDM conversations.

However, given time constraints and social norms, physicians may lack the motivation to incorporate cost conversations into SDM. Some may also believe that introducing cost discussions before making treatment decisions is contrary to the philosophy of good health care. However, because patients often consider out-of-pocket costs as part of SDM, they need to understand the cost associated with their treatment choices.

Identifying out-of-pocket expenses for patients during SDM is an ethical practice that can also help support patients. A physician need not understand a particular patient's exact out-of-pocket cost, but can certainly discuss relative cost burdens, lower cost options, and resources that may be applicable, such as discounted drug programs and cost comparison tools.

Physicians may also want to include a discussion of direct and indirect care costs because these costs may become a heavy burden and affect the patient's expectations and potential benefits of treatment.

For physicians, being proactive about the financial conversation and staying ahead of the costs for patients during SDM — rather than waiting for patients to bring up a problem or become nonadherent because of costs — can help patients prepare for potential financial issues and subsequent treatment decisions.[18]

Studies also help underscore that SDM contributes to reduced costs in health care overall. *The New England Journal of Medicine* reports that as many as 20 percent of patients who participate in SDM choose less invasive surgical options and more conservative treatments over patients who do not participate in SDM.

In a 2008 report from the Lewin Group, patients participating in SDM for 11 procedures were estimated to have saved more than $9 billion over 10 years. Additionally, providing SDM aids to patients eligible for knee and hip replacement procedures significantly reduced surgery rates and costs.[19]

Another study compared the cost of uncomplicated menorrhagia among patients who received an SDM aid alone and those who also received nurse coaching vs. those who did not receive SDM, coaching, or aids (the control group). Results showed that the patients who received the aid, alone or with coaching, had lower mean costs than patients in the control group ($2,026 and $1,566 vs. $2,751).[20]

BENEFITS OF A PARTNERSHIP FOR PHYSICIANS

SDM can also be a transformative approach for physicians. Due to the focus on benefits for patients, physicians may be unaware of the many ways in which SDM can be beneficial for them.

Strengthening the physician-patient relationship

One of the most profound benefits for physicians is that the relationship between patients and physicians is enhanced during the SDM process. This includes forming a collaborative partnership, building trust, fostering respect and mutual understanding, and learning more about patients as people. These factors lead to a more enduring and solid connection as well as a more positive experience for both physician and patient.

In one study of 399 participants, researchers revealed that the physician-patient relationship and the process of SDM were two critical factors in patient compliance with treatment and improved patient

outcomes. Building a strong relationship with patients — tethered by the SDM process — helps physicians provide their patients with a better understanding of treatment options and increases a patient's trust in their physician when expectations have been met.

Further, this study suggests a patient's noncompliance with treatment may occur because of their limited participation in treatment decisions. This supports the argument that strengthening the physician-patient relationship helps both physician and patient.[15]

Enhanced job satisfaction

Physicians who practice SDM frequently report higher levels of job satisfaction. By offering patients the opportunity to voice concerns, share values, and engage in the decision-making process, physicians can become more satisfied in the practice of medicine. In addition, witnessing the positive impact of SDM on patients can enhance a physician's sense of fulfillment and commitment to patient-centered care.

Interestingly, one study investigated provider-related attributes of SDM by asking gynecologists to rank 10 case vignettes by "complexity" or "job satisfaction." The vignettes included three cases of SDM-related scenarios (decision-making); three emotional cases that included intense emotional displays of anger, frustration, and sadness; and four technical cases (including bleeding and complications).

Results showed that participants experienced more satisfaction when performing technical cases rather than cases dealing with emotions or SDM. Further, technical cases were perceived as less complex than those that involved strong emotions. The researchers hypothesized that this may be because the study participants were out of their comfort zone with the emotional cases and SDM, even though SDM should be considered business-as-usual rather than something out of a physician's comfort zone. The study recommends integrating SDM into daily routines to promote a culture change that deals with non-technical problems as part of the daily work life. Doing so might help mitigate issues in SDM implementation.[21]

Improves physician wellness and burnout

Physicians historically have higher rates of burnout, depression, and suicidal ideation than the general population. Despite the attention to this issue over the past decade, the trend continues. Emotional exhaustion, overwork, lack of autonomy, depersonalization, and reduced sense of personal accomplishment contribute to physician burnout. This burnout negatively affects patient care and satisfaction and contributes to higher incidences of workplace turnover and providers exiting the medical field entirely.

But just as physician-patient encounters can be negatively affected by physician burnout or depression they can be positively affected during a caring clinical encounter. Because social and emotional support is associated with improved health outcomes, patients who feel validated and cared for have a more positive experience and a more grateful impression of their patient-physician relationship.

In turn, these positive engagements may also have a beneficial effect on physicians. The satisfaction gained from listening to patients with empathy and guiding them in a clinical decision through SDM may help to reduce burnout and restore a sense of accomplishment, personal satisfaction, and meaning to patient care.

Anecdotal evidence supports that collaborative communication, such as with SDM, is associated with positive emotions for both physician and patient. Long-term implementation studies are needed to further evaluate the connection between burnout, depression, suicidal ideation, and meaningful patient encounters. SDM may have a valid place in increasing meaningful work and creating more positive experiences that can contribute to improved wellness for the physician.[22]

Reducing conflict and complaints

SDM can significantly reduce treatment-related conflicts and misunderstandings between physicians and their patients. When patients participate in their treatment decisions, it reduces the likelihood of miscommunication or dissatisfaction with care. Physicians may experience fewer complaints or grievances, a more harmonious practice, and it may aid in the retention of patients.

In a simulation study that looked at SDM and the effect on patients' likelihood of filing a complaint

against their physician, participants who were exposed to different levels of SDM rated their physician more highly; reported a higher level of trust; and were less likely to blame their physician in the event of an adverse outcome. Researchers examined whether emergency department patients would perceive fault and liability differently if the examining physician engaged participants in SDM, rather than being offered the same treatment plan using a more physician-centric approach.

Researchers hypothesized that patients may be less likely to engage in a liability claim against their physician if SDM measures were in place.

Participant groups included those that received "No SDM," "Brief SDM," and "Thorough SDM." Of those in the "No SDM" group, 41 percent responded that they were "somewhat" or "very likely" to contact a lawyer about litigation. In the "Brief SDM" group, 12 percent reported they were somewhat or very likely to contact a lawyer, and in the "Thorough SDM" group, 11 percent of respondents said they were "somewhat" or "very likely" to seek litigation.

While SDM's emphasis is on informed consent and transparent communication, it may also reduce legal risks for physicians. When physicians thoroughly discuss these risks and benefits of multiple treatment options and engage patients in the process, they are more likely to obtain informed consent, which can help mitigate the risk of legal disputes and malpractice claims.[23]

Another study found that offering patients a decision aid during SDM protected physicians against a malpractice verdict in a mock trial. While evidence may be ambiguous, malpractice litigation remains a concern.[24]

More efficient use of resources

Through SDM, physicians can optimize and allocate resources that best support their patients' needs and preferences. Working with patients on their care goals can ensure that health care resources are used most efficiently, and unnecessary tests, treatments, or referrals are avoided. Physicians are then free to devote their time and expertise to the treatment plans and choices that benefit their patients the most.

SDM can also lead to a reduction in unnecessary medical interventions, conserving health care resources. Treatment plans can be adjusted to an individual patient's needs, saving the physician time, and ensuring resources are allocated for interventions most likely to resonate with the patient.

Several studies indicate that SDM leads to cost savings for health care systems. One study compared the effects on patients who received the usual level of support in making a medical decision with patients who received enhanced support. The patients with additional support received more contact with coaches through email, phone, or online. These patients had a 5.3 percent overall lower medical cost than patients who did not receive the improved decision-making support.

Further, the enhanced support group had 12.5 percent fewer hospital admissions and fewer preference-sensitive surgeries. The findings suggest that SDM generates savings on multiple levels. It also meant that a remote model of support combined with traditional SDM and aids could lead to lower-cost interventions for patients and conserved resources.[25]

Professional fulfillment and growth

Physicians who incorporate SDM may experience greater professional fulfillment and personal growth. Engaging in open and honest discussions with patients, having empathetic interactions, and sharing their educational knowledge and medical expertise with patients enhances their skills and helps them deliver patient-centered care.

The ongoing professional rewards of SDM can contribute to a sense of professional integrity and increase physician job satisfaction and awareness of their own altruism by helping their patients to the best of their abilities.

Research suggests that the process of SDM and sharing aids with patients when decision-making leads to richer discussions between physician and patient that benefit them both by creating an increased understanding of the risks, benefits, and tradeoffs through frank conversation rather than when physicians simply describe treatment options to the patient.[26]

HOW TO INCLUDE PATIENTS IN SDM

Getting patients involved in SDM starts with creating a collaborative and patient-centered approach to health care.

Steps can be simplified into a handful of factors that include:

- identifying a patient's diagnosis (establish open communication);
- discussing treatment options (offer clear, unbiased information and aids);
- eliciting patient preferences and values (actively listen and pay attention to questions and preferences);
- jointly deciding on a treatment plan and any related contingency plan (engage in deliberative discussion, offer support, weigh pros and cons);
- documenting the SDM (include details about the options discussed and patient preferences in the patient's medical record);
- following up (periodically reevaluate decisions and follow treatment progress); and
- honoring the patient's views and standpoint (even when they differ from the typical recommendations or personal preference).

The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality has developed the SHARE approach as a five-stage method to help health care professionals work with patients to make the best possible treatment and health care decisions. These stages are as follows.[27]

Stage 1: Seek *your patient's participation.* Using a shared approach begins with inviting your patient to be part of the SDM process and alerting them that a health care choice may exist and that their participation in the process is essential.

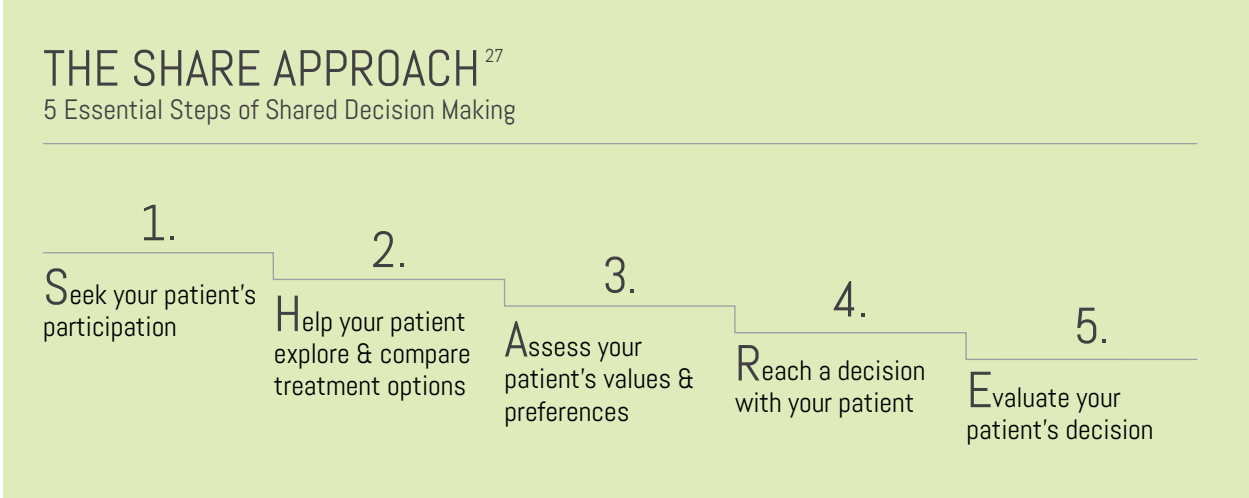
During this stage, you will:

- summarize their health problem;
- include family and caregivers; and
- emphasize to patients that their participation is essential.

Stage 2: Help *your patient explore and compare treatment options.* Since many health care issues have multiple treatments, including opting out of treatment, explaining the options to the patient using evidence-based resources or aids is imperative.

- Discuss the options with open, honest conversation.
- Clearly communicate the benefits and risks of each option and include tradeoffs such as, "medicine x is known to be more effective but is more expensive than medicine y."
- Offer decision-aid tools and resources whenever available to increase your patients' knowledge and understanding of their options.

Stage 3: Assess *your patient's values and preferences.* Research shows that physicians may not always understand the most troubling aspects and concerns of patients during SDM. To meet these patient concerns:



- encourage patients to share what matters most to them regarding their illness;
- ask about and discuss how each option will affect the patient's daily life;
- listen actively for clues and information about what they share;
- use nonverbal communication cues, such as head nodding, to encourage them to continue sharing;
- use verbal encouragement to learn more, such as, "Tell me more about how your work would be affected," "Will you have support at home?" or "Tell me more about that, I would like to learn more";
- show empathy and interest in the details your patients share; and
- acknowledge and confirm a patient's values and preferences by repeating what you think they said, such as "I think I understand that you feel strongly about getting through treatment as quickly as possible."

Stage 4: Reach *a decision with your patient.* Making decisions, especially about a serious illness or a life-changing health care diagnosis, can be extremely difficult for patients. When the health care choice is irreversible — like surgery or embarking on a multi-course cancer treatment protocol such as chemotherapy, surgery, and radiation in combination — patients may need additional time to decide and often may want to discuss it with other family members who are not present.

In these scenarios:

- help patients move toward a decision by asking what other resources and information you can provide to help them;
- if the patient wants time to think about their decision, schedule a follow-up visit to cement their decision when they are ready;
- confirm the decision with the patient and verify next steps with the patient; and
- schedule follow-up appointments, tests, or procedures to initiate the selected treatment plan.

Stage 5: Evaluate *your patient's decision.* Documenting the SDM process is an essential step. Follow these steps to fully document the SDM process with a patient.

- Document the informed consent conversation. This is essential for protecting both physician and patient.
- Note the patient's needs and values in making the decision.
- Remain unbiased even when you do not agree with the patient's decision.
- Monitor the patient's decision over time to ensure the decision is still what they want. Continue to work and plan around the decision.
- Help remove any barriers to the chosen treatment. This may include offering information about support programs, community resources, and access to additional information.[27]

DO PATIENTS PREFER SDM?

Patients should be encouraged to become involved in the SDM process. When they understand that they have helped their physician know their unique needs, desires, and care preferences, they become empowered and take an active role in their own health care. While SDM is an important factor in improved health outcomes, it may be challenging to enlist patients in the SDM process.

Patients' preferences for SDM may vary by a number of factors. These include their health condition, cultural background, personal values, a lack of health care literacy, an absence of confidence in their skills or judgement, and fears about making an incorrect decision. Others may take a more passive or deferential role, preferring the physician to make all decisions on their behalf.

Again, these preferences may be the result of age or cultural demographics. Research shows that these preferences can change over time, especially when patients are encouraged to participate in the SDM process.

One study assessed the views of adults over 65 who took at least one medication. Researchers interviewed patients to determine their views and perceptions about participating in their medication choices. The study determined that both physician and system factors affected the patients' ability to participate in the SDM process when choosing their medications.

Communication skills, the number of available medications, and multiple physicians prescribing their medications impeded their interest and ability in SDM. A perceived lack of knowledge, low self-efficacy, and fear also played a role. In addition, the presence or absence of trust in the prescribing physician was crucial in whether patients were impeded or enhanced to participate.

Only one participant of the 51 enrolled in the study clearly favored the SDM process for their medication decisions. The study concluded that changing older people's perception of the process could be challenging.[28]

Another study focused on the challenges physicians faced in obtaining patient buy-in during the SDM process. Researchers found doctors may have a poor understanding of what patients want from their treatment. Physicians wrongly estimated hypertensive patients' preferences about discussing options 40 percent of the time.[29]

In addition, some patients may not want to make the final choice but want the information to be offered. Therefore, the stage 2 SDM process may have two components:

1. identifying the right treatment option; and
2. selecting the most desirable one.

Finally, physicians may also face patients who prefer not to be involved in SDM. Most of the reasons have been identified in this article, but a lack of knowledge, experience, and fear tops the list. Though this group may prefer to abstain from the final decision, they still want the physician to understand and consider their preferences, values, and needs even if they ask the physician to make the final decision.

Ultimately, patient preferences for SDM can vary significantly. While most patients appreciate being actively engaged in their health care decisions, physicians must assess each patient's perspective and tailor the approach to SDM accordingly. SDM is the preferred methodology, but patients should be able to choose the level of involvement that aligns with their values and comfort level. After all, respecting patients' preferences is a fundamental practice of patient-centered care.[30]

OVERCOMING THE BARRIERS TO SDM

Implementing SDM is not without its challenges. Barriers can include time constraints, lack of training, perceived patient resistance, and clinical attitudes and beliefs.

Time constraints

Time is a perpetual barrier to patient care, and this constraint is particularly egregious in the SDM process. The task of informing patients of a diagnosis, explaining treatment options, imparting SDM aids, and then actively listening to patients' concerns, values, and preferences may seem daunting, especially as patient visits have shortened over the past few decades.

Yet, taking the time at an early stage of treatment may be beneficial because it allows follow-up care discussions to be more succinct. There is no doubt, though, that physicians perceive the time constraint as one of the most significant barriers to SDM. Physicians also find it much easier to begin the SDM process with a long-time or well-known patient than with a single-visit or new patient, in which there has not been enough time to develop a trusting, honest relationship.

Physicians can overcome this barrier through an SDM process designed for new patients. This process focuses on getting to know the new patient and building trust.[30]

Many patients are aware of the time constraints placed on physicians, and they may refrain from participating in the decision-making process for fear of taking up too much time or not wanting to ask too many questions. Physicians must be careful not to rush through SDM processes. Doing so may alienate patients and can make them feel rushed and unsatisfied, especially when faced with a difficult diagnosis.

Many studies agree that SDM does not need to add vast amounts of time to patient visits. One study found that appropriate levels of SDM can be reached with surgical patients in an average of 17.8 minutes. This same study found that 15.4 minutes was ineffective.

In addition, using SDM aids can improve communication, information sharing, and risk

assessment while only adding 2.6 minutes on average to the appointment time. Aids also improve the flow of the SDM process and allow the patient to make decisions in a more timely manner.

To help overcome time constraints, physicians may choose to focus on enhancing the quality of the time spent with patients. Increase the value of patient visits by asking questions and addressing fears and goals. Another option may be to restructure patient encounters to allow more time for the SDM process.[31]

Lack of training and education

Many physicians may not have received formal training in SDM processes. They may feel ill equipped or ill prepared to engage in the process. Older physicians may also believe that making more authoritative decisions for their patients worked well in the past and be more hesitant to change. To overcome these barriers, health care organizations can implement training, provide tools, and seek out support to encourage the practice of SDM.

In one study, 103 second-year medical students were given an exercise that included role playing and questionnaires to practice SDM. Following the exercises, these students were more motivated to use SDM, and expressed favorable attitudes about using SDM tools.[32]

In another review of SDM training programs for general practitioners (GPs), where SDM methodology is seldom used, SDM training was shown to improve clinician behavior and enhance its use in patient encounters. The skills learned through role play, demonstrations of SDM, and peer observation showed positive outcomes for GPs.[33]

Patient resistance

As stated, some physicians may experience resistance from patients who prefer a more traditional approach to health care decision-making. Examples of patient resistance to SDM may include a patient's beliefs, values, education, and traditional feelings that "doctors should tell you what to do" and "health care providers know what is best." Educating patients on their rights and the expectation that they should advocate for themselves can help in some cases.

Other resistance factors occur when patients come from a culture where people with a higher status, such as physicians, are considered better suited to make health care decisions. While the literacy level of patients has also been documented as a resistance to participate, it should not discourage physicians from trying the SDM process.[34]

Physicians may also encounter specific circumstances related to patients such as those with a lowered decision-making ability due to the influence of drugs or cognitive decline. In these situations, a proxy may step in for the patient and participate in the SDM process.

Profound uncertainty in the presence of serious or incurable illness may be another circumstance in which a patient resists participation. Studies show comprehension can be affected when a prognosis is dire. In times of great upset over a diagnosis, patients tend to give the authority of decision-making over to the physician.[35]

USING DECISION-MAKING TOOLS

Evidence-based shared decision-making tools can provide accurate and unbiased information and describe relevant outcomes. Using patient decision-making aids (PDAs) has been shown to improve patients' knowledge and understanding of their condition and their treatment choices. PDAs also can reduce decisional conflict and increase patient participation. Tools come in a variety of formats, including algorithms, worksheets, clinical guidelines, videos, and brochures.[36]

Algorithms

Algorithms can provide a step-by-step guide to help patients navigate complex medical choices. They typically present a series of points and criteria to consider that can help a patient arrive at a decision. Medical algorithms range from simple clinical calculators, like a BMI calculator,[37] to risk prediction tools that can estimate the risk of cardiac arrest[38] and software that uses artificial intelligence to identify a patient's risk of colon cancer.[39]

Worksheets

Decision worksheets are interactive tools patients can use to organize their thoughts, and write preferences, concerns, and questions related to their health care decisions. Worksheets are designed to prompt patterns that help patients clarify their choices.

MAINTAINING SDM WITH PATIENTS THROUGH A SERIOUS ILLNESS

When a patient is facing a serious or life-threatening illness, emotions may hinder their ability to make treatment decisions. Instead, many patients may want their physicians to take over and adopt a more prominent role. In so doing, the physician must take care not to abandon any progress made in building a strong shared decision-making (SDM) relationship with the patient.

At first glance, physicians may feel that providing recommendations may seem too controlling or authoritative. But patients, caregivers, and families often seek out and deeply appreciate caring, understanding guidance from their physicians when making important decisions around a serious illness.

As discussed, maintaining patient autonomy is one of the important goals of SDM. A physician can maintain this goal by making recommendations that prioritize the patient's values and wishes.

With the patient's permission, physicians may also talk with family members to confirm the patient's wishes, values, and goals to ensure that all parties agree on what is most important to the patient (quality of life, comfort, survival, being at home, length of life, independence, etc.) when making treatment choices.

The Journal of Pain and Symptom Management offers a three-step approach to making treatment recommendations within an SDM framework for patients with a poor prognosis or serious illness. The steps are as follows.[45]

Step 1: Evaluate the prognosis and treatment options for the specific patient. When reviewing a patient's prognosis, take time to consider how each treatment option may benefit or potentially harm the patient. This includes looking at whether the long-term effects of a treatment correspond with a patient's long- or short-term goals. Avoid offering or recommending treatments that you, using your own experience, medical expertise, and understanding of the patient, would consider unhelpful to the patient. Weigh how individual treatment options might affect the patient's values, concerns, or preferences (time at home, comfort, staying positive, etc.).

Step 2: Understand the range of priorities that are important to your patient, given the prognosis. In this step, the physician helps the patient develop a deeper understanding of his or her condition and then explores what is most important as the patient moves through the progression of their condition. When patients have more information about what to expect from a diagnosis and prognosis, priorities can often change. For example, patients with a prognosis of weeks to months often have a different set of priorities than those who expect to live for years.

Physicians can ask patients follow-up questions to obtain a better picture of a range of priorities. For example:

- "I understand that you want to spend more time with your family. What else is important to you?"
- "If your health continues to decline, what would be most important to you then? Would your priority change?"
- "Would you like to try treatment 'X?' Doing so might give you more time with loved ones, but you may be in more pain."

By discussing a range of options and goals, the patient becomes more oriented to different potential outcomes and decisions may come more naturally. More difficult options, such as a comfortable death, can be more easily discussed within the context of being one of many possible outcomes.

Step 3: Base your recommendation on the patient's priorities most compatible with the likely prognosis and available treatment options. Using clinical judgement, the physician must now decide which of the patient's goals and values to prioritize and formulate a recommendation based on the prognosis and available treatments.

Patients and their families are managing strong emotions and often equally challenging family dynamics when faced with end-of-life decisions. The following phrases may help the physician start the conversation or keep the conversation going with hesitant patients or family members.

Continued on page 21

Worksheets are not intended as a standalone tool but as part of a multi-comprehensive set of PDAs. Mass General Brigham HealthCare System has a variety of downloadable worksheets for conditions such as depression, high cholesterol, and acute low back pain, among others. These worksheets are found at https://mghdecisionsciences.org/tools-training/decision-worksheets/.[40]

Clinical guidelines
Clinical guidelines provide evidence-based recommendations for specific medical conditions and procedures. They can serve as a reference point to help the physician present information and to aid in the patient's understanding of the information. For example, clinical guidelines for managing hypertension outline different medication options, their effects, and preferred lifestyle options or changes. Studies show these types of tools help with the flow of conversation during SDM and aid in patient comprehension during the process.[41]

Videos, brochures, and online tools
Tools like videos and web-based PDAs can also help the patient learn about their medical condition and treatment options. They may include testimonials from patients, which can be impactful for the patient to view. Web-based applications include questions and exercises that guide patients through the process of decision making. Brochures can include printed and digital information that outlines treatment guidelines and options and the importance of the SDM process.

These tools not only help the patient understand their choices but also help the physician facilitate the conversation and offer visual and interactive aids that make the physician's job less onerous. They also offer patients an opportunity to review and "re-review" the information in their own time to help them feel more confident making health care decisions.

In a study that examined the efficacy of an educational video PDA vs. a pamphlet on acne awareness and isotretinoin, knowledge was significantly improved in patients of different genders and age groups after watching the video compared to reading the pamphlet. In addition, watching the video improved patient satisfaction and reduced patient anxiety.[42]

Another study concluded that cancer-related PDAs were highly effective in increasing patient knowledge when faced with cancer-related decisions.[43] A study on aids used in breast cancer concluded that 25 percent of participants who used an aid were more likely to choose a breast-conserving surgery over mastectomy. They also increased patient satisfaction with the decision-making process.[44]

CONCLUSION

SDM remains a pivotal approach to achieving health care outcomes that reflect a patient's values, preferences, and unique needs. Throughout this article, we've explored the multifaceted world of SDM, shedding light on its implementation, barriers, and evidence-based realities.

SDM is more than a buzzword; its transformative paradigm has empowered patients and fostered a deeper collaboration between physician and patient. SDM places patients at the center of their health care journey where they were always intended to be. By respecting a patient's opinions and values, engaging in open communication, and offering a range of decision aids, physicians can pave the way toward a health care landscape that nurtures a deeper, more collaborative relationship between physician and patient.

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Continued from page 16

- "I know this is difficult for you. Would it be helpful if I offered a recommendation?"
- "Because you are most concerned with (being at home/being comfortable/having independence/etc.), I would recommend…"
- "Keeping in mind what you have told me in the past, I would recommend…"
- "You have been very clear with me about what is most important to you. So, I would recommend…"

If a patient, caregiver, or family member is not ready to make a decision – either from feelings of overwhelm, denial, or disagreement — the physician may be called upon to provide even stronger guidance. This may be required in an urgent or unstable situation. In these situations, the following phrases may be appropriate.

- "I know there is a lot to consider. May I make a recommendation?"
- When the patient is clinically stable: "I understand you need more time. We will continue to figure this out together. I am here to help you and answer any questions."
- When the patient is in an unstable situation: "I know this is difficult to talk about, but we need to be prepared in case your status changes. Can we talk more about what to do if things don't go as we hope?" [45]

CLAIMS BY SPECIALTY: MPL ASSOCIATION'S 2017-2021 NATIONAL CLOSED CLAIM DATA

by Tanya Babitch, Assistant Vice President, Risk Management

When meeting with physicians, risk managers at Texas Medical Liability Trust (TMLT) are often asked to identify prevalent liability risks by specialty. The Medical Professional Liability (MPL) Association, a trade association of medical liability insurance companies, has been compiling data on medical claims since 1985 as part of its Data Sharing Project (DSP). Data sharing with the MPL Association allows insurers, including TMLT, to identify specialty-specific liability trends.

Since its inception, MPL Association members have shared more than 350,000 physician and dental professional claims with the DSP.[1] The DSP was created "to provide critical information needed to pinpoint areas of medical practice that have proven most vulnerable to MPL claims as well as support efforts seeking effective medical liability reform." [2]

The following is a compilation of medical malpractice claim data from 2017 to 2021, submitted by member companies in the United States of the MPL Association. When submitting data, companies report data in a de-identified, codified format. Personally identifying information, such as names of claimants and insureds are not reported.

More than 32,000 closed claims and lawsuits were reported to the DSP between 2017 and 2021. During this period, the average cost to defend these claims was approximately $48,000 and nearly one-third of all claims (27.5%) resulted in an indemnity payment. The average indemnity payment to the claimant was $356,572. However, 65.9% of submitted closed claims were either dropped, withdrawn, or dismissed without indemnity payment to the claimant.[2]

The following report highlights the top five presenting medical conditions; chief medical factors; and outcomes per specialty. The paid-to-closed ratio is also provided.[3]

- The ***chief medical factors*** categorize the general allegation or reason for claim against the medical provider. Please note, the MPL Association has implemented process changes within the past few years. For some specialties, one of the top chief medical factors was in a no longer existing/reportable category. Those have been excluded from the information presented in this article.
- The ***presenting medical condition*** is the disease, symptom, complaint, or reason for the patient's visit; significant to the treatment provided at the time of the accident or incident.
- The ***outcome*** is the medical condition that occurred after a medical encounter and led to the chief medical factor named in the claim.[4]

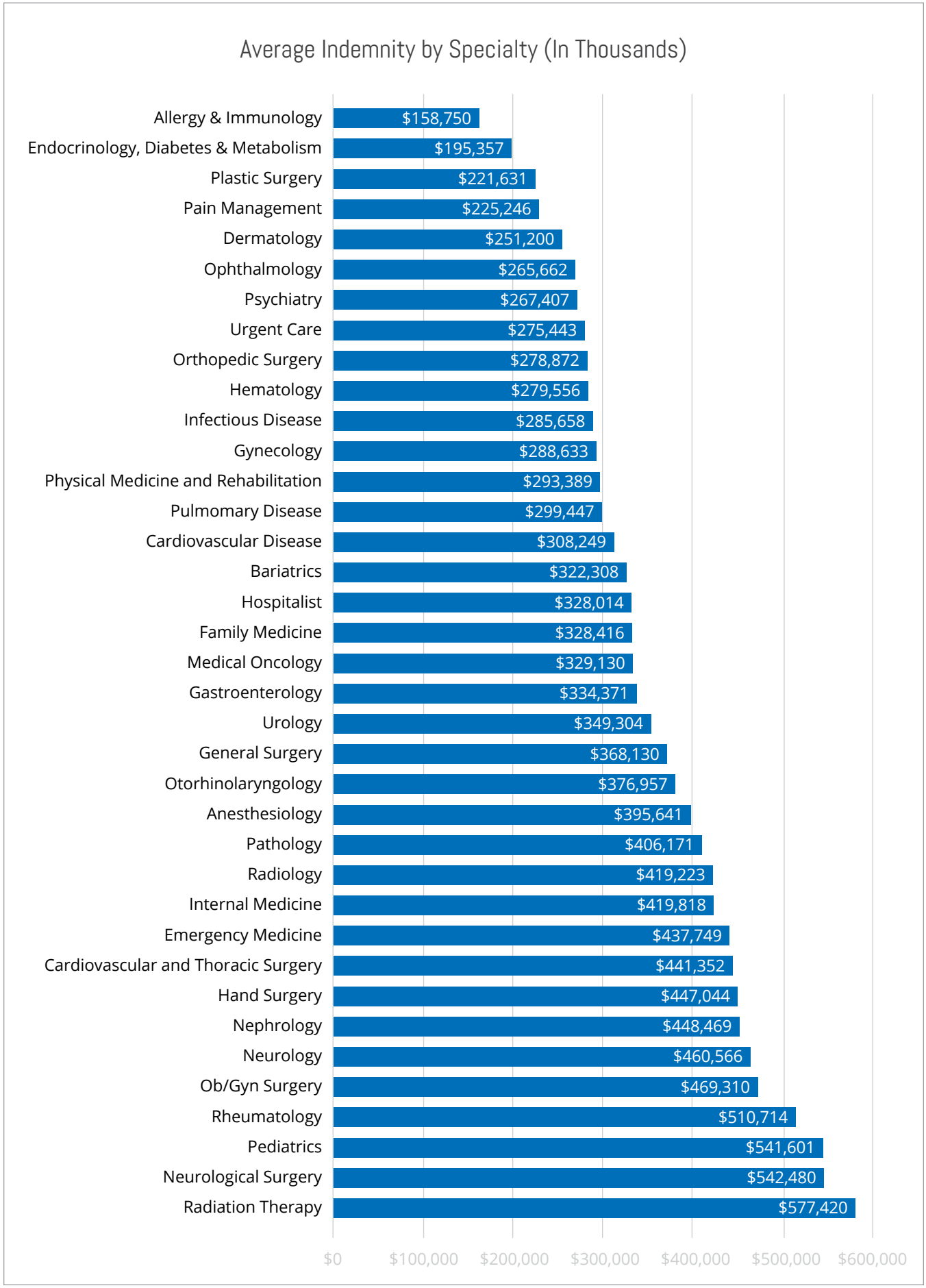
When reviewing this information, consider that some specialties may have a very low reported claim volume. This provides context and helps to explain information that seems counter-intuitive for a particular specialty.

For example, a medical outcome that seems unusual for a specialty may be due to a report of only one claim — and this claim could be an outlier. In addition, "top" presenting medical conditions or outcomes may reflect an incident that involved one patient, but multiple physicians or providers. Depending on the manner of the claim(s) submission — one versus multiple claims — this may make an issue appear more significant. Other outliers might include events such as a fall in the office that caused an injury, or other issues not directly related to the patient's presenting condition. These outcomes might appear especially prominent if the specialty has few reported claims.

What follows is a snapshot summary of claims by specialty. This information is designed for use as a risk management tool to inform physicians about the nationwide risk trends for their specialty. We have included a 5-year span to capture pre-pandemic claims data.

The average indemnity for medical specialties is shown in the graph below, by lowest to highest average indemnity. Specialties with fewer than five paid claims during the 5-year timeframe are not included in the data.[5]

Data for additional specialties, including all the specialties listed in the graph on he next page, is available online at https://hub.tmlt.org/home/claims-by-specialty-mpl-association-s-2017-2021-national-closed-claim-data.


Average Indemnity by Specialty (In Thousands)
Allergy & Immunology $158,750
Endocrinology, Diabetes & Metabolism $195,357
Plastic Surgery $221,631
Pain Management $225,246
Dermatology $251,200
Ophthalmology $265,662
Psychiatry $267,407
Urgent Care $275,443
Orthopedic Surgery $278,872
Hematology $279,556
Infectious Disease $285,658
Gynecology $288,633
Physical Medicine and Rehabilitation $293,389
Pulmomary Disease $299,447
Cardiovascular Disease $308,249
Bariatrics $322,308
Hospitalist $328,014
Family Medicine $328,416
Medical Oncology $329,130
Gastroenterology $334,371
Urology $349,304
General Surgery $368,130
Otorhinolaryngology $376,957
Anesthesiology $395,641
Pathology $406,171
Radiology $419,223
Internal Medicine $419,818
Emergency Medicine $437,749
Cardiovascular and Thoracic Surgery $441,352
Hand Surgery $447,044
Nephrology $448,469
Neurology $460,566
Ob/Gyn Surgery $469,310
Rheumatology $510,714
Pediatrics $541,601
Neurological Surgery $542,480
Radiation Therapy $577,420
$0
$100,000
$200,000
$300,000
$400,000
$500,000
$600,000

ANESTHESIOLOGY

Paid-to-close ratio: 28.4%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Procedure: Failure to recognize complication
3. Medication/IV fluids: Adverse drug reaction

Top presenting medical conditions

- Dorsalgia
- Pain, not elsewhere classified (NEC)
- Thoracic, thoracolumbar, and lumbrosacral intervertebral disc disorders
- Other spondylopathies
- Osteoarthritis of the knee

Top outcomes

- Cardiac arrest
- Intraoperative and postprocedural complications and disorders of nervous system, NEC
- Complications of procedures, NEC
- Accidental puncture or laceration during a procedure, NEC
- Other disorders of brain

CARDIOLOGY (CARDIOVASCULAR DISEASE)

Paid-to-close ratio: 26.6%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Diagnostic: Incomplete/inadequate
3. Procedure: Failure to recognize complication

Top presenting medical conditions

- Chronic ischemic heart disease
- Atrial fibrillation and flutter
- Acute myocardial infarction
- Pain in throat and chest
- Other cardiac arrhythmias

Top outcomes

- Cardiac arrest
- Accidental puncture or laceration during a procedure, NEC
- Acute myocardial infarction
- Complications of procedures, NEC
- Cerebral infarction

CARDIOVASCULAR AND THORACIC SURGERY

Paid-to-close ratio: 25.3%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Procedure: Failure to recognize complication
3. Diagnostic: Incomplete/inadequate

Top presenting medical conditions

- Chronic ischemic heart disease
- Aortic aneurysm and dissection
- Nonrheumatic aortic valve disorders
- Acute myocardial infarction
- Arterial embolism and thrombosis

Top outcomes

- Complications of procedures, NEC
- Cardiac arrest
- Intraoperative and postprocedural complications and disorders of circulatory system, NEC
- Cerebral infarction
- Complications of cardiac and vascular prosthetic devices, implants, and grafts

DERMATOLOGY

Paid-to-close ratio: 22.3%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Diagnostic: Incomplete/inadequate
3. Procedure: Failure to recognize complication

Top presenting medical conditions

- Other and unspecified malignant neoplasm of skin
- Encounter for procedures for purposes other than remedying health state
- Other disorders of skin and subcutaneous tissue, NEC
- Malignant melanoma of skin
- Follicular cysts of skin and subcutaneous tissue

Top outcomes

- Other and unspecified malignant neoplasm of skin
- Atrophic disorders of skin
- Complications of procedures, NEC
- Malignant melanoma of skin
- Emotional distress only

EMERGENCY MEDICINE

Paid-to-close ratio: 27.3%

Top chief medical factors

1. Diagnostic: Incomplete/inadequate
2. Diagnostic: Not performed when indicated
3. Procedure: Incomplete/inadequate

Top presenting medical conditions

- Abdominal and pelvic pain
- Pain in throat and chest
- Dorsalgia
- Headache
- Fever of other and unknown origin

Top outcomes

- Cardiac arrest
- Cerebral infarction
- Paraplegia (paraparesis) and quadriplegia (quadriparesis)
- Acute appendicitis
- Other disorders of brain

FAMILY MEDICINE

Paid-to-close ratio: 33.9%

Top chief medical factors

1. Diagnostic: Incomplete/inadequate
2. Procedure: Incomplete/inadequate
3. Diagnostic: Unavailable/failure to diagnose

Top presenting medical conditions

- Dorsalgia
- Encounter for general examination without complaint, suspected or reported diagnosis
- Abdominal and pelvic pain
- Pain, NEC
- Pain in throat and chest

Top outcomes

- Cardiac arrest
- Pulmonary embolism
- Malignant neoplasm of bronchus and lung
- Emotional distress only
- Complications of procedures, NEC

GASTROENTEROLOGY

Paid-to-close ratio: 23.7%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Diagnostic: Incomplete/inadequate
3. Procedure: Failure to recognize complication

Top presenting medical conditions

- Encounter for screening of malignant neoplasms
- Abdominal and pelvic pain
- Other disease of digestive system
- Other diseases of esophagus
- Cholelithiasis

Top outcomes

- Accidental puncture or laceration during a procedure, NEC
- Intraoperative and postprocedural complications and disorders of digestive system, NEC
- Other diseases of intestine
- Cardiac arrest
- Injury of intra-abdominal organs

GENERAL SURGERY & BARIATRICS (COMBINED SPECIALTIES)

Paid-to-close ratio: 30.9%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Procedure: Failure to recognize complication
3. Diagnostic: Incomplete/inadequate

Top presenting medical conditions

- Cholelithiasis
- Cholecystitis
- Overweight and obesity
- Abdominal and pelvic pain
- Diverticular disease of intestine

Top outcomes

- Complications of procedures, NEC
- Intraoperative and postprocedural complications and disorders of digestive system, NEC
- Accidental puncture or laceration during a procedure, NEC
- Injury of intra-abdominal organs
- Other diseases of intestine

HOSPITAL MEDICINE (HOSPITALIST)

Paid-to-close ratio: 21.7%

Top chief medical factors

1. Diagnostic: Incomplete/inadequate
2. Procedure: Incomplete/inadequate
3. Procedure: Failure to recognize complication

Top presenting medical conditions

- Pneumonia, unspecified organism
- Abnormalities of breathing
- Other sepsis
- Pain in throat and chest
- Type 2 diabetes mellitus

Top outcomes

- Cardiac arrest
- Other sepsis
- Pulmonary embolism
- Symptoms and signs specifically associated with systemic inflammation and infection
- Intracranial and intraspinal abscess and granuloma

INFECTIOUS DISEASE

Paid-to-close ratio: 16.2%

Top chief medical factors

1. Diagnostic: Incomplete/inadequate
2. Procedure: Incomplete/inadequate
3. Medication/IV Fluids: Adverse drug reaction

Top presenting medical conditions

- Osteomyelitis
- Other sepsis
- Complications of procedures, NEC
- Complications of internal orthopedic prosthetic devices, implants, and grafts
- Intracranial and intraspinal abscess and granuloma

Top outcomes

- Acute kidney failure
- Intracranial and intraspinal abscess and granuloma
- Other sepsis
- Cardiac arrest
- Symptoms and signs specifically associated with systemic inflammation and infection

INTERNAL MEDICINE

Paid-to-close ratio: 24.2 %

Top chief medical factors

1. Diagnostic: Incomplete/inadequate
2. Diagnostic: Unavailable/failure to diagnose
3. Procedure: Incomplete/inadequate

Top presenting medical conditions

- Abdominal and pelvic pain
- Pain in throat and chest
- Abnormalities of breathing
- Dorsalgia
- Pressure ulcer

Top outcomes

- Cardiac arrest
- Pulmonary embolism
- Cerebral infarction
- Pressure ulcer
- Other sepsis

NEUROLOGY

Paid-to-close ratio: 31.5%

Top chief medical factors

1. Diagnostic: Incomplete/inadequate
2. Procedure: Incomplete/inadequate
3. Diagnostic: Unavailable/failure to diagnose

Top presenting medical conditions

- Cerebral infarction
- Dorsalgia
- Headache
- Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders
- Epilepsy and recurrent seizures

Top outcomes

- Cerebral infarction
- Emotional distress only
- Paraplegia (paraparesis) and quadriplegia (quadriparesis)
- Blindness and low vision
- Other disorders of brain

OBSTETRICS & GYNECOLOGY (COMBINED SPECIALTIES)

Paid-to-close ratio: 33.2%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Diagnostic: Incomplete/inadequate
3. Procedure: Failure to recognize complication

Top presenting medical conditions

- Leiomyoma of uterus
- Pregnant state
- Excessive, frequent, and irregular menstruation
- Encounter for supervision of normal pregnancy
- Other obstructed labor

Top outcomes

- Birth injury to peripheral nervous system
- Complications of procedures, NEC
- Other disturbances of cerebral status of newborn
- Emotional distress only
- Accidental puncture or laceration during a procedure, NEC

OPHTHALMOLOGY

Paid-to-close ratio: 20.2%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Procedure: Failure to recognize complication of treatment
3. Procedure: Unavailable/not performed when indicated

Top presenting medical conditions

- Other cataract
- Age-related cataract
- Disorders of refraction and accommodation
- Retinal detachments and breaks
- Glaucoma

Top outcomes

- Blindness and low vision
- Poisoning by; adverse effect of; and underdosing of diuretics and other and unspecified drugs, medicaments, and biological substances
- Complications of procedures, NEC
- Visual disturbances
- Retinal detachments and breaks

ORTHOPEDIC SURGERY

Paid-to-close ratio: 34.3%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Procedure: Failure to recognize complication
3. Procedure: Unavailable/not performed when indicated

Top presenting medical conditions

- Other joint disorder, NEC
- Osteoarthritis of knee
- Osteoarthritis of hip
- Fracture of lower leg, including ankle
- Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders

Top outcomes

- Other joint disorder, NEC
- Complications of internal orthopedic prosthetic devices, implants, and grafts
- Complications of procedures, NEC
- Other acquired deformities of limbs
- Intraoperative and postprocedural complications and disorders of nervous system, NEC

OTORHINOLARYNGOLOGY

Paid-to-close ratio: 32.5%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Procedure: Failure to recognize complication
3. Diagnostic: Incomplete/inadequate

Top presenting medical conditions

- Chronic sinusitis
- Encounter for procedures for purposes other than remedying health state
- Other and unspecified disorders of nose and nasal sinuses
- Chronic diseases of tonsils and adenoids
- Diseases of vocal cords and larynx, not elsewhere classified

Top outcomes

- Complications of procedures, NEC
- Accidental puncture or laceration during a procedure, NEC
- Intraoperative and postprocedural complication and disorders of nervous system, NEC
- Diseases of vocal cords and larynx, NEC
- Unhappy with results of plastic surgery

PAIN MANAGEMENT

Paid-to-close ratio: 37.7%

Top chief medical factors

1. Procedure: Incomplete/Inadequate
2. Medication/IV Fluids: Wrong storage
3. Procedure: Failure to recognize complication

Top presenting medical conditions

- Dorsalgia
- Pain, NEC
- Spondylosis
- Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders
- Other spondylopathies

Top outcomes

- Intracranial and intraspinal abscess and granuloma
- Emotional distress only
- Complications of other internal prosthetic devices, implants, and grafts
- Dorsalgia
- Poisoning by; adverse effect of; and underdosing of narcotics and psychodysleptics

PEDIATRICS

Paid-to-close ratio: 29.6%

Top chief medical factors

1. Diagnostic: Incomplete/inadequate
2. Procedure: Incomplete/inadequate
3. Diagnostic: Not performed when indicated

Top presenting medical conditions

- Encounter for general examination without complaint, suspected or reported diagnosis
- Disorders of newborn related to short gestation and low birth weight, NEC
- Nausea and vomiting
- Encounter for procedures for purposes other than remedying health state
- Neonatal jaundice from other and unspecified causes

Top outcomes

- Cardiac arrest
- Emotional distress only
- Other disorders of brain
- Intracranial laceration due to birth injury
- Other disturbances of cerebral status of newborn

PLASTIC SURGERY

Paid-to-close ratio: 26%

Top chief medical factors

1. Procedure: Incomplete/inadequate
2. Procedure: Failure to recognize complication
3. Procedure: Wrong process/treatment/procedure

Top presenting medical conditions

- Encounter for procedures for purposes other than remedying health state
- Other disorders of breast
- Hypertrophy of breast
- Complications of other internal prosthetic devices, implants, and grafts
- Malignant neoplasm of breast

Top outcomes

- Complications of procedures, NEC
- Unhappy with results of plastic surgery
- Complications of other internal prosthetic devices, implants, and grafts
- Disorders of retroperitoneum
- Emotional distress only

RADIOLOGY

Paid-to-close ratio: 30.2%

Top chief medical factors

1. Diagnostic: Incomplete/inadequate
2. Diagnostic: Unavailable/failure to diagnose
3. Procedure: Incomplete/inadequate

Top presenting medical conditions

- Abdominal and pelvic pain
- Dorsalgia
- Encounter for screening for malignant neoplasms
- Unspecified lump in breast
- Other joint disorder, NEC

Top outcomes

- Malignant neoplasm of breast
- Malignant neoplasm of bronchus and lung
- Complications of procedures, NEC
- Cerebral infarction
- Cardiac arrest

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