SENATE BILL REPORT
SB 5619

As Reported By Senate Committee On:
Health & Long-Term Care, February 21, 2007

Title: An act relating to modifying unwarranted variation in health care.

Brief Description: Addressing unwarranted variation in health care.

Sponsors: Senators Pflug, Keiser, Parlette, Marr, Weinstein, Fairley, Kastama, Kline and Kohl-Welles.

Brief History:
Committee Activity: Health & Long-Term Care: 2/07/07, 2/21/07 [DPS].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5619 be substituted therefor, and the substitute bill do pass.

Signed by Senators Keiser, Chair; Franklin, Vice Chair; Pflug, Ranking Minority Member; Carrell, Kastama, Marr and Parlette.

Staff: Edith Rice (786-7444)

Background: Current law provides that in order to obtain damages for an injury which is the result of health care, a plaintiff must establish one or more of the following: (1) the injury was the result of the health care provider failing to follow the accepted standard of care; (2) the health care provider promised that the injury would not occur; or (3) the patient did not consent to the health care which caused the injury.

In order to prove that an injury is the result of the failure by the health care provider to follow the accepted standard of care, the plaintiff must prove that: (1) the health care provider failed to exercise the degree of care, skill and learning expected of a reasonably prudent health care provider at that time in the profession in the state of Washington, in similar circumstances; and (2) that failure was the proximate cause of the injury.

In order to show that the patient did not consent to the health care which caused the injury, all of the following elements must be proved: (1) that the health care provider failed to inform the patient of a material fact relating to the treatment; (2) that the patient consented without being fully informed of the material facts; (3) that *a reasonably prudent patient* under similar circumstances would not have consented if they had been fully informed; and 4) the treatment caused the injury to the patient.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Informed consent requires that a consent form be in language which the patient can reasonably be expected to understand which describes: (1) the nature of the treatment; (2) the anticipated results of the treatment; (3) possible alternative forms of treatment; and (4) the risks, complications and benefits related to the treatment, its alternatives and including non-treatment. As an alternative, a patient can state that he or she elects not to be informed.

Summary of Bill: Failure to engage in shared decision making that is the proximate cause of an injury, is added as an element that can be used to prove that the health care provider failed to follow the accepted standard of care.

Informed consent now requires that the patient participate in a process called shared decision making with the physician. A patient decision aid is used as part of this process. Shared decision making provides the opportunity for a patient to ask questions and share relevant personal information with the physician, which might make one treatment or side effect more or less desirable than others. The patient and the physician are required to sign the informed consent form. A patient decision aid is information designed to improve decision making by providing high-quality information about the medical condition, values clarification, and guidance to improve the patient's involvement in the decision-making process. The Health Care Authority (HCA) is to approve the use of a credentialed patient decision aid.

In order to show that a patient did not consent to the health care which caused the injury, the same elements must be shown except that *the patient* would not have consented to the treatment if he or she had been informed of the *relevant* facts.

An informed consent form now must list the diagnosis, its seriousness, treatment options, and benefits of the recommended and alternative treatments, including nontreatment, discomforts, side effects, impact, length of treatment, and cost.

EFFECT OF CHANGES MADE BY RECOMMENDED SUBSTITUTE AS PASSED COMMITTEE (Health & Long-Term Care): The legislative intent focuses on the shared decision making process and the use of effective decision aids in the state's laws on informed consent and encourages collaborative efforts to use and certify decision aids which meet high quality standards.

The HCA will work to increase awareness of decision aids. This effort must focus on preference-sensitive conditions with high rates of unwarranted variation in Washington.

The HCA is to identify a certification process for decision aids in consultation with the National Committee for Quality Assurance and can accept donations to do so.

The HCA is to develop a demonstration project with health care providers/carriers and a research group to demonstrate shared decision making in clinical practice. Specific elements for the demonstration project are listed and include evaluation. The HCA may solicit funding for the demonstration project.

The patient can sign a consent form or an acknowledgment of shared decision-making.

If the patient signs an acknowledgment of shared decision-making (which meets the specific criteria set out in the bill) this is prima facie evidence that the patient gave informed consent

for the treatment and the patient would have to rebut this by clear and convincing evidence to successfully challenge the informed consent.

"Patient decision aid" is defined and can be a written, audio visual, or online tool certified by a national organization approved by the HCA.

Failure of the health care provider to engage in shared decision making with the patient is no longer listed as proof of failure to follow accepted standards of care.

Failure to use a form or to engage in shared decision-making with or without the use of a patient decision aid is not admissible as evidence of failure to obtain informed consent.

A health care provider incurs no liability for choosing either the signed consent form or acknowledgment of shared decision making.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: The bill takes effect on January 1, 2009.

Staff Summary of Public Testimony: PRO: Research supports the use of shared decision making. There are concerns about variation in medical practice, and patients involved in shared decision making make better decisions. Doctors often don't know what their patients want. Having certified decision aids will cut costs and help patients get the care they desire. Decision aids are not perfect, and we shouldn't do a pilot, we have the information to move forward. Care needs to be more patient-centered. This bill is aligned with the Blue Ribbon Commission's recommendations. Our system currently rewards procedures, not outcomes.

CON: This bill should not leave doctors open to more malpractice claims.

Persons Testifying: PRO: Senator Pflug, prime sponsor; John Wennberg, Ben Moulton, American Society of Law, Medicine and Ethics; Jaime King, Center for Law and Biosciences; Dr. Robert Mecklenburg, Virginia-Mason Hospital; Karen Merriken, Group Health Cooperative; Dr. Hugh Maloney, Washington State Medical Association; Dr. Cathleen Carr, citizen.

CON: Martin L. Ziontz, Washington State Podiatric Medical Association.