

requirement substantially burdens the religious beliefs of employers. Two courts have observed that the rule does not require employers to use contraceptives or even to approve of their use. It asks the employer only to make a benefit available, which the employee must then decide whether or not to use. Employers object, however, that they should not have to pay for services that they consider to be morally wrong. The question of whose interests and

beliefs — those of the employer or those of the employee — ought to determine access to contraception benefits is one that the courts, and no doubt ultimately the Supreme Court, will have to decide.

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Shared Decision Making to Improve Care and Reduce Costs

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A sleeper provision of the Affordable Care Act (ACA) encourages greater use of shared decision making in health care. For many health situations in which there's not one clearly superior course of treatment, shared decision making can ensure that medical care better aligns with patients' preferences and values. One way to implement this approach is by using patient decision aids — written materials, videos, or interactive electronic presentations designed to inform patients and their families about care options; each option's outcomes, including benefits and possible side effects; the health care team's skills; and costs. Shared decision making has the potential to provide numerous benefits for patients, clinicians, and the health care system, including increased patient knowledge, less anxiety over the care process, improved health outcomes, reductions in unwarranted variation in care and costs, and greater alignment of care with patients' values.

However, more than 2 years after enactment of the ACA, little has been done to promote shared decision making. We believe that the Centers for Medicare and Medicaid Services (CMS) should begin certifying and implementing patient decision aids, aiming to achieve three important goals: promote an ideal approach to clinician–patient decision making, improve the quality of medical decisions, and reduce costs.

In a 2001 report, *Crossing the Quality Chasm*, the Institute of Medicine recommended redesigning health care processes according to 10 rules, many of which emphasize shared decision making. One rule, for instance, underlines the importance of the patient as the source of control, envisioning a health care system that encourages shared decision making and accommodates patients' preferences.

Unfortunately, this ideal is inconsistently realized today. The care patients receive doesn't always align with their preferences. For example, in a study of more

than 1000 office visits in which more than 3500 medical decisions were made, less than 10% of decisions met the minimum standards for informed decision making.¹ Similarly, a study showed that only 41% of Medicare patients believed that their treatment reflected their preference for palliative care over more aggressive interventions.²

There's also significant variation in the utilization of procedures, particularly those for preference-sensitive conditions, which suggests that patients may receive care aligned not with their values and preferences, but with their physicians' payment incentives. Among Medicare patients in more than 300 hospital regions, the rate of joint-replacement procedures for chronic hip arthritis varied by as much as a factor of five, and the use of surgery to treat lower back pain varied by nearly a factor of six. Other studies have found wide regional variation in the treatment of early-stage breast and prostate cancers and in the use of cardiac procedures.

Section 3506 of the ACA aims to facilitate shared decision making. Primarily, it funds an independent entity that would develop consensus-based standards and certify patient decision aids for use by federal health programs and other interested parties. In addition, the secretary of health and human services is empowered to fund, through grants or contracts, the development and evaluation of these tools. Decision aids are meant to be evidence-based and inform patients of the risks and benefits of tests and treatments, their relative effectiveness, and their costs. Health care providers will be eligible for grants to implement these tools and to receive training and technical support for shared decision making at new resource centers. The ACA also authorizes the Center for Medicare and Medicaid Innovation to test shared-decision-making models designed to improve patients' and caregivers' understanding of medical decisions and assist them in making informed care decisions. For approaches that provide savings or improve quality of care, implementation can be mandated throughout Medicare without additional legislation.

Randomized trials consistently demonstrate the effectiveness of patient decision aids. A 2011 Cochrane Collaborative review of 86 studies showed that as compared with patients who received usual care, those who used decision aids had increased knowledge, more accurate risk perceptions, reduced internal conflict about decisions, and a greater likelihood of receiving care aligned with their values. Moreover, fewer patients were undecided or passive in the decision-making process — changes that are essen-

tial for patients' adherence to therapies.

Studies also illustrate the potential for wider adoption of shared decision making to reduce costs. Consistently, as many as 20% of patients who participate in shared decision making choose less invasive surgical options and more conservative treatment than do patients who do not use decision aids.³ In 2008, the Lewin Group estimated that implementing shared decision making for just 11 procedures would yield more than \$9 billion in savings nationally over 10 years. In addition, a 2012 study by Group Health in Washington State showed that providing decision aids to patients eligible for hip and knee replacements substantially reduced both surgery rates and costs — with up to 38% fewer surgeries and savings of 12 to 21% over 6 months.⁴ The myriad benefits of this approach argue for more rapid implementation of Section 3506 of the ACA.

The Department of Health and Human Services could quickly launch pilot programs for shared decision making while it works to standardize and certify decision aids. The International Patient Decision Aid Standards Collaboration has developed evidence-based guidelines for certification indicating that decision aids should include questions to help patients clarify their values and understand how those values affect their decisions; information about treatment options, presented in a balanced manner and in plain language; and up-to-date data from published studies on the likelihood of achieving the treatment goal with the proposed intervention and on the nature and frequency of side effects and complications. In addition, it

would be helpful to include validated, institution-specific data on how often the specified procedure has been performed, the frequency of side effects and complications, and the cost of the procedure and any associated medication and rehabilitation regimens. We believe that decision aids should be written at an eighth-grade level and should be brief.⁵

In our view, it seems most critical to begin with the 20 most frequently performed procedures and to require the use of decision aids in those cases. Many decision aids have already been rigorously evaluated, so CMS could rapidly certify these tools and require their use in the Medicare and Medicaid programs. To give such a requirement teeth, full Medicare reimbursement could be made contingent on having documentation in the patient's file of the proper use of a decision aid for these 20 procedures. Providers who did not document the shared-decision-making process could face a 10% reduction in Medicare payment for claims related to the procedure in year 1, with reductions gradually increasing to 20% over 10 years. This payment scheme is similar to that currently tied to hospital-readmissions metrics.

In addition, the improved quality of care and savings gained through shared decision making can be maximized by integrating this approach into other ACA initiatives. For example, the documented use of patient decision aids could be used as a quality metric in patient-centered medical homes, accountable care organizations, and systems caring for patients eligible for both Medicare and Medicaid. Eligibility criteria for incentives to adopt

electronic health record technology might be expanded to include the use of shared decision making and patient decision aids. Moreover, information gathered by the Patient-Centered Outcomes Research Institute (PCORI) could be incorporated into certified decision aids and used to provide physicians and patients with valuable information for making health care decisions. Data about the effectiveness of shared-decision-making techniques could also be collected and disseminated by PCORI for continuous improvement of these approaches.

Unfortunately, implementation of ACA Section 3506 has been slow. More rapid progress on this front would benefit patients and the health care system as a whole.

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The Bystander Effect in Medical Care

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In the predawn hours of March 13, 1964, Catherine “Kitty” Genovese made her way back to her apartment in Queens, New York, after finishing a shift at the nearby sports tavern where she worked as a manager. But the 28-year-old Genovese never made it home. In a case that would spark national attention and debate, she was brutally stabbed to death by Winston Moseley, who confessed to the crime and remains in prison in New York to this day.¹ Nearly as shocking as the violence of Genovese’s murder were reports indicating that approximately 38 witnesses either observed the attacks or heard the victim’s pleas for help and yet did not intervene.^{1,2}

The tragedy and circumstances of her death were subsequently transformed into moral parable, prompting a large body of psychological research into what is now commonly known as the “bystander effect” — the human tendency to be less likely to offer help in

emergency situations when other people are present.³ Today, the term “Genovese syndrome” is used synonymously with “bystander effect” to designate this unfortunate manifestation of collective behavior.

A central factor in the bystander effect is diffusion of responsibility. The larger the group of people involved in the process of making important decisions, the more likely it is that any one person will assume that either the mantle of responsibility rests elsewhere in the group or that those responsible for taking action have already done so. The bystander effect generally increases with the size of the group and is more likely to manifest when responsibilities are not explicitly assigned.

Recent changes in the structure of graduate medical education and the delivery of health care services to hospitalized patients make awareness of this phenomenon and its potential dangers particularly

salient. Increasingly stringent limits on resident work hours, born of appropriate concern about physician fatigue and patient safety, in concert with increasing medical specialization and subspecialization, have resulted in a substantial increase in the average number of doctors and other professionals involved in the care of a hospitalized patient — all of which may result in decay of coordination of care.⁴

The simple question of “Who is my doctor?” now has a longer, complex, and often unclear answer. A recent case at our institution illustrates the difficulty physicians may face in addressing this issue and underscores the inherent risk of bystander effect in our current health care environment.

Our dermatology service was consulted to evaluate a new-onset cutaneous eruption in a previously healthy 32-year-old man who had fallen acutely ill after 3 days of nonspecific prodromal symptoms. He was transferred to our hospital