Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Informed Consent and Your Practice (Pt. 1)

AN INTERVIEW WITH SIMON DAGENAIS, DC, PHD, MSC.

Earlier this year, *The Back Letter* gave extensive coverage to an article by Dagenais, et al., in *The Journal of Manipulative and Physiological Therapeutics* on informed consent in the chiropractic profession, calling it "perhaps the best article ever written on informed consent for low back pain." In this interview [reprinted with permission from *Health Insights Today*, a web publication of Cleveland Chiropractic College - Kansas City], Dr. Dagenais discusses a wide range of issues related to informed consent, including the need for practitioners of all types to become well-informed about all alternative treatment approaches so they may share these in an unbiased way with patients, thus enabling patients to make informed decisions about their health care choices.

Dr. Dagenais, your article focused specifically on informed consent in the chiropractic profession, but The Back Letter *saw it as very relevant for all types of practitioners who treat low back pain. Let's start by looking at the basic purpose of informed consent. Doctors often think of it as a way to minimize their chances of being sued. Is there more to it?* I first learned about informed consent in chiropractic school and didn't really know what they were trying to teach us. It seemed that some people were approaching informed consent as a way to protect yourself against lawsuits – no matter what else you do, have informed consent.

But that wasn't the only view. Some people also just viewed informed consent as a routine office procedure that they delegated to their front staff, like collecting the person's insurance information. It was something you were expected to do, but that wasn't worth spending much time on. And I think other people viewed it as a sales pitch: an opportunity to put whatever treatment you're offering in the best light so that during the informed consent, you are further convincing the person that they've made the right decision by coming to you.

Other doctors probably feel that informed consent is just a waste of time. They don't understand it, they feel annoyed by it and they don't see any legitimate purpose for it. Informed consent is just another thing to slow them down, another administrative burden.

Informed Consent: A Reaction to World War II Atrocities

Informed consent was not always a part of health care. How and why did it begin? There's been a big shift in how people view doctors. A hundred years ago, doctors made decisions and people followed them. That's just the way it was, and no one questioned it. But that patriarchal and paternalistic model was eventually questioned.

The ethical foundation for informed consent in health care came out of the atrocities committed by doctors in World War II. In hindsight, people recognized that society shouldn't assume doctors are always right and benevolent. But even if they are, we should still make sure it's the patient making decisions about what really affects them.

What came out of all that is the principle that patients have the ability to decide what happens to them. No matter what the doctor thinks is best, it's up to the patient to determine that for themselves.

Y*et the patient, on his or her own, does not necessarily have all the information they would need to make that decision, unless it's provided by the doctor.* That's the rub. The doctor might think he has all of the information the patient needs to make the right decision, but he doesn't get to make the decision. And the patient doesn't have all that knowledge and expertise, but it's still their decision. So you're always left with a bit of friction.

This is the "agent problem." In economics, when you have someone who depends on someone else to help them make a decision because of their expertise, you are counting on that agent acting in your best interest. But it's a difficult thing to ensure. It's one thing to trust your mechanic to tell you what's wrong with your car and how to fix it. But when it comes to your own body and your health, the stakes are high. You always have an uneven amount of knowledge between the person making the decision and the person giving them information to help them.

Should Informed Consent Be the Same for All Patients?

Can informed consent be effectively standardized in terms of the information doctors of various kinds are expected to, or possibly required to, provide to patients? I think many elements could become standardized, but the difficulty there is that we start assuming all patients are alike. But my risk for experiencing harms with manipulation is not the same as your risk, or the same as an elderly woman with osteoporosis in her spine.

So, if we want to start to standardize things, how do you do that? Do you include all information applicable to anyone, so that standardizing means people have to read through a bunch of things that don't apply to them? Or do you take the worst-case scenario? Do you write informed consent for the highest possible risk and make people who don't have that high a risk sign off anyway? It's not easy.

Dr. Simon Dagenais isuniquely qualified as an expert in a wide range of health and health-policyareas. After receiving his doctor of chiropractic degree from the SouthernCalifornia University of Health Sciences in 2000, he received a PhD inenvironmental health, science and policy (with emphasis in epidemiology andpublic health) from the University of California, Irvine in 2005, followed bya Master of Science degree in health economics, policy, and management fromthe London School of Economics in 2011. He is also certified in biomedicalregulatory affairs by the University of California, San Diego, and certifiedas a clinical research coordinator by the Association of Clinical ResearchProfessionals.

Along with ScottHaldeman, DC, MD, PhD, Dr. Dagenais was an instrumental contributor to thewidely respected Bone and Joint Decade 2000-2010 Task Force on Neck Pain andIts Associated Disorders, whose work was documented in eight papers in *Spine* in 2008. Currently, heis the program co-chair for nonoperative treatment of the North AmericanSpine Society (NASS) and also serves on the NASS value committee.

The list of his otheraccomplishments is extraordinarily impressive for a relatively young researchand policy expert – perhaps best illustrated by the fact that hispeer-reviewed articles, commentaries, technical reports, books and book chapterstotaled 100 as of mid-2013.

I think in an ideal world, the informed consent would be an extension of everything else your doctor does. When doctors take a history, the questions are a little bit standardized, but the follow-up questions are based on your answers. And when they do an exam, the outline is somewhat standardized, but if they find something abnormal, they'll tailor the rest of the exam to pursue those findings. If doctors already have the ability to individualize their history and exam, why not bring the same level of professionalism to informed consent?

To study the current state of informed consent in chiropractic, or at least within chiropractic educational institutions, for your 2012 JMPT *article, your group evaluated the informed consent forms at all but one of the institutions that are part of the Association of Chiropractic Colleges, seeking to determine whether 20 different questions were addressed either directly or implicitly. Without asking you to list all 20 questions, what are some key examples that illustrate the areas that need to be covered?* I should clarify that we did look at all of the informed-consent documents, but it turned out that one of the institutions did not use a written document. I approached the questions against which

the informed-consent documents would be evaluated from an informed patient's perspective. Instead of making up arbitrary criteria about document quality, we came up with a list of questions that, in an ideal world, informed consent would be able to answer; so that after reading the informed consent, the patient would be in a better position to make a decision about the treatment.

The basic elements that you would expect are the risks and benefits of the treatment, and the alternatives. Taking a step back from that, I thought it would also be important to tell the person *why* that treatment is being recommended in the first place. What condition do I have? What's my diagnosis? Why do you think I have that? If you don't start there, how do you evaluate potential benefits and risks?

It's also important to describe the treatment. People often skip over that part in the informed consent, perhaps assuming that people listen perfectly when you describe the treatment, but I think putting it in the informed-consent document is a good reminder.

So, if an informed-consent document covers why the treatment is being recommended, what the treatment is, the benefits, the risks and the alternatives, those are probably the main elements patients need to know.

Dr. Daniel Redwood, the interviewer, is a professor at Cleveland Chiropractic College – Kansas City. He is the editor-in-chief of Health Insights Today, associate editor of Topics in Integrative Healthcare, and serves on the editorial board of the Journal of the American Chiropractic Association. Visit Dr. Redwood's website and health-policy blog at www.redwoodhealthspeak.com.

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