Shared Decision-Making

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MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

UC San Diego Health

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No other disclosures

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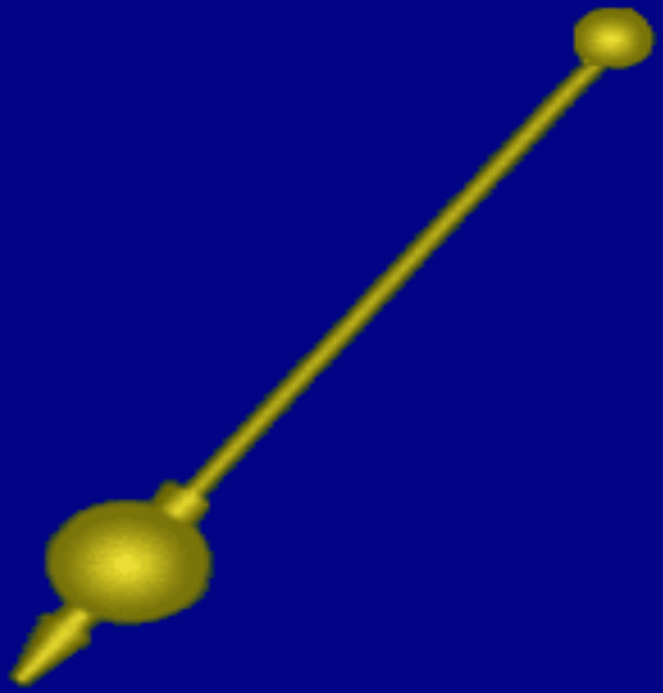
Outline

1. What ***IS*** shared decision-making in the ICU and
2. How do we do it?
   - 2016 SCCM/ATS SDM Policy Statement
   - 2017 SCCM/ACCM Family Centered Care Guidelines

19th Century Medicine

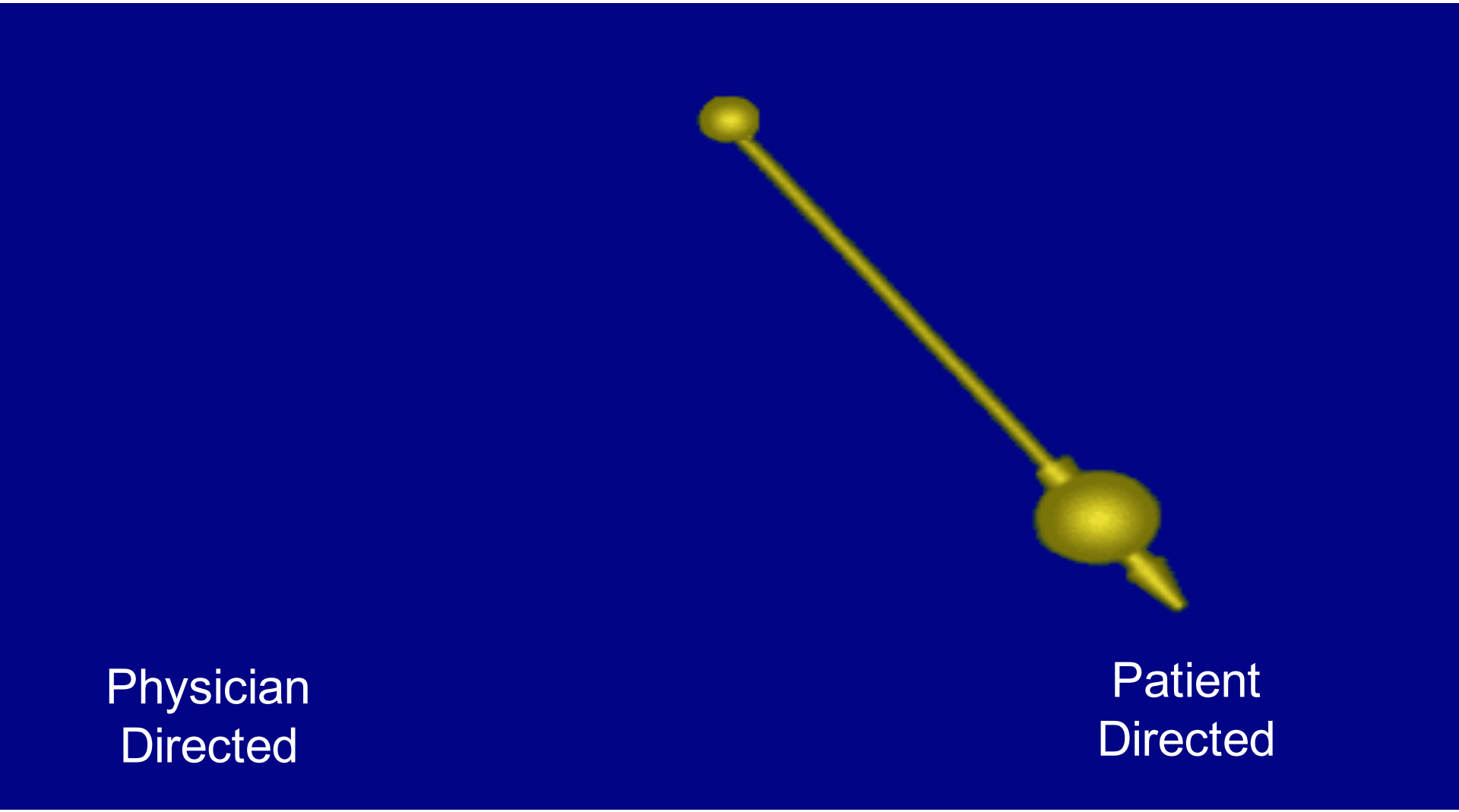


Physician Directed

Patient Directed

(Pendulum art adapted from www.flash-game-design.com)

Rise of Patient-Driven Decision-Making in the 20th Century



Rationale for Patient-Driven Decision-Making

- Based on long-held principle: *Respect for Persons*
  - Immanuel Kant. Critique of Pure Reason. 1781.
- People have a right to decide what is done to them
- People want control in decision-making
- Beauchamp & Childress. Principles of Biomedical Ethics. 1979
  - Respect for Autonomy
  - Nonmaleficence
  - Beneficence
  - Justice
- Law Suits
- Research Consent Laws

Problems with "Forced Autonomy"

- Erich Loewy: "abandoning patients to their own autonomy"

- What if people don't want complete control?

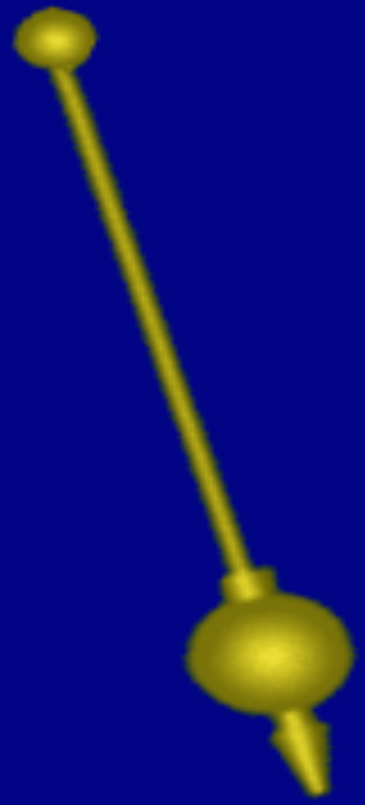
International Data

- France. Over half prefer doctors make decisions. (Azoulay *et al.*)
- Australia. 58% of women, 36% of men prefer shared decision-making. (Salkeld *et al.)*
- Canada. 90% prefer shared decision-making. (Heyland *et al.)*
- Thailand. 57% prefer doctors make decisions. (Sittisombut and Inthong)

U.S. Data: Outpatient Care

State	n	Patient	Shared	Physician	Author
PA	48	25%	58%	17%	Anderson
NY	73	22%	25%	52%	Elkin
WA	340	43%	39%	18%	Helmes
CO	239	18%	66%	16%	Johnson
OR	200	16%	63%	23%	Mazur
USA	3209	28%	62%	9%	Murray

Late 20th Century
Pendulum Swings Again



Physician
Directed

Patient
Directed

Follow the Data

- Fundamental Principle: *Respect for Persons*
- Data show that most people want a shared decision-making process
- Shift away from patient-driven to shared decision-making
- Allow room for patient-driven, shared, or physician-driven decisions depending on patient/surrogate preferences

2003 International Consensus Conference in Critical Care

- Society of Critical Care Medicine (SCCM)
- American Thoracic Society (ATS)
- European Respiratory Society (ERS)
- European Society of Intensive Care Medicine (ESICM)
- Société de Réanimation de Lange Française (SRLF)

- Advocates a shared decision-making approach over either paternalistic or strict autonomy decision-making in end-of-life care.

- Carlet J, Thijs LG, Antonelli M, et al. Challenges in end-of-life care in the ICU. Statement of the 5th International Consensus Conference in Critical Care: Brussels, Belgium, April 2003. Intensive Care Medicine 2004;30:770-84.

2007 SCCM/ACCM

- *Clinical Practice Guidelines for Support of the Family in the Patient-Centered ICU*

- Recommendation 1: “Decision making in the ICU is based on a partnership between the patient, his or her appointed surrogate, and the multiprofessional team.”

- Grade of Recommendation B.

- Davidson JE, et al. Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004-2005. Critical Care Medicine 2007;35:605-22.

American Medical Association

- AMA Policy: D-373.999 *Informed Patient Choice and Shared Decision Making*

- "Our AMA will … educate and communicate to physicians about the importance of shared decision-making…."

2008 American Academy of Pediatrics

- "The AAP argues for shared decision-making, points out limits on parental authority, and justifies the importance of involving the child in decision-making…. Rejected are outright medical paternalism and total parental authority."

- Mercurio MR, et al. American Academy of Pediatrics policy statements on bioethics: summaries and commentaries: part 1. Pediatr Rev. 2008;29(1):e1-8.

Special Article

Guidelines for Family-Centered Care in the Neonatal, Pediatric, and Adult ICU

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2017, CCM

Communication *(SCCM Guidelines: Davidson, 2017)*

- Open flexible Family Presence, FP on Rounds
- Explain what care is being given and why in understandable terms
- Consider use of pamphlets, videos, etc.
- Include the nurse in decision-making discussions
- Use structured model of pt/fam conferencing
  - Such as VALUE or Spikes model
  - Include messages of hope, caring, non-abandonment
  - Assess values and listen before your agenda
- Use validated decision-making tools

What IS Shared Decision-Making?

- Over half of those surveyed prefer it
- Professional organizations support it
- Frequently not defined in surveys or policy statement

Shared Decision Making in ICUs: An American College of Critical Care Medicine and American Thoracic Society Policy Statement

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Wynne Morrison, MD, MBE, FCCM[4]; Marion Danis, MD, FCCM[5]; Douglas B. White, MD, MAS[6]

- Kon AA, Crit Care Med. 2016 Jan;44(1):188-201.

Six Recommendations

1. Definition of SDM
2. When to use SDM
3. Default SDM approach
4. Range of ethically supportable approaches
5. Communication skill training
6. Future research

Definition of SDM

Shared decision making is a collaborative process that allows patients, or their surrogates, and clinicians to make healthcare decisions together,

taking into account the best scientific evidence available, as well as the patient's values, goals, and preferences.

Based on the definition proposed by the Informed Medical Decisions Foundation

When to use SDM

- Clinicians engage in a SDM process to define goals of care
- Including decisions regarding limiting or withdrawing life-prolonging interventions
- And when making major treatment decisions that may be affected by ***personal values, goals, and preferences***.

Examples

- Chronic vent vs palliative care
- Chronic dialysis with a co-existing terminal condition

When NOT to use SDM

- Routine decisions
  - how often to check vital signs and laboratory tests
  - which fluids to administer
  - what antibiotics to use and at what dosages

- Following SDM resulting in goals the clinician uses experience and specialized knowledge to prescribe appropriate testing and treatment

Default SDM Approach

- Clinicians should use as their "default" approach a shared decision making process that includes three main elements:
  1. Information exchange
  2. Deliberation
  3. Making a treatment decision

The Default SDM Process

1. Share information needed to make a patient-centered decision
   - Clinicians share information about the relevant treatment options and their risks and benefits
   - Patient/surrogate shares information about the patient's values, goals, and preferences

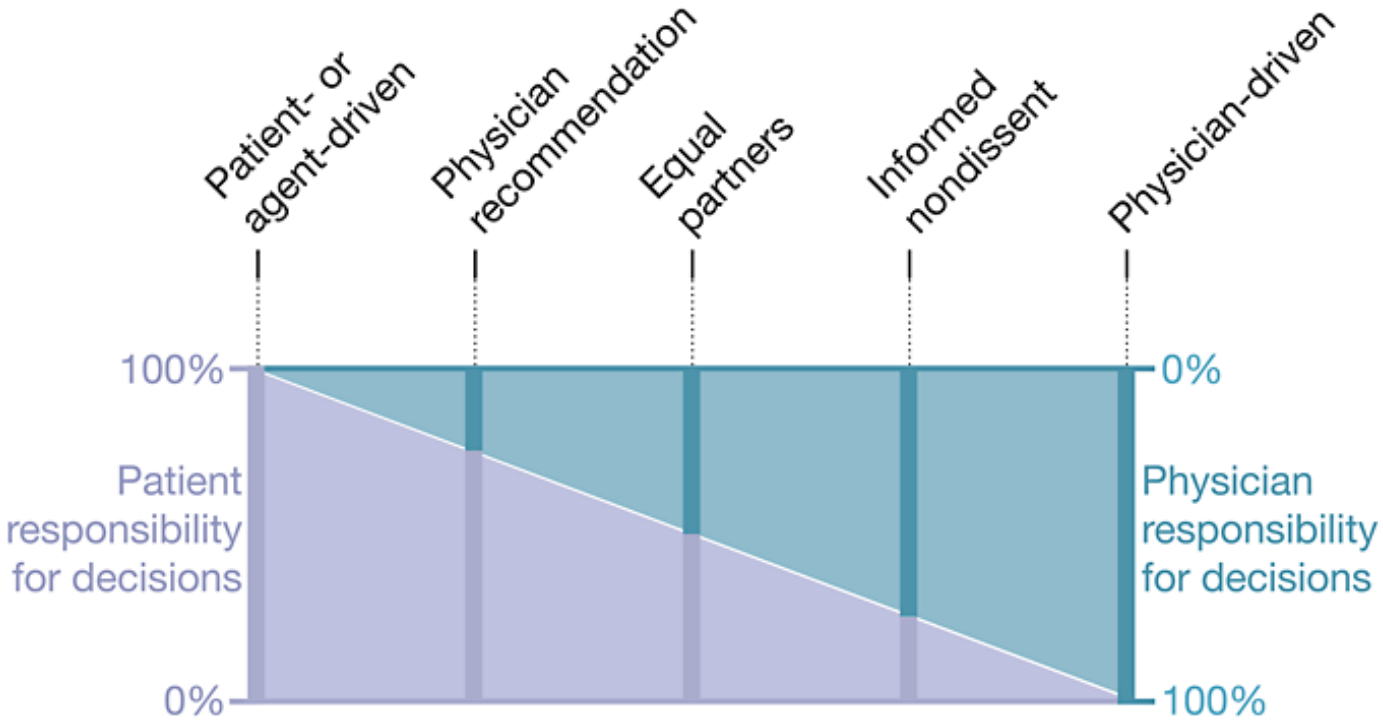
2. Deliberation (sharing opinions, asking questions, correcting misperceptions, explaining perspective)

3. Agree on a decision to implement

Range of Ethically Supportable Approaches to SDM

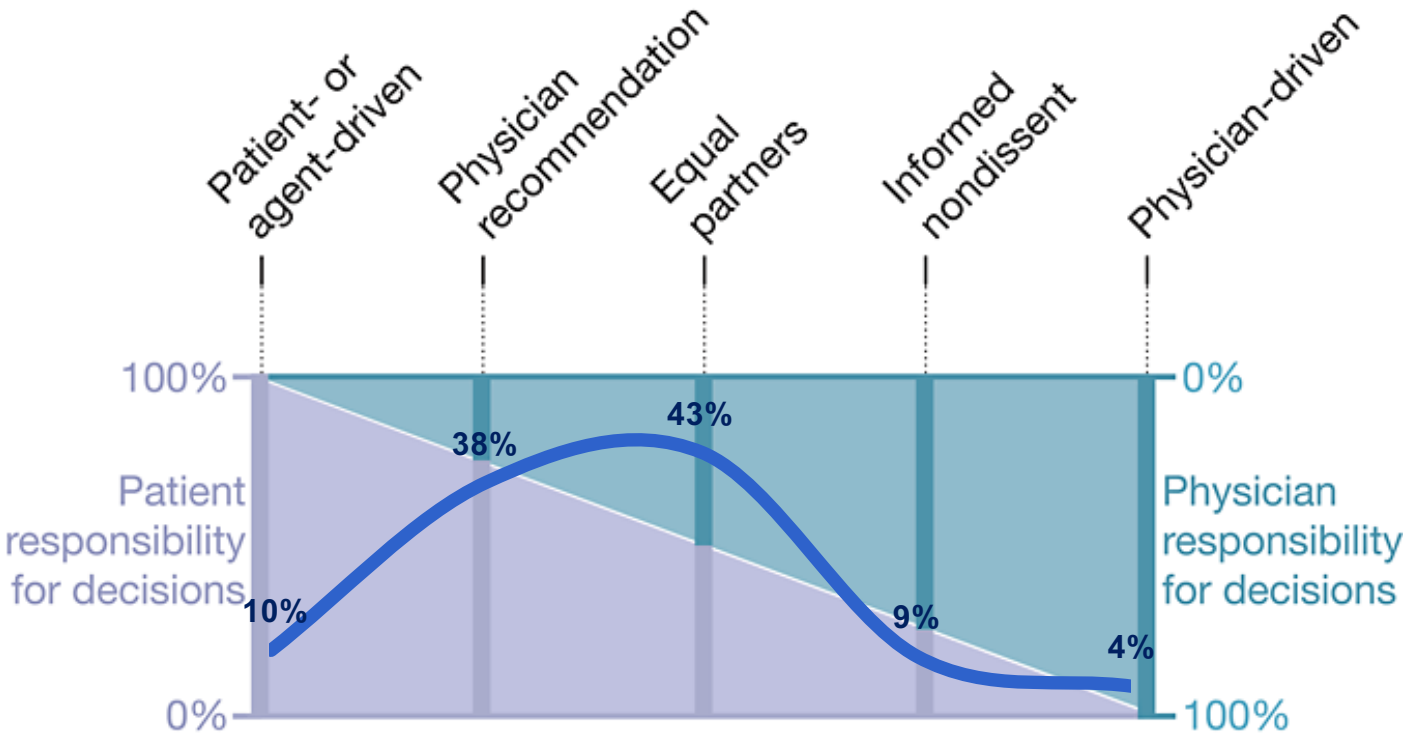
- Start with SDM
- Tailor the decision-making process based on the preferences of the patient or surrogate.
- Shift to paternalistic or patient-driven
  if that is their preference

Shared Decision-Making Continuum



- Kon AA. The Shared Decision-Making Continuum. JAMA 2010;304:903-904.

SDM Preferences: Value-Laden



- Adapted from: Kon AA. The Shared Decision-Making Continuum. JAMA 2010;304:903-904.

Patient- or Agent-Driven

- Clinician determines the range of medically appropriate treatment options
- Patient/surrogate chooses from among those

Informed Non-Dissent

- Clinician
  - discusses the medical condition
  - explains available treatment options
  - and elicits the patient's (or parents') values, goals, and preferences
- Surrogate wishes for clinicians to make treatment decisions
  - so that the patient can receive care
  - consistent with his/her values
  - without the surrogate feeling responsible for the decision

- Curtis JR, Burt. Point: the ethics of unilateral "do not resuscitate" orders: the role of "informed assent". Chest 2007 132(3):748-51.
- Kon AA. Informed nondissent rather than informed assent. Chest. 2008 133(1):320-1.
- Kon AA. The "window of opportunity:" helping parents make the most difficult decision they will ever face using an informed non-dissent model. Am J Bioeth. 2009 9(4):55-6.
- Kon AA. Informed non-dissent: a better option than slow codes when families cannot bear to say "let her die". Am J Bioeth. 2011 11(11):22-3.
- Curtis JR. The use of informed assent in withholding cardiopulmonary resuscitation in the ICU. Virtual Mentor. 2012 14(7):545-50.

Informed Non-Dissent

- Prior to use of informed non-dissent consider:
  - inadequate information
  - inadequate support from clinicians

Informed Non-Dissent Process

- Clinician explains what decision is being made and rationale
- The clinician explicitly gives the surrogate the opportunity to disagree
- If the surrogate does not disagree, it is reasonable to implement the care decision

Communication Skills Training

- See SCCM/ATS Policy Statement text and Table 3 for suggestions regarding optimizing communication with patients and surrogates in the ICU

- Example language available in publication

“The Captain of the Ship” Analogy

- Mrs. Jones wants to take a vacation
- Capt. Smith rents his yacht/crew to vacationers
- Mrs. Jones has specialized knowledge regarding what she likes in a vacation
- Capt. Smith has specialized knowledge of the islands, beaches, and seas
- Together,
- they decide where to sail

Specialized Knowledge

- Capt. Smith has expert knowledge of the islands and seas. He has no specialized knowledge of what makes a "good" vacation.

- Physicians have specialized medical knowledge, not necessary of:
  - What makes her life worth living?
  - What constitutes her fate worse than death?

Questions?