What is Shared Decision Making?

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Background

“The jury advocates a “shared” approach to EOL decision-making involving the caregiver team and the patient’s surrogate.

**GAPS:** What exactly is shared decision-making (DM)? Should it always be used? What discrete communication behaviors does it entail?

Carlet J. Intensive Care Med. 2004
Purpose(s):

- To endorse a definition of shared DM;
- To propose when shared DM should be used;
- To recommend a strategy to incorporate shared DM into counseling families;
- To propose core communication skills for shared DM that should be taught to ICU clinicians.

Five Recommendations
Recommendation 1- Endorsed definition: Shared DM is a process of communication in which patients (or their surrogates) and clinicians work together to make healthcare decisions, taking into account the best scientific evidence available, as well as the patient’s values, goals, and preferences.

Justification

🌟 Widely accepted definition in the field (Charles C. BMJ 1999; informedmedicaldecisions.org).

🌟 It focuses on clinician-family collaboration that combines medical expertise and knowledge of the patient as a person.

🌟 Not prescriptive about who holds final decisional authority.
# Elements of Shared Decision-Making

<table>
<thead>
<tr>
<th>Steps</th>
<th>Communication behaviors</th>
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<tbody>
<tr>
<td><strong>Creating the conditions for shared DM</strong></td>
<td>For clinicians:</td>
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<tr>
<td></td>
<td>• Providing emotional support</td>
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<td></td>
<td>• Activating family- explaining how important is their input</td>
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<td>For clinicians:</td>
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<td></td>
<td>• Explaining patient status and prognosis</td>
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<td>• Explaining treatment options</td>
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<td><strong>For surrogates:</strong></td>
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<td></td>
<td>• Sharing the patient’s previously expressed treatment preferences and health-related values.</td>
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<td><strong>Exchanging information</strong></td>
<td>For clinicians and surrogates:</td>
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<td></td>
<td>• Talking about treatment options in light of patient values</td>
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<td>• Sharing opinions</td>
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<td>• Feeling out decisional roles</td>
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Charles C. BMJ. 1999; Elwyn G. JGIM. 2012
**Recommendation 2**: Clinicians should use shared DM as their “default” approach to defining overall goals of care and also when making other major treatment decisions that may be affected by personal values, goals, and preferences.

<table>
<thead>
<tr>
<th>Example 1</th>
<th>Example 2</th>
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<tbody>
<tr>
<td>Whether to pursue ongoing life-prolonging treatment vs palliative treatment in a patient w COPD who has failed weaning trials.</td>
<td>Whether to pursue decompressive hemicraniectomy vs medical management in severe ischemic stroke.</td>
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</table>
**Recommendation 2:** Clinicians should use shared DM as their “default” approach to defining overall goals of care and also when making other **major** treatment decisions that may be affected by personal values, goals, and preferences.

**Preference-sensitive decision:** A decision for which the correct answer is contingent upon a patient’s values rather than purely on medical knowledge.

- Involves weighing the value of various burdens and benefits.
- Reasonable people may make different choices.

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www.dartmouthatlas.org/topics/preference_sensitive.pdf
**Recommendation 2**: Clinicians should use shared DM as their “default” approach to defining overall goals of care and also when making other major treatment decisions that may be affected by personal values, goals, and preferences.

<table>
<thead>
<tr>
<th>Justification for Clinician Involvement</th>
<th>Justification for Family Involvement</th>
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<tr>
<td>1. Expertise in treatment options and outcomes</td>
<td>1. Manifests respect for patient as a person by incorporating their values and preferences.</td>
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<tr>
<td>2. Expertise in making complex medical decisions</td>
<td>2. Most patients want their family involved in medical decisions.</td>
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<tr>
<td>3. Professional obligation to ensure that medical care is consistent with patient’s values.</td>
<td>3. Manifests respect for family unit.</td>
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<tr>
<td>4. (+/-) Professional obligation to encourage judicious use of medical resources.*</td>
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</tbody>
</table>
Recommendation 2: Clinicians should use shared DM as their “default” approach to defining overall goals of care and also when making other major treatment decisions that may be affected by personal values, goals, and preferences.

“Lower stakes” preference sensitive decisions

- How often to check vital signs; daily imaging, labs
- Whether to enlist expert consultation
- Whether to pursue imaging vs watchful waiting with a slow to resolve case of respiratory failure
- Whether to attempt extubation on a particular day in a "borderline" patient vs waiting one more day
- Whether the risks of resistant bugs are sufficient to justify very broad spectrum abx, etc, etc...

The committee did not recommend routine shared DM for all preference-sensitive decisions in ICUs.

Infeasible for all to involve full shared DM.
Committee rejected a one-size-fits-all approach

Justification for tailoring:
- Families have differing abilities and role preferences (Johnson S. AJRCCM. 2011).
- Forcing families into roles they do not want may heighten distress and worsen decisions (Gries C. Chest. 2010).
Families Vary in Their Preferred Role in Preference Sensitive Life Support Decisions

Hypothetical decision: “Imagine that your loved one’s illness worsened considerably and there was a small chance he would survive with continued use of life support and ICU treatment. If he survived, he would have physical and cognitive disabilities, and he/she would be dependent on others for basic tasks such as bathing, paying bills, and preparing meals, but would be able to communicate.”

Lower levels of trust in the ICU physician were independently associated with surrogates' preference for more control over the life support decision \( (p<0.0001) \)

Johnson S. AJRCCM. 2011
**Recommendation 3:** Clinicians should tailor the decision-making process based on the needs and preferences of the family.

**Implication:** clinicians need to develop proficiency with more than one approach to DM.

- Family-led DM
- Clinician-led DM
**Recommendation 4:** Clinicians should develop competence in core communication skills that are needed to implement shared DM.

**Recommended Communication Skills**

1. Building partnership with families
2. Providing emotional support
3. Assessing family’s understanding of patient condition
4. Explaining the patient’s condition and prognosis
5. Educating family about the role of surrogate decision-maker
6. Highlighting that there is more than one reasonable treatment plan
7. Explaining treatment options
8. Eliciting patient values, goals, and preferences
9. Deliberating with family about decision
10. Making a recommendation
**Recommendation 5**: Research needed to address knowledge gaps.

 Trials are needed to evaluate various strategies to improve shared DM in advanced illness, including:

- Decision aids
- Communication skills training for physicians
- Interventions testing inter-professional collaboration
- Patient navigators/decision support counselors.
Potential Concerns & Responses

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units


This Official Policy Statement of the American Thoracic Society (ATS) was approved by the ATS, January 2015, the American Association for Critical Care Nurses (AACN), December 2014, the American College of Chest Physicians (ACCP), October 2014, the European Society for Intensive Care Medicine (ESICM), September 2014, and the Society of Critical Care Medicine (SCCM), December 2014.
Potential Concerns & Responses

Must clinicians provide any intervention requested by family during shared deliberations?

- No. Shared DM is a method to help select the best treatment option from among medically accepted, available treatment options.
- In cases of persistent conflict, pursue fair process of dispute resolution.

Isn’t “clinician-led decision making” just another name for paternalism?

- No. In contrast to paternalism, in shared DM:
  1. Family chooses to defer (rather than the physician imposing this);
  2. Clinicians’ obliged to elicit and incorporate patient’s values into the treatment decisions.