

**Shared decision-making in the intensive care unit requires more frequent and high-quality communication: A research critique**

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Title: Shared decision making in ICU requires more frequent and high-quality communication: a research critique.

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### Research article for critique:

Scheunemann, L.P., Ernecoff, N.C., Buddadhumaruk, P., Carson, S.S., Hough, C.L., Curtis, J. R., White, D.B. (2019). Clinician-Family Communication About Patients' Values and Preferences in Intensive Care Units. *JAMA Internal Medicine*, 179(5), 676-684.  
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### Introduction:

Informing and actively involving patients and their families in decision making is a goal of patient and family centred healthcare<sup>1</sup>. Shared decision making is a collaborative process which enables healthcare decisions to be made between patients and/or families and clinicians, with consideration of patient values and preferences, while also using the best available scientific evidence to make recommendations<sup>2</sup>. This collaborative process is recommended by critical care societies<sup>3</sup> and health care organisations internationally<sup>4-6</sup>. Patients in intensive care units (ICUs) are often incapacitated and unable to communicate their treatment preferences. In these instances, the patient's families and friends assume the role of surrogate decision makers (surrogates). Often, these surrogates find themselves in family meetings with clinicians where they are faced with challenging decisions made even more complex by the uncertainty of patient prognoses<sup>1</sup>. Scheunemann et al (2019), recently explored this important area in a study of 249 family conferences, analysing how patient values and preferences are elicited during family meetings and how these preferences are applied to shared decisions made between surrogates and clinicians. A critique of this article is presented below.

### Study Summary:

#### Objective

To determine how often information about non-capacitated ICU patients' previously expressed preferences and values is exchanged between clinicians and surrogates during family conferences, and the extent to which that information is used during deliberation and treatment planning.

#### Design, setting and participants

A secondary analysis of data from a prospective multicentre study was undertaken. Clinician-family conferences for 249 critically ill adult patients were audio recorded at 13 ICUs across six academic and community medical centres in the U.S. Patient eligibility criteria included incapacity to make decisions, acute respiratory distress syndrome, APACHE II scores that predicted in-hospital mortality of 50% or more, and at least one surrogate decision maker.

Two coders analysed transcripts of recorded conversations. A quantitative coding scheme allowed the coders to count frequencies of how closely clinicians and surrogates attended to recommended shared decision-making practices. The elements of shared decision-making practices that were coded included *information exchange* between clinicians and surrogates about patients' values and preferences, and *deliberation* about those stated values and preferences. Values were defined as patients' lifestyle, activities, attitudes, feelings and beliefs about what makes life worth living. Preferences referred to previously stated wishes about life-extending treatments. Deliberation about values and preferences included three strategies: a) interpreting how the patient might feel about prognosis and treatment options; b) ascertaining what treatment the patient might choose; and c) the clinician's treatment recommendations based on patient values and preferences.

## Results

Conferences that involved goals of care discussions were included in the analysis (244 of the 249 recorded); 450 surrogates and 141 clinicians were represented in the recordings. Mean (SD) patient age was 58.2 (16.5) years; 134 patients (54.9%) were men. Mean age of surrogates was 49.4 (13.9) years; 155 (34.4%) were men.

Overall, 63 (25.8%; 95% CI) conferences contained no information exchange or deliberation about patient values or preferences. Clinicians and surrogates exchanged information about patient values and preferences in 167 (68.4%; 95% CI) conferences and specifically deliberated how the patient's values applied to the decisions in 108 (44.3%; 95% CI). End-of-life considerations including physical, cognitive, social functioning or spirituality were discussed in 87 (35.7%) of the conferences. The most frequently used deliberative strategy was discussing how to interpret the patient's values and preferences in the current clinical situation (91 [37.3%]), and these discussions commonly addressed how the patient would feel about dying or being on prolonged life-support. Surrogates provided a substituted decision in 33 conferences (13.5%), and clinicians made treatment recommendations informed by the patient's values and preferences in 20 conferences (8.2%).

## Critique

The results of this study suggest that ICU clinician-family conferences about treatment planning commonly lack important elements of shared decision making as these conferences rarely followed recommended practices such as communicating about patients' values and preferences and deliberation about the decisions which are in the best interest of the patient<sup>7</sup>. Patient- and family-centred care and shared decision making is undermined when clinicians and surrogates do not share a common understanding of these issues.

Strategies to improve the shared decision-making process should be aimed at both surrogates and clinicians. For clinicians, the ability to explicitly communicate about the incapacitated patient's health status as it currently stands aids in developing a shared understanding of what decisions need to be made during shared decision making<sup>3</sup>. Barriers to high-quality communication and patient- and family-centered decision making can be related to clinician knowledge, attitudes, and practices<sup>8</sup>. Eliciting values and preferences in an open-ended unrestricted manner, where the surrogate may not explicitly see the conflict between competing values, may not be helpful in determining the best plan of care for seriously ill patients<sup>9</sup>. Optimally, surrogates should be asked about these values in a way that highlights the inevitable trade-offs of competing values. For example, a clinician could use an approach that compels the surrogates to see two opposing choices that must be decided: "*Would your loved one prefer a natural death, or would they be willing to accept the use of machines, such as breathing machines, to prolong their life as long as possible?*" The surrogate must decide which option to choose based on the patient's previously stated preferences or values. The details of how values were elicited were not reported in the Scheunemann paper. More research may be needed to measure the frequency and quality with which values elicitation is done and the impact of this approach on communication and health-related outcomes. Clinical communication tools such as the Serious Illness Conversation Guide for clinicians (SICG) have demonstrated that improving clinician communication skills is challenging<sup>10</sup>. However, a limitation of the SICG is that clinicians are not trained to elicit values in a way that highlights competing values or provides guidance on language strategies to facilitate shared decision making. Frameworks or guides about shared decision making, such as the planwellguide.com, which offer resources for surrogates and clinicians are important resources in this area<sup>11</sup>.

Surrogates, on the other hand, need meaningful tools to empower and capacitate their understanding of shared decision making<sup>12</sup>. As highlighted by Scheunemann et al. (2019), more tools "to better prepare surrogates to represent patients' values and preferences" are needed. Tools already available include a web-based decision support intervention<sup>13</sup> to elicit values prior to family conferences in a

way that informs their decision making so they are better prepared to express the patient's authentic values and preferences<sup>13, 14</sup>. The hope is that empowering and capacitating surrogates will improve the quality of the conversation during family conferences with a resultant positive effect on decision making<sup>12</sup>. Developing interventions that both better prepare surrogates for difficult conversations and improve clinicians' communication skills in eliciting and including patients' values and preferences into treatment decisions are areas for further research<sup>7</sup>.

Scheunemann et al (2019) provides rich description regarding information exchange and deliberation practices; however, it may be argued that there is an absence of shared decision-making language that is effective. A further analytic step of shared-decision making practice could include decisional responsibility, or who decides<sup>15</sup>. In true shared decision making, the clinician would never place decisional responsibility totally with the surrogates, which occurs when the physician who asks, "What do you want us to do?" There is limited information on this subject in the Scheunemann paper, and this could be an additional area for further research.

The study by Scheunemann et. al (2019) sheds light into frequencies of how shared decision making behaviours are incorporated into family meetings. The rigorous approach taken by the authors in coding for behaviours is consistent with published shared decision-making guidelines and makes an important contribution to our understanding of how family meetings are conducted. While this coding system furthers our understanding about whether shared decision making is occurring and its frequency, as noted in the limitations of their study, it does not tell us about the *quality* of the shared decision-making conversation. In other words, while this coding system attends to *whether* communication behaviours related to shared decision making occur, it could benefit from additional attention to *how well* (i.e., the quality) communication goals are achieved<sup>16</sup>. Capturing the quality of shared decision making is important because "more" communication does not always mean "better" communication<sup>17, 18</sup>.

To address this issue, a methodology has been developed that assesses the quality of communication<sup>16</sup>, as explained by the Multiple Goals Theory, which defines high-quality conversations as those that attend to multiple (i.e., "task", "relational," and "identity") goals simultaneously<sup>17</sup>. These goals often compete with one another, and high-quality communication occurs when all three types of goals (rather than only one or two types) are attended to during conversation. This methodology, called Communication Quality Analysis (CQA), has undergone preliminary validation in published and pending works<sup>16, 18, 19</sup>. CQA involves rating participants using 7-point scales and results in quantitative scores based on how well participants attend to the multiple goals of communication, including task goals (for example: content, engagement), relational goals (for example: relationships, emotion), and identity goals (for example: face, under-accommodation, over-accommodation). CQA shifts focus from the *quantity* of communication as measured by frequency counts of communication behaviors to the *quality* of communication as measured using contextual, nuanced, and theory-driven ratings. Work is ongoing that seeks to evaluate the relationships of CQA to shared decision-making outcomes and long-term health outcomes.

Scheunemann et al.'s (2019) coding system is an important advance in how to evaluate shared decision making in the context of ICU family meetings, and the system may be synergistic with CQA. Combining quantity and quality assessments of shared decision making is key to understanding how best to design interventions for families and training for clinicians. Capturing the quality (not only the frequency) of shared decision making may provide insight into (a) how to apply these techniques in real time to provide clinician education and feedback on 'in the moment decision-making'<sup>20</sup> and (b) whether those assessments are in fact related to patient- and family-centered health outcomes.

## Conclusion

To achieve patient- and family-centred care, clinicians and families must share a common understanding of the incapacitated patient's values and preferences and deliberate about how the patient would feel in the current situation regarding their expected level of functioning, if the patient

survives<sup>3</sup>. Both patient/surrogate and clinician communication tools are needed to achieve this. Training interventions that better prepare clinicians to facilitate shared decision-making conversations may help clinicians achieve effective partnerships resulting in a shared understanding with surrogates. Interventions that better prepare surrogates for shared decision making are also necessary and could include tools that elicit values in a way that empower surrogates to accurately express the patient's values and preferences. Future researchers should consider combining both quantity and quality assessment frameworks when coding communication to learn whether both surrogates and clinicians achieve a meaningful approach to shared decision making in the ICU. There is much work to be done to optimise strategies for improving the frequency and quality of shared decision-making during family conferences. Doing so may reduce barriers to effective surrogate decision making and improve key elements of shared decision making.

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