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Critical care physicians' approaches to negotiating with surrogate decision makers: a qualitative study

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Abstract

Objective—To describe how critical care physicians manage conflicts with surrogates about withdrawing or withholding patients' life support.

Design—Qualitative analysis of key informant interviews with critical care physicians during 2010. We transcribed interviews verbatim and used grounded theory to code and revise a taxonomy of themes and to identify illustrative quotes.

Setting—3 academic medical centers, 1 academic-affiliated medical center and 4 private practice groups or private hospitals in a large Midwestern city

Subjects—14 critical care physicians

Measurements and main results—Physicians reported tailoring their approach to address specific reasons for disagreement with surrogates. Five common approaches were identified: (1) building trust, (2) educating and informing, (3) providing surrogates more time, (4) adjusting surrogate and physician roles, and (5) highlighting specific values. When mistrust was an issue, physicians endeavored to build a more trusting relationship with the surrogate before re-addressing decision making. Physicians also reported correcting misunderstandings by providing targeted education, and some reported highlighting specific patient, surrogate, or physician values that they hoped would guide surrogates to agree with them. When surrogates struggled with decision making roles, physicians attempted to reinforce the concept of substituted judgment. Physicians noted that some surrogates needed time to "come to terms" with the patent's illness

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Study Location

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before agreeing with physicians. Many physicians had witnessed colleagues negotiate in ways they found objectionable, such as providing misleading information, injecting their own values into the negotiation, or behaving unprofessionally towards surrogates. While some physicians viewed their efforts to encourage surrogates' agreement as persuasive, others strongly denied persuading surrogates and described their actions as "guiding" or "negotiating."

Conclusions—Physicians reported using a tailored approach to resolve decisional conflicts about life support; and attempted to change surrogates' decisions in accordance with what the physician thought was in the patients' best interests. While physicians acknowledged their efforts to change surrogate's decisions, many physicians did not perceive these as persuasive.

Keywords

Physician-patient relations; Conflict (psychology); Intensive care; Withholding Treatment; Communication barriers; Medical ethics

INTRODUCTION

The majority of patients who die in the intensive care unit have their life support withdrawn or withheld. (1,2) Since many critically ill patients are unable to fully participate in decision-making (1,3), clinicians often must rely on surrogate decision makers to guide clinical decisions about care in critical care units, including decisions about withholding or withdrawing life support. (4) To make matters more complicated, the majority of patients in intensive care units lack advance directives or living wills that clearly outline what should and should not be done.

Several models for surrogate decision-making in the intensive care unit (ICU) have been proposed, with recent views favoring a shared decision-making approach between surrogates and clinicians. (5–7) Critical care professional societies recommend "a dynamic process of negotiation where the outcome will be determined by the personalities and beliefs of the participants, and ideally, all should be involved in the decision, culminating in a shared agreement." (5) Shared decision making proceeds smoothly when the involved parties agree on a decision to continue, limit, or discontinue therapies. However, disagreements between clinicians and surrogates about decisions to limit life-support are not uncommon. (8,9).

These conflicts frequently stem from disagreements about withholding or withdrawing life sustaining therapy. (8–11) Such disagreements are important sources of stress and frustration for physicians and nurses and have been associated with clinician burnout. (10,12) Surrogates perceive these disagreements as well. In one study 42% of surrogates recalled conflict, usually with physicians, during their family members ICU stay, and some surrogates noted they felt pressured by physicians to make certain decisions. (13) While some research has been used to describe critical care physicians' general interactions with surrogates (14–16), little is known about how physicians manage disagreement with surrogates about the course of care. To explore these issues, we conducted key informant interviews with critical care physicians from academic and non-academic settings in a large Midwestern city.

MATERIALS AND METHODS

Participants

We contacted potential subjects between February and October of 2010 and performed in-person interviews using a semi-structured interview guide. We used purposeful sampling to identify practicing critical care physicians who varied with respect to their training as well as type of practice. (17) The University of Chicago Institutional Review Board approved this

study, all participating subjects provided written informed consent and strict measures were undertaken to preserve subjects' confidentiality.

Interviews

Two investigators (DB and GCA) created the initial semi-structured interview guide based on our clinical experiences and an extensive literature review. We piloted the interview guide with a group of health services researchers and medical ethicists. After the first three interviews were completed, we again iteratively revised the guide for clarity and breadth. The final guide explored 4 main topics using open-ended questions: (1) subject's general approach when discussing decisions about life support with surrogates, (2) how they negotiate with surrogates when they and the surrogates disagree about withdrawing life support, (3) what helpful or unhelpful negotiation techniques have they or their colleagues have employed, and (4) to what degree, if at all, they attempt to persuade surrogates when disagreement is present. (Appendix) Each interview was conducted by one critical care clinician-investigator (DB). Interviews lasted between 35 and 90 minutes, were audio taped and transcribed verbatim by research assistants. Any information in the transcripts that could potentially identify participants was redacted, a numeric identifier was used to identify participants, and audio files were destroyed after transcription.

Analysis

Two investigators (DB and GCA) read the initial transcripts to determine major themes and to identify areas worthy of additional inquiry. We also used these early interviews to review the interviewer's technique. After the interviews were completed, we (DB and CB) randomly selected and analyzed three transcripts to build a preliminary taxonomy of themes using the principals of grounded theory, a systematic method for analyzing raw qualitative data. (18, 19) We then analyzed the remaining transcripts and revised the taxonomy to incorporate new themes and subthemes.

We employed several methods related to grounded theory to ensure the rigor of our analysis. (20–22) We asked extensive questions to clarify participants' views and encouraged them to expound upon previous statements and we continued to interview subjects until theme saturation was achieved. We used a process of constant comparison to organize the data and delineate themes within and amongst interviews, and employed the principal of reflexivity to better understand our preconceptions and experiences to decrease the likelihood of biased interactions during interviewing and during data analysis.

RESULTS

Physician Characteristics and Experiences

Of sixteen physicians invited to participate, two declined citing time constraints. Our 14 participants had been in practice as critical care attendings for a median of 9 years (range 6 to 30). Three of the physicians were women. Seven physicians worked at three large university medical centers, 5 worked with two private practice groups, and 2 were employed by private community hospitals. Most were trained in pulmonary and critical care medicine but two were trained in anesthesia and critical care. All physicians had experience caring for patients in the intensive care unit within the last year.

All physicians had recent experiences deliberating with surrogates about limiting patients' life support. In general, physicians had very similar approaches with one another when conducting these discussions. They all reported providing surrogates with medical information and prognostication, most worked with surrogates to identify patients' values and preferences, and many reported routinely providing specific treatment

recommendations. While physicians commonly stressed that the surrogates had the "final word", many viewed it as their role to guide or try to alter surrogates' decisions, especially if they felt surrogates were making decisions that were not in patients' best interests. One physician observed:

> "The number one reason to have a family meeting, as I mentioned earlier, is when there's some disagreement between what the team thinks is in the best interest of the patient and what the surrogate seems to be advocating."

When physicians discussed their typical experiences disagreeing with surrogates over life support decisions, the vast majority described disagreements where they advocated withholding or withdrawing life support and the surrogate objected. Disagreements where physicians advocated a more medically aggressive approach and surrogates desired withdraw of life support were noted to occur rarely.

Resolving disagreement with surrogates

When surrogates disagreed with physicians about whether to limit a patient's life support, nearly all physicians reported attempting to understand the basis for the surrogate's disagreement. One physician expressed a common sentiment: "*If they disagree with the recommendation first I try to figure out why. Is it because the person they're speaking for has told them that they wanted everything done forever, or there's a religious issue, or is it an educational issue that they don't understand?*" In general, identifying reasons for disagreement allowed physicians to target their negotiations to address specific surrogate concerns. Another physician said: "*You have to understand where the family is coming from and what their base is…so you have to find out the information they have and where to start the negotiation process*."

Negotiation techniques used to garner surrogate agreement

No physician highlighted a single approach that could reliably alter a surrogates' decision: "*There aren't a lot of hard and fast things that always work or always don't work*." Instead, all physicians tailored their approaches to address surrogates' specific reasons for disagreement. Physicians' reported five general approaches to reach agreement with surrogates: 1) building trust, 2) providing education, 3) giving more time for decision making, 4) adjusting surrogate or physician roles, and 5) highlighting specific values to alter surrogate decisions (Table 1).

Building trust—For most physicians, earning the surrogate's trust was a critical part of the negotiation process. Trust was cited as especially important because surrogates were likely to reject even factual information from physicians they mistrusted. One physician said:

> "Because I think ultimately if you're not a critical care physician and you have to make decisions based on critical care medicine, you have to ultimately defer to the physician. If you don't have full trust and confidence in that physician, then that is a very difficult thing to do."

Many physicians built trust by communicating more frequently, honestly and sincerely with surrogates and by attempting to present a unified message to the surrogate. Many physicians also said it was helpful to recruit practitioners who had formed trusting relationships with patients and surrogates, such as the patient's long-standing physician, to join negotiations. A few physicians reported delaying negotiations, and even initial discussions, until they had gained the surrogate's trust.

Educating and informing—Nearly all physicians said that educating and informing surrogates was a key component of their negotiations when disagreement was present.

Physicians explained that dispelling misunderstandings or misconceptions about the patient's condition or prognosis often changed surrogates' decisions and led to more informed decisions. One physician offered an example: "*… it's pretty rare for families, once they hear the data, to want to go through CPR*." Building a logical argument was often cited as an effective means of resolving disagreements with surrogates. One physician said: "*I do it simply: you teach residents the way to get [surrogates] to think the right way is to present them the facts, and present things in a logical way, and get them to follow the logic and agree with you*."

While most physicians focused their educational efforts on medical facts and prognostication, a few physicians sought to also educate surrogates about patients' suffering. One physician said about highlighting a patient's suffering: "*It's not that I only [discuss a patient's suffering] with people I think we should withdraw support on, it's that I never use that approach on people that I think we should press ahead on*."

Providing more time to decide—Physicians reported that negotiations were not only a time intensive process, but that time itself could be utilized by physicians to help resolve disagreements. Because the decision process takes significant time, physicians reported starting the negotiation process early, especially when they anticipated a decisional conflict between the medical team and the surrogate. Physicians recognized that surrogates often changed their decisions over time as they were able to assimilate what was happening and "*come to terms with things*". Many physicians noted that with more time, surrogates often came to agree with physicians' views. One physician noted a commonly expressed sentiment "*…often it takes some time for them to witness what is happening with the patient, not improving, things getting worse, to come around to trusting the physician's professional judgment*." Physicians commonly said that they often ended meetings by providing a time frame after which the discussion or decision would be readdressed. The timing of subsequent negotiations was very important to some physicians, who noted that trying to readdress decision making too frequently could be viewed by surrogates as badgering: " *…you have to give families time to process what you've asked them to think about, and you don't want to harass them with too many meetings*."

Adjusting surrogate and physician roles—Some physicians perceived that guilt felt by surrogates sometimes prevented them from agreeing with physicians to limit a patient's life support. Physicians said they tried to alleviate this guilt by reinforcing the concept of substituted judgment and encouraging the involvement of other family members in decision making. A few physicians said that they would assume the responsibility of decision making if they perceived that the surrogate desired more directive physician involvement. One physician described his experience telling surrogates he would unilaterally decide not to perform CPR "*… if you make that statement and they seem even visibly unburdened and relieved at times, which occasionally seems to be the case, then you've clearly done the right thing*."

Highlighting specific values—Some physicians said that helping surrogates reflect on specific patient values sometimes helped lead surrogates to change their decisions. One physician gave an example of contrasting for a surrogate the difference between the patient's value of fierce independence and their current dependence on life support. A few physicians reported negotiating by invoking what they would do for their own loved ones, while other physicians viewed this behavior as inappropriate.

Objections to other physicians' approaches

Many physicians had seen their colleagues attempt to negotiate with surrogates in objectionable ways (Table 2). These approaches clustered into three sub-themes: physicians misleading surrogates, physicians injecting their own values into the negotiation process, and unprofessional conduct from physicians. Physicians had seen colleagues mislead surrogates in a number of ways: prognosticating with an unreasonable degree of certainty to sway surrogates, intentionally withholding information, and by one physician's account, directly lying to surrogates. Physicians strongly objected to misleading surrogates. One physician explained:

> "I have witnessed physicians misrepresenting a patient's status… I've seen people representing that a cancer was back or growing when we had no objective evidence that that was the case…they've strayed beyond what I think to be the moral of right and wrong to generate an outcome that they want."

Several physicians objected to using monetary costs in discussions because they felt that physicians were not in a position to accurately assess direct cost to the surrogate and their family. One physician said:

> "I have seen practitioners talk about the direct expense of care, and how the burden of that to the family would increase if they didn't accede to changing the goals of care… Well it's not clear to me that that was actually going to happen."

Some physicians also objected when physicians inserted their own religious or secular values to try to change surrogates' decisions. A few physicians also said they objected to the practice of sharing how a clinician would decide if the patient was their family member, even though they noted that this was not an uncommon surrogate question. One physician explained that he objected to this approach because different physicians could have considerably different answers. He said:

> "So why would it be by the luck of the draw that the person who is in front of you right now, their family relations determines what happens to your family?… I just say listen, this is not my father and I don't know what its like to have a father who has had cancer and you know, etc, so it's really hard for me to answer what that means."

Some physicians also had witnessed colleagues act unprofessionally towards surrogates. Anger directed towards the surrogate, the use of intimidation and being overly confrontational were seen as inappropriate and objectionable. Physicians stressed that these were difficult decisions that required physicians to demonstrate tact and sensitivity. They also perceived that aggressive or insensitive physician behavior often upset surrogates and derailed the decision making process.. One physician explained:

> "You always want to try and work with, bring them along so that they feel they've been heard and in the end they have to live with the decision. For me, a more empathetic, gentle approach over four or five days works better than coming in and saying "We're at decision point day, let's make a decision"."

Disparate views on persuading surrogates

Although every physician we spoke with described situations where they tried to change surrogates' decisions, physicians were divided about whether such attempts should be viewed as an attempt to persuade (Table 3). One senior academic physician described discussions with surrogates this way:

> "Once again, with a few exceptions the preponderance of these meetings are called to persuade the family to go along with a decision. And every word that is uttered

> by the physician in these discussions…is intended to produce—persuade them to accede to the recommendation. As far as I'm concerned, in many of these [meetings], if you're still talking, you're still persuading."

Unexpectedly, physicians who acknowledged persuading surrogates seemed to have more concern for the effects of physician influence on surrogates. For instance, the same senior academic attending had said earlier in the interview "*… some of my greatest regrets as a practitioner have arisen from talking people into things that they were very reluctant to do, and really didn't want to do, and only did because I was twisting their arm*." In contrast, physicians who denied persuading surrogates reported employing more forceful techniques, including some that other participants found objectionable. One physician who reported: "*I tell people 'If this was somebody I loved, I would not do that to them because it's a horrible way to die*'" denied persuading surrogates and said, "*it's not so much persuading, its informing*."

Some physicians objected to the use of the word persuasion to describe their actions, although these physicians freely described techniques they used to try to change surrogate's decisions. One senior physician in private practice said, "*Persuasion is a hard word… [You] see negotiate is not a confrontational term in my mind*.", also described his approach as one where: "*You want to get the family to logically come up with what you think is the right decision*." Another physician noted: " *I see persuasion as presenting the family with a list of arguments as to why they would not want to do something. I try not to do that*." This same physician said that he routinely provided specific recommendations to surrogates about life support decisions and commented: "*whether this is persuasion, probably so, but I cannot get away without saying what I would recommend*."

DISCUSSION

In this qualitative study of critical care physicians, participants readily recalled their approaches to resolving disagreements with surrogates and nearly all physicians stressed that these approaches had to be tailored to the individual surrogate, patient, and circumstance to succeed. Five common approaches were identified: (1) building trust, (2) educating and informing, (3) providing surrogates more time, (4) adjusting surrogate and physician roles, and (5) highlighting specific values.

Experts have recommended that physicians should avoid using a "one sized fits all" approach to shared decision making (23, 24), instead aligning their behavior with the surrogate's needs and desired role in decision making to improve the decision making process, rather than to reach a specific decision. By contrast, the physicians we interviewed often reported individualizing their approach because doing so was an effective way to encourage surrogates to agree with the decisions favored by physicians. Most physicians described taking on a more active role in decision making when there were important disagreements about limiting life support. This shift has been also noted in audio taped family meetings between critical care physicians and surrogates where conflict was present (15), suggesting that physicians' approaches to decision making may significantly differ depending on whether they agree with surrogates' decision.

Our participants invoked a variety of reasons for trying to change surrogates' decisions about withholding or withdrawing life support. Most commonly, physicians perceived the surrogate was making decisions that were not in the patients' best interest. While a best interest standard was commonly invoked, a few physicians who used it noted that such a standard could be quite difficult to discern. Critical care physicians generally lack longstanding relationships with patients, often cannot communicate with them directly, and frequently must rely on patients' surrogates, who themselves may struggle to identify the

patients' preferences. In one study decisions to limit life support were more strongly related to the identity of the physician in charge than to the patients' acute diagnostic category, source of ICU admission or comorbid conditions (25). Some have raised concern that physicians' decisions for patients may have considerable interphysician variability, may be influenced by external factors such as bed availability or legal liability, and may promote health care disparities by offering certain interventions to some and not others. (24, 25) Variations in physician decision making could also be guided by individual experience gained over time in the care of patients as well as by variations in how they incorporate evidence-based outcomes research into their practice. Because assessments of best interests are inherently subjective, a physician's or medical team's assessment of a patient's best interests may also differ considerably from a surrogate's assessment. When physicians and surrogates cannot come to agreement about which decisions are in a patient's best interests, ethics consultations may be helpful. (5, 28)

The physicians we spoke with also described various helpful techniques they used when negotiating with surrogates; the most commonly mentioned involved building trust, educating patients and timing discussions carefully, rather than adjusting roles or highlighting specific values. If these indeed are among the approaches physicians use to address disagreement after it has occurred, interventions to address surrogate distrust, provide information and education to surrogates, and enhance physician-surrogate communication might help to minimize, or even prevent, some conflicts over limiting life support. There may also be other unrecognized or underutilized techniques that could prevent or minimize conflicts over limiting life support.

Physicians varied in the degree of influence they reported trying to exert on surrogates. Some reported providing education to correct a surrogate's misunderstanding of objective facts, while others reported using education to build a logical argument that supported the decision they thought was best. When physicians highlighted specific values, some sought to only highlight patient values related to the decision, while a few felt that highlighting their own values was an effective means to encourage surrogates to change their decisions. While physician influence has been recognized as an important component in some models of shared decision making, so too has the ease with which even well meaning physicians may slide into behaviors that control or coerce. (29–31) An ethnographer who followed 100 critically ill patients noted that in half of the family conferences she witnessed the physicians had to persuade families to agree to limit life support. (32) It is unclear how physicians' attempts to influence surrogates' decision making affects surrogates, but research has suggested that some surrogates complain of feeling pressured by physicians and are concerned about physician influence. (13,24) Some surrogates are profoundly burdened by their experiences as surrogate decision makers (33) and symptoms associated with anxiety, depression and post-traumatic stress disorder are not rare. (34)

The physicians we interviewed also varied as to whether they viewed their attempts to change surrogate's decisions as persuasive. Surprisingly, physicians who embraced the term persuasion generally endorsed more mild degrees of influence, while physicians who denied the term reported influence to greater degrees. Greater physician insight regarding the use of persuasion could be associated with greater restraint in deliberations. Alternatively, physicians who more intensely attempt to influence surrogates may be more likely to deny the use of persuasion. Finally, some physicians viewed the term "persuasion" pejoratively, even though such physicians acknowledged trying to alter surrogate decisions.

Our study has several limitations. First, as is common in qualitative studies, our limited sample size and non-random selection of participants limits the ability to generalize these findings to other critical care physicians across the US and outside the US, nor can they be

generalized to other types of physicians. Rather, the views and approaches cited by participants are meant to generate hypotheses for practicing clinicians and further research. Second, participants' recollections about their approach to disagreements may not accurately depict their own practice. Third, our findings may have been influenced by our own preconceptions and experiences. We attempted to minimize this impact by using methods commonly employed in qualitative research, such as reflexivity, triangulation, and continuing interviews until theme saturation was achieved. (20)

CONCLUSIONS

Shared decision making among critical care physicians and surrogates takes place commonly and is consistent with the recommendations of critical care professional societies. Despite this, disagreements regarding patients' course of care are not uncommon and may have important effects on both care providers as well as patients and their surrogates. Our findings illuminate the breadth of approaches that clinicians may use in these settings, and also provide an opportunity to consider how such approaches may affect surrogates and impact patients' care. Further investigation and discussion regarding the appropriate application of physician influence in life support decision making with surrogates may help physicians refine their approach and may identify approaches that are effective at guiding surrogate's decisions, acceptable to surrogates and ethically appropriate.

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Appendix 1: Questions included in key-informant interviews

You have generously agreed to discuss your views and experiences. Please keep in mind three things. First, there are no right or wrong answers to these questions. Second, your responses will be kept strictly confidential. And third, we appreciate your help. Do you have any questions?

Let's get started with the first question…

1. Physicians have different approaches to discussing end-of-life decision making with surrogates. What is your approach?
    - **a.** What are the key steps you take?
    - **b.** Does this differ depending upon the clinical case? How so?
    - **c.** What role do trainees play?

Now let's talk a little about family meetings, which represent one context in which communication between surrogates and family members may take place.

2. How often do you have a formal "family meeting" with surrogates?
    - **a.** What factors prompt you to suggest a family meeting?
3. What are the outcomes of these meetings?

4. To what degree, if at all, do you come to family meetings with an opinion about what the outcome of the meeting should be?

   a. If yes, how do you develop this opinion?

   b. If no, why not?

5. How important is it when a surrogate disagrees with your view?

Now let's talk a little about particular cases when there may be disagreement between the physician and the patient's surrogate about end-of-life decision making.

6. Can you describe a recent example of a disagreement between yourself and the patient's surrogate decision maker about end-of-life decision making?

   a. How did you handle the situation?

7. In the past, what experiences have you had in negotiating with surrogates about end-of-life decision making for your patients?

   a. Please describe an especially memorable experience you've had negotiating with a surrogate about end-of-life decision making.

   b. What negotiation strategies did you employ?

   c. What ethical issues were at stake?

8. What helpful negotiation techniques have you used when discussing end-of-life decision making with surrogates?

   a. What was helpful about this technique?

   b. Can you describe other helpful techniques?

9. Have you witnessed other physicians negotiate with surrogates in ways that you admired?

   a. Can you describe their approach?

   b. What was admirable about their approach?

   c. At what level of training was this physician?

10. What unhelpful negotiation techniques have you used when discussing end-of-life decision making with surrogates?

   a. What was unhelpful about this technique?

   b. Can you describe other unhelpful techniques?

11. Have you witnessed other physicians negotiate with surrogates in ways that you found objectionable?

   a. Can you describe their approach?

   b. What was objectionable about their approach?

   c. At what level of training was this physician?

12. How, if at all, do physicians employ persuasion to convince surrogates to change their decisions?

13. How would you improve negotiations between physicians and surrogates about end-of-life decision making?

14. What do you think are the important, unanswered questions about managing disagreements between physicians and surrogate decision makers?

Finally, a few questions about you:

15. How long have you been a critical care attending?

16. Any other insights you would like to share?

References

1. Cook D, Rocker G, Marshall J, et al. Withdrawal of mechanical ventilation in anticipation of death in the intensive care unit. N Engl J Med. 2003; 349:1123–32. [PubMed: 13679526]
2. Prendergast TJ, Claessens MT, Luce JM. A national survey of end-of-life care for critically ill patients. Am J Respir Crit Care Med. 1998; 158:1163–7. [PubMed: 9769276]
3. Smedira NG, Evans BH, Grais LS, et al. Withholding and withdrawal of life support from the critically ill. N Engl J Med. 1990; 322:309–15. [PubMed: 2296273]
4. Prendergast TJ, Luce JM. Increasing incidence of withholding and withdrawal of life support from the critically ill. Am J Respir Crit Care Med. 1997; 155:15–20. [PubMed: 9001282]
5. Thompson BT, Cox PN, 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: executive summary. Crit Care Med. 2004; 32:1781–4. [PubMed: 15286559]
6. Davidson JE, Powers K, Hedayat KM, 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. Crit Care Med. 2007; 35:605–22. [PubMed: 17205007]
7. Bone RC, Rackow EC, Weg JG, et al. Ethical and moral guidelines for the initiation, continuation, and withdrawal of intensive care. American College of Chest Physicians/ Society of Critical Care Medicine Consensus Panel. Chest. 1990; 97(4):949–58. [PubMed: 2182302]
8. Breen CM, Abernethy AP, Abbott KH, Tulsky JA. Conflict associated with decisions to limit life-sustaining treatment in intensive care units. J Gen Intern Med. 2001; 16:283–9. [PubMed: 11359545]
9. Studdert DM, Mello MM, Burns JP, et al. Conflict in the care of patients with prolonged stay in the ICU: types, sources, and predictors. Intensive Care Med. 2003; 29(9):1489–97. [PubMed: 12879243]
10. Azoulay E, Timsit JF, Sprung CL, et al. Prevalence and factors of intensive care unit conflicts: the conflicus study. Am J Respir Crit Care Med. 2009; 180(9):853–60. [PubMed: 19644049]
11. Danjoux Meth N, Lawless B, Hawryluck L. Conflicts in the ICU: perspectives of administrators and clinicians. Intensive Care Med. 2009; 35(12):2068–77. [PubMed: 19756499]
12. McBride Robichaux C, Clark AP. Practice of expert critical care nurses in situations of prognostic conflict at the end of life. Am J Crit Care. 2006; 15:480–491. [PubMed: 16926369]
13. Abbott KH, Sago JG, Breen CM, Abernethy AP, Tulsky JA. Families looking back: one year after discussion of withdrawal or withholding of life-sustaining support. Crit Care Med. 2001; 29(1): 197–201. [PubMed: 11176185]
14. White DB, Braddock CH 3rd, Bereknyei S, Curtis JR. Toward shared decision making at the end of life in intensive care units: opportunities for improvement. Arch Intern Med. 2007; 167(5):461–7. [PubMed: 17353493]
15. White DB, Malvar G, Karr J, Lo B, Curtis JR. Expanding the paradigm of the physician's role in surrogate decision-making: an empirically derived framework. Crit Care Med. 2010; 38(3):743–50. [PubMed: 20029347]
16. Torke AM, Moloney R, Siegler M, Abalos A, Alexander GC. Physicians' views on the importance of patient preferences in surrogate decision-making. J Am Geriatr Soc. 2010; 58(3):533–8. [PubMed: 20158556]
17. Miles, MD.; Huberman, AM. Qualitative Data Analysis: An Expanded Sourcebook. Thousand Oaks, Calif: Sage Publications; 1994. p. 27-34.

18. Strauss, AL.; Corbin, J. Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. Thousand Oaks, CA: Sage; 1988.
19. Glaser, BG.; Strauss, AL. Discovery of Grounded Theory. Chicago: Adeline; 1967.
20. Malterud K. Qualitative research: standards, challenges, and guidelines. Lancet. 2001; 358(9280): 483–8. [PubMed: 11513933]
21. Strauss, AL.; Corbin, J. Basics of qualitative research Grounded theory procedures and techniques. Newbury Park: Sage; 1990.
22. Giacomini MK, Cook DJ. Users' guides to the medical literature: XXIII. Qualitative research in health care A Are the results of the study valid? Evidence-Based Medicine Working Group. JAMA. 2000; 284(3):357–62. [PubMed: 10891968]
23. Curtis JR, White DB. Practical guidance for evidence-based ICU family conferences. Chest. 2008; 134(4):835–43. [PubMed: 18842916]
24. White DB, Evans LR, Bautista CA, Luce JM, Lo B. Are physicians' recommendations to limit life support beneficial or burdensome? Bringing empirical data to the debate. Am J Respir Crit Care Med. 2009; 180(4):320–5. [PubMed: 19498057]
25. Garland A, Connors AF. Physicians' influence over decisions to forego life support. J Palliat Med. 2007; 10(6):1298–305. [PubMed: 18095808]
26. Manthous CA. "My advice is…": beneficent or veiled paternalism. Chest. 2011; 139(2):243–4. [PubMed: 21285052]
27. Perkins HS, Bauer RL, Hazuda HP, Schoolfield JD. Impact of legal liability, family wishes, and other "external factors" on physicians' life-support decisions. Am J Med. 1990; 89(2):185–94. [PubMed: 2382667]
28. Schneiderman LJ, Gilmer T, Teetzel HD, et al. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial. JAMA. 2003 Sep 3; 290(9):1166–72. [PubMed: 12952998]
29. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. JAMA. 1992; 267(16):2221–6. [PubMed: 1556799]
30. Quill TE, Brody H. Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. Ann Intern Med. 1996; 125(9):763–9. [PubMed: 8929011]
31. Swindell JS, McGuire AL, Halpern SD. Shaping patients' decisions. Chest. 2011; 139(2):424–9. [PubMed: 21285056]
32. Kauffman, SR. …And a time to die: how American hospitals shape the end of life. New York: Scribner; 2005.
33. Braun UK, Beyth RJ, Ford ME, McCullough LB. Voices of African American, Caucasian, and Hispanic surrogates on the burdens of end-of-life decision making. J Gen Intern Med. 2008; 23(3): 267–74. [PubMed: 18172738]
34. Gries CJ, Engelberg RA, Kross EK, et al. Predictors of symptoms of posttraumatic stress and depression in family members after patient death in the ICU. Chest. 2010; 137(2):280–7. [PubMed: 19762549]

Table 1

Select themes and illustrative quotes about negotiation techniques physicians use to garner surrogate agreement.

Techniques	Quotes
Building trust	"Trust, availability…so being there for questions and when families see engagement on my part I think they're more willing to spend time listening and trying to understand what I have to say "Generally, I just try to …re-approach the situation, establish a rapport, and hopefully that trust will build up in time. And then in the majority of cases the outcome comes out in a way that I think is acceptable to everyone"
Educating and informing	"I try to educate them as much as possible about what the situation is…I try to keep the conversation open-ended if possible so that the surrogate has a chance to voice their concerns, has a chance to express either their understanding or their misunderstanding of what I'm saying." If they really have no insight in terms of what the disease is or what the patient has been going through the last year or two or six months, then there's more education [to provide] on a basic level. "Probably the most important thing that you have to do is to extinguish their hope that there's going to be some miraculous cure that comes along and changes the outcome."
Providing more time	"at some point you need to step back and hope that with some more time the family will start to understand this person is not going to get better. And that usually happens." "The surrogate's decisions evolve over time, the physician's recommendations evolve over time, and I think it's a dynamic process." "…if I get the sense that they are resisting [DNR] I still mention it but let them know they don't have to decide right away."
Adjusting roles	"The best thing that I've found to make them make the right decision is you tell the family or surrogate or whoever it may be: "It's not your decision. It's the patient's decision, it's just that they can't vocalize it." And I do think sometimes it is the role of the ICU physician to "take the reigns", for lack of a better term, and to drive the direction of the care of the patient…"
Highlighting Values	" …sometimes, when you do that you discover that there is some core value…once you learn of it you actually realize that you can provide an educational piece that redirects their decision making" "Every once in a while I'll be in a situation where its just absolutely obvious that the patient has to be DNR and the family is either hesitant or resistant or something, I will occasionally say "If this were my family member, this is what I'd do". I don't do it routinely but sometimes I do." In that situation I tell people "If this was somebody I loved, I would not do that to them because it's a horrible way to die".

Table 2

Select themes and illustrative quotes about physicians' objections to their peers approaches to negotiating with surrogates.

Objectionable approaches	Quotes
Misrepresenting information	"In some situations only one side of the coin is presented and the physician paints the picture in very dark colors…if the family sees some improvement in the patient a day or two later, this whole structure falls apart because now they understand that the physician was trying to tell them something that was not right." "I think that certain physicians actually mislead families to believe that the prognosis is better than it is in order to continue to perform life prolonging treatment. Letting people die is not a good way to continue to bill them." "I have seen some things which I think are just the wrong way to do it. One is to bring cost into it…I think that is also a very dangerous technique because for some, costs are very difficult to understand in medical care"
Imposing physician values	"I also don't personally think the whole "if this were my dad I would do this" sort of motto is very appropriate…I see many physicians do that. "Well, I've seen religion being used as a way to convince people that they should stop an active therapy…that its time to go and God is calling. Which again without exploring the religious beliefs of the family and without good through knowledge of them I would never do that." "I've certainly witnessed some physicians who will tell a surrogate "We are torturing this person, you must stop." Essentially using some guilt in an overt way…"
Unprofessional behavior	"I remember a doctor…who was trying to describe someone's downhill course and now, not content to make a mere analogy to a plane that was diving, crashing, but actually in the spur of the moment sort of reenacted this crash" "The worst thing I've seen is a physician, whether it was intentional or not, making a surrogate feel incapable or unworthy or unappreciated or stupid. You see that at times…it's usually arrogance that leads to that." "I have seen people go in and say "Your loved one is going to die and there's nothing we can do about it". It's delivering the bad news or the unfavorable outcome in a cold, pragmatic, upfront manner… I think [surrogates] have a tough time with it."

Table 3

Select themes and illustrative quotes related to physicians' views on persuading surrogates to change their decisions about life support.

	Quotes
Physicians endorsing persuasion	"The first thing is that I believe that, in one sense, everything we do is persuasive…the order in which I present things and the things that I choose to highlight out of a whole sea of data play an enormous role in presenting to decision makers one picture or the other." "Yes I do [persuade], but to varying degrees. Again if you have a situation where the outcome is unclear the preferences of the patient aren't clear, then I'm not likely to use persuasion as much." "Persuasion is important if the persuasion is to enlighten a surrogate about some belief or preconception they have that's either not true or unrealistic." "Well of course there is a natural sort of balance, sort of respect and power that the physician often holds, or usually holds, I think with the patient's family. So there's probably some level of being persuasive just from the nature of their position that's not necessarily related to what they are actually saying."
Physicians not endorsing persuasion	"…I think our role is much like a judge in a court of law. It's to mediate and to make sure things run according to the rules but to not influence." "I see persuasion as presenting the family with a list of arguments as to why they would not want to do something. I try not to do that. I try to again give them options and let them know what I would recommend but leave it open rather than persuade them to do anything." "The bottom line is you're not persuading the family, what you want is to negotiate a good outcome for your patient and it depends on how you get there. You want to get the family to logically come up with what you think is the right decision."