Shared Decision-Making in Intensive Care Units

Executive Summary of the American College of Critical Care Medicine and American Thoracic Society Policy Statement

Shared decision-making is a central component of patient-centered care in the intensive care unit (ICU) (1–4); however, there remains confusion about what shared decision-making is and when shared decision-making ought to be used. Further, failure to employ appropriate decision-making techniques can lead to significant problems. For example, if clinicians leave decisions largely to the discretion of surrogates without providing adequate support, surrogates may struggle to make patient-centered decisions and may experience psychological distress (5). Conversely, if clinicians make treatment decisions without attempting to understand the patient's values, goals, and preferences, decisions will likely be predominantly based on the clinicians' values, rather than the patient's, and patients or surrogates may feel they have been unfairly excluded from decision-making (1, 2). Finding the right balance is therefore essential. To clarify these issues and provide guidance, the American College of Critical Care Medicine (ACCM) and American Thoracic Society (ATS) recently released a policy statement that provides a definition of shared decision-making in the ICU environment, clarification regarding the range of appropriate models for decision-making in the ICU, a set of skills to help clinicians create genuine partnerships in decision-making with patients/surrogates, and ethical analysis supporting the findings (6).

To develop a unified policy statement, the Ethics Committee of the ACCM and the Ethics and Conflict of Interest Committee of the ATS convened a writing group composed of members of these committees. The writing group reviewed pertinent literature published in a broad array of journals, including those with a focus in medicine, surgery, critical care, pediatrics, and bioethics, and discussed findings with the full ACCM and ATS ethics committees throughout the writing process. Recommendations were generated after review of empirical research and normative analyses published in peer-reviewed journals. The policy statement was reviewed, edited, and approved by consensus of the full Ethics Committee of the ACCM and the full Ethics and Conflict of Interest Committee of the ATS. The statement was subsequently reviewed and approved by the ATS, ACCM, and Society of Critical Care Medicine leadership, through the organizations' standard review and approval processes.

ACCM and ATS endorse the following definition: Shared decision-making is a collaborative process that allows patients, or their surrogates, and clinicians to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values, goals, and preferences.

Clinicians and patients/surrogates should use a shared decision-making process to define overall 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 (7, 8). Once clinicians and the patient/surrogate agree on general goals of care, clinicians confront many routine decisions (e.g., choice of vasoactive drips and rates, laboratory testing, fluid rate). It is

logistically impractical to involve patients/surrogates in each of these decisions. Partnerships in decision-making require that the overall goals of care and major preference-sensitive decisions be made using a shared decision-making approach. The clinician then has a fiduciary responsibility to use experience and evidence-based practice when making day-to-day treatment decisions that are consistent with the patient's values, goals, and preferences. Throughout the ICU stay, important, preference-sensitive choices often arise. When they do, clinicians should employ shared decision-making.

Clinicians should generally start with a default shared decision-making approach that includes the following three main elements: information exchange, deliberation, and making a treatment decision. This model should be considered the default approach to shared decision-making, and should be modified according to the needs and preferences of the patient/surrogate. Using such a model, the patient or surrogate shares information about the patient's values, goals, and preferences that are relevant to the decision at hand. Clinicians share information about the relevant treatment options and their risks and benefits, including the option of palliative care without life-prolonging interventions. Clinicians and the patient/surrogate then deliberate together to determine which option is most appropriate for the patient, and together they agree on a care plan. In such a model, the authority and burden of decision-making is shared relatively equally (9). Although data suggest that a preponderance of patients/surrogates prefer to share responsibility for decision-making relatively equally with clinicians, many patients/surrogates prefer to exercise greater authority in decision-making, and many other patients/surrogates prefer to defer even highly value-laden choices to clinicians (10–13). Ethically justifiable models of decision-making include a broad range to accommodate such differences in needs and preferences.

In some cases, the patient/surrogate may wish to exercise significant authority in decision-making. In such cases, the clinician should understand the patient's values, goals, and preferences to a sufficient degree to ensure the medical decisions are congruent with these values. The clinician then determines and presents the range of medically appropriate options, and the patient/surrogate chooses from among these options. In such a model, the patient/surrogate bears the majority of the responsibility and burden of decision-making. In cases in which the patient/surrogate demands interventions the clinician believes are potentially inappropriate, clinicians should follow the recommendations presented in the recently published multiorganization policy statement on this topic (14).

In other cases, the patient/surrogate may prefer that clinicians bear the primary burden in making even difficult, value-laden choices. Research suggests that nearly half of surrogates of critically ill patients prefer that physicians independently make some types of treatment decisions (10–13). Further, data suggest that approximately 5–20% of surrogates of ICU patients want clinicians to make highly value-laden choices, including decisions to limit or

withdraw life-prolonging interventions (12, 13). In such cases, using a clinician-directed decision-making model is ethically justifiable (15–24).

Employing a clinician-directed decision-making model requires great care. The clinician should ensure that the surrogate's preference for such a model is not based on inadequate information, insufficient support from clinicians, or other remediable causes. Further, when the surrogate prefers to defer a specific decision to the clinician, the clinician should not assume that all subsequent decisions are also deferred. The surrogate should therefore understand what specific choice is at hand and should be given as much (or as little) information as the surrogate wishes. Under such a model, the surrogate cedes decision-making authority to the clinician and does not need to explicitly agree to (and thereby take responsibility for) the decision that is made. The clinician should explain not only what decision the clinician is making but also the rationale for the decision, and must then explicitly give the surrogate the opportunity to disagree. If the surrogate does not disagree, it is reasonable to implement the care decision (19–24). Readers may review references 19–24 for detailed descriptions and ethical analyses of clinician-directed decision-making.

The statement was intended for use in all ICU environments. Patients and surrogate decision-makers have similar rights both to participate in decision-making when appropriate and to rely more heavily on providers when they wish to do so, regardless of the type of ICU. Similarly, the statement is equally applicable in pediatric and neonatal settings, where decision-making partnerships between parents and the ICU team are equally important. As noted in the statement, including children in some decisions can often be appropriate as well. The statement is also intended to be applicable internationally. Although patient and surrogate decision-making preferences may differ globally, the default approach presented and the recommendation to adjust the decision-making model to fit the preferences of the patient or surrogate are universal. Both ACCM and ATS are international organizations, and the literature review included publications from many countries. The statement focuses on the ICU environment because critically ill patients are often, but not always, unable to participate in decision-making themselves, and because many decisions in the ICU are value-sensitive. The recommendations in the statement, however, could be equally applicable in all patient care settings.

To optimize shared decision-making, clinicians should be trained in specific communication skills. Core categories of skills include establishing a trusting relationship with the patient/surrogate; providing emotional support; assessing patients'/surrogates' understanding of the situation; explaining the patient's condition and prognosis; highlighting that there are options to choose from; explaining principles of surrogate decision-making; explaining treatment options; eliciting patient's values, goals, and preferences; deliberating together; and making a decision. The full policy statement provides significant guidance and examples in these areas (6).

Finally, ACCM and ATS recommend further research to assess the use of various approaches to decision-making in the ICU. The use of decision aids, communication skills training, implementation of patient navigator or decision support counselor programs, and other interventions should be subjected to randomized controlled trials to assess efficacy. Considerations regarding the cost and time burdens should be weighed against

anticipated benefits from such interventions when determining which efforts to implement. ■

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