ENJOY IN SDM COACHING

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While shift changing at the Respiratory Care Center (RCC)—

"RCC-6 SBT (spontaneous breathing trial) 10 hours, we have to notify the doctor to arrange a family meeting to discuss the option of palliative care or tracheostomy…"

"Yi-Ching, please come quickly, the family of RCC-6 are fighting over disagreement on the option of tracheotomy, and they have been acting rude towards our staff…"

"The family of RCC-8 cannot seem to understand the doctor's explanations, always asking the same question without answering any of ours. The patient's SBT is about to finish, what should we do?"

"Yi-Ching, I think our communication today with the patient's family is chaotic, and there are so many patients upstairs waiting for me, my time is constantly compressed," a doctor said.

Confronted with the predicaments above, what else can we do?

On the annual report of 2014 Taiwan Patient Safety

Reporting System (TPR), out of all the patient safety incidents related to communication factor, 31.6% are communication problems between "medical teams and patients". To resolve the issue, shared decision making (SDM) was born. The purpose of DSM is to achieve quality informed decision-making by factoring in patients' priorities and values, using structured steps to guide patients and families to come forward with their considerations, and reduce cognitive dissonance, or even prevent medical disputes, via shared decision making and shared information.

As Joint Commission of Taiwan (JCT) begin to promote SDM in 2016 by building the fundamentals and rapidly publicizing the concept, it is understandable how a physician may face conflicts during diagnosis, discussion options, and screening decisions. The nature of the roles patients and their families play in terms of identification, considerations, and priorities are clearly defined, but I cannot but wonder, as a nursing staff in the front line, what roles should we play in the process of SDM? While learning, I was fortunate to be able to discuss with my seniors, during which I acquired the concept of SDM coaching that shed light on my exploration, helping me to define and optimize the functionality of my role. SDM coaches are played by medical personnel other than physicians. They assess critical needs (critical conflicts, knowledge, clarity of values, support), provide EBM (Evidence-based Medicine) SDM tools base on patients' needs, monitor and facilitate development (solve needs and decision quality), and screen and implement clinical decided needs, which means SDM coaches can assist and prepare patients in decision making. The following case is a personal experience of mine.

The elderly patient in bed seven, 96 years old, suffered from cancer and exhibited signs of dementia. The progression of his disease caused carbon dioxide accumulation, which led to repeated intubation. One morning, the patient's oldest son stopped the

staff from explaining and shouted, “You stop talking. Whatever you are saying, I know. But you don’t understand how I, his son, feels. If I give up on him, I have to live with the guilt. If he survives, I am old, I am financially incapable to caring for him, and no one else can too. So I have decided to sign a DNR order (no cardiopulmonary resuscitation (CPR), no drug, no shock treatment, only intubation), and we refuse tracheostomy!” This decision implied that the patient would have to endure the pain of intubation.

As a SDM coach, I could feel the rising tension within the family. I walked over to the bed and told him, “It must be tough on you. You must be very anxious facing such a difficult decision. As the eldest son, it must hurt when your father has not been making much progress. Can you give me some time so we can talk?”

During a two-hour long meeting, I identified the key issue to be that the son was unwilling to drag his father through the pain and was hoping for palliative care. However, the family members were divided on the matter, and the fact that the patient was resilient, the agreement was that in the case of respiratory failure, the patient should be intubated and resuscitated. I proposed the request for a family meeting, during which I would analyze the situation to all family members, clarify misconceptions of tracheotomy, the pros and cons of each treatment, and which method would pose the least pain to the patient. After the meeting, the son smiled and thanked me for letting him know enough to decide the best option for his father.

During the implementation of SDM, we encourage our patients and their families to reach an autonomous decision with a full understanding of the situation, and assist in clarifying responsibilities and consequences of their actions. During these perplexing moments, the medical team will act as their ally and accompany them throughout.

SDM in Taiwan is still in its infancy. After numerous clinical practices, participation in doctor-patient communications, and extensive literary reviews, I concluded that the requirements of a SDM coach are as follows:

1. Interested in people: Interested not in people's privacy, but in people and everything relevant.
2. Physically and mentally mature, and emotionally stable.
3. Self-awareness: Avoid subjective intervention, facilitate patient and family needs.
4. Focused and flexible attitude: Listen to patients' needs and embrace it with flexibility and openness; build doctor-patient relationship and truly understand patients' expressions.
5. Observant: Observant of patients' and families' messages (including implications) that are essential to the progression of following proceedings.
6. Sincerity: Genuine care for others, face patients and families as who they are instead of the roles they assume; willing to open one-self, as admitting personal limitations is the best method of resolving confrontations.
7. Communication: A critical skill that can be divided into two major categories: listening and reacting. Listening entails mindfulness to patients' expressions, and reacting is to respond what one hears, observes, and feels to patients, or to provide opinions to patients as reference.
8. Extensive knowledge: Including professional and general knowledge. An extensive general knowledge and life experience is beneficial in empathizing with patients' feelings and troubles, and providing professional knowledge that can effectively facilitate informed autonomous decision by patients and families.
9. Support: The role of SDM coach, to me, is to provide mental coaching. A familiar scenario during clinical practice is the concern of patients and families about the possibility of regretting their decisions.