

# Stroke Dilemmas: When the Right Answer Isn't Clear

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# Disclosure

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NINDS

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# Clinical Case

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66 year old man with AF (off AC temporarily for colonic poly removal) admitted with a large left MCA infarct. On day #2, he appears more sleepy, is globally aphasic with dense right sided hemiplegia and unable to swallow. Family asks:

- ▶ Should we do surgery to relieve brain swelling?
  - ▶ Should we start anticoagulation at this time to prevent another stroke?
  - ▶ Should we insert a feeding tube for nutrition?
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- ***None of these are just “medical” questions***

# Stroke is Not Only a Biological Event It is Also a Lived Experience

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In stroke care some of the hardest decisions  
*are not what we can do*

But *should we do it* for this patient at this  
juncture in their lives

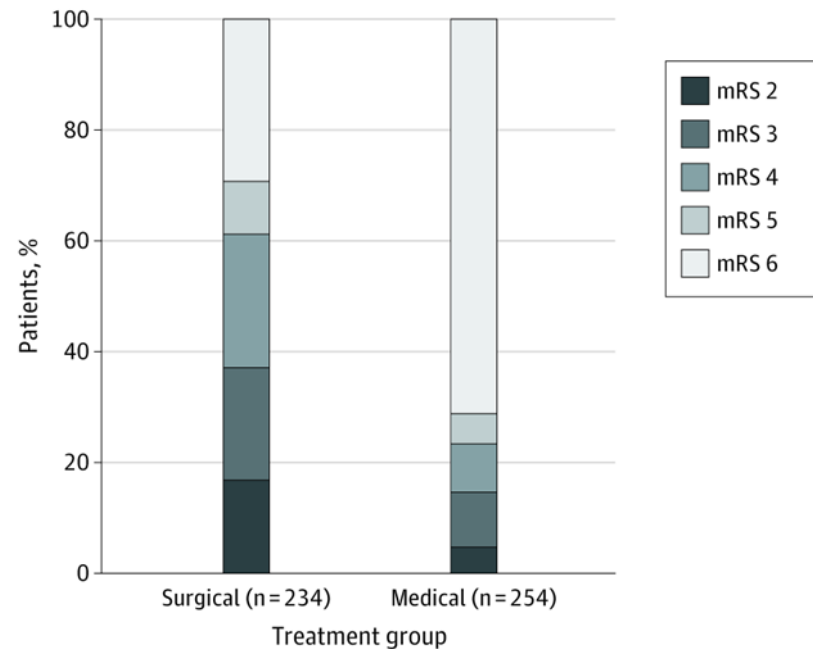
## **Reality of Stroke Decisions:**

- Uncertainty
- Emotionally Charged
- Times Pressure
- Proxy Decision Makers
- System Pressure

*Guidelines inform but do not  
decide*

# Decompressive Hemicraniectomy: Why Goals of Care Matter

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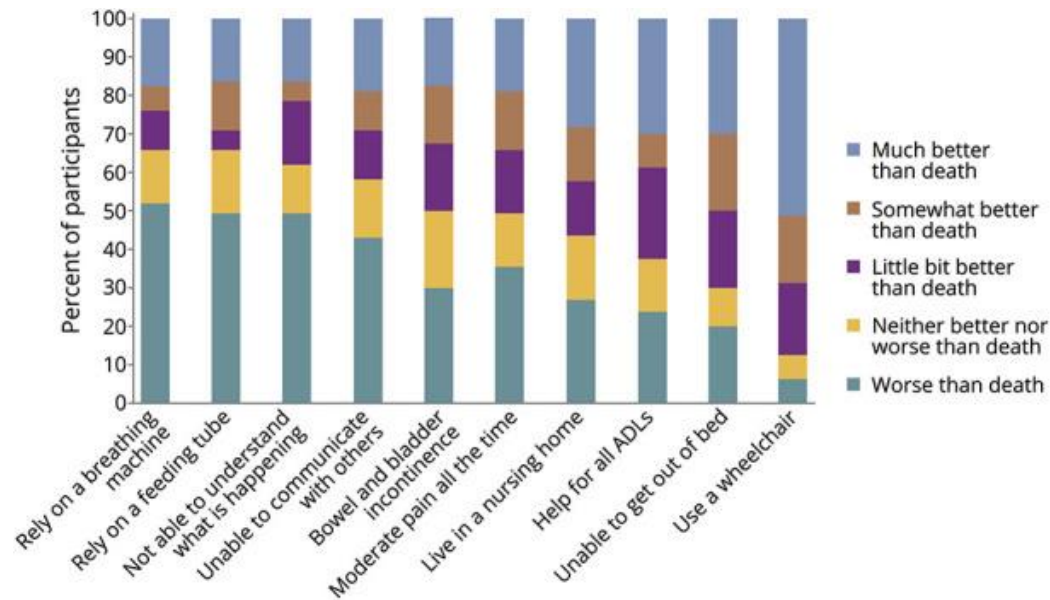
## Key Tension:

Are the interpretation of results a *framing artefact*- “Improved Outcome” or *transformation of death into survival with disability*?

Outcomes are not universally valued-some *patients* prioritize survival at any costs whereas others prioritize function and independence

Individual Patient Meta-analysis of Randomized Clinical Trials. JAMA Neurol. 2021

# Preferences



## Heath States Worse than Death

Everett et al., 2021

The lack of documentation of preferences in a cohort of adults who died after ischemic stroke

**Table 2** Extent of documentation of patient preferences (n = 198)

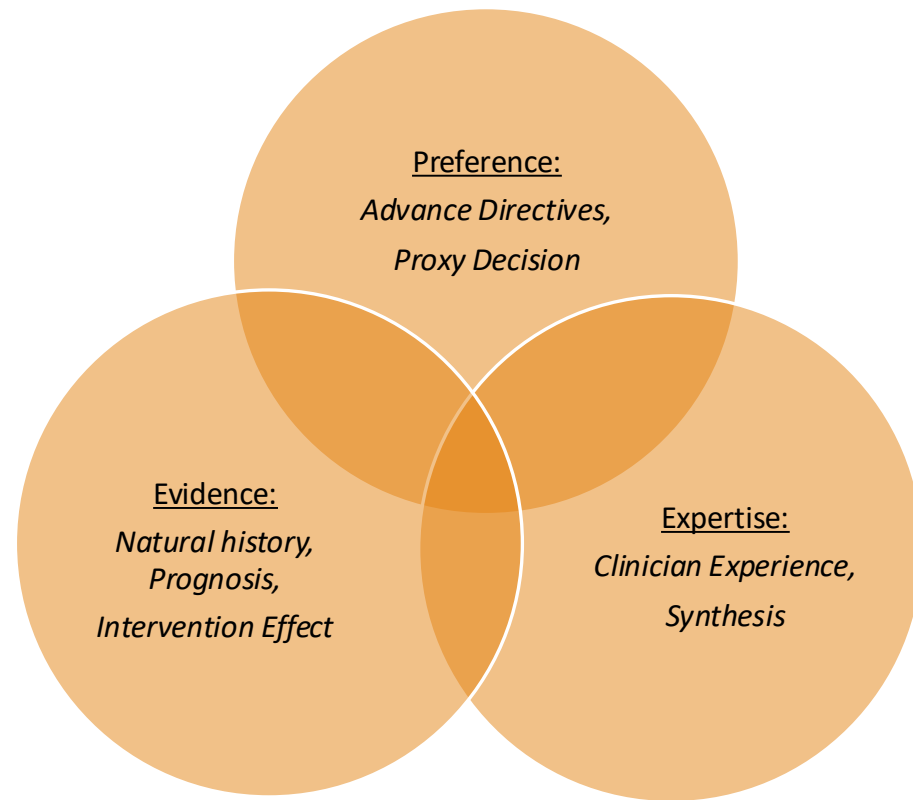
Life-sustaining intervention	Documentation of physician communication, n (%)	Median days of communication before death (25th, 75th percentile)	Documented preference for limitation within 48 h of admission, n (%)
No CPR <sup>a</sup>	68 (34.3)	3.5 (1.5, 9.0)	87 (43.9)
No mechanical ventilation	46 (23.2)	2.5 (1.0, 9.0)	39 (19.7)
No nasogastric tube feeding	20 (10.1)	5 (1.5, 9.0)	11 (5.6)
No percutaneous enteral feeding	11 (5.6)	5 (2.0, 8.0)	6 (3.0)
No dialysis	1 (0.5)	3 (3.0, 3.0)	3 (1.5)
Any of these 5 interventions	78 (39.4)		93 (47)

Abbreviation: CPR = cardiopulmonary resuscitation.

<sup>a</sup> Some of the CPR preferences were documented before admission and noted on admission, thus this number exceeds the number of cases where physician communication during hospitalization was documented.

# Complexities of Decision Making

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## Stroke






Volume 53, Issue 8, August 2022; Pages 2673-2682  
<https://doi.org/10.1161/STROKEAHA.121.038493>



## TOPICAL REVIEWS

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### Ethical Considerations in Surgical Decompression for Stroke

Nathan A. Shlobin, BA , Jeffrey R. Clark, BA , Justin M. Campbell, BS , Mark Bernstein, MD, MHSc , Babak S. Jahromi, MD, PhD , and Matthew B. Potts, MD

# Anticoagulation for AF-related Strokes

**AF + Large Stroke – Bleeding Risk**  
**Delayed AC- Risk of recurrent AIS**

Recommendations for Anticoagulants Referenced studies that support the recommendations are summarized in the <a href="#">online data supplement</a> .		
COR	LOE	Recommendations
2a	A	1. In carefully selected (eg, milder severity) patients with AIS with atrial fibrillation, a strategy of early oral anticoagulation poststroke is low risk and is reasonable compared with a strategy of delayed anticoagulation, although the efficacy of early anticoagulation for prevention of early recurrent stroke is not established. <sup>1–3</sup>

Original Research Article

## Shared Decision Making Tools for People Facing Stroke Prevention Strategies in Atrial Fibrillation: A Systematic Review and Environmental Scan

**MDM**  
Medical Decision Making

Medical Decision Making

2021, Vol. 41(5) 540–549

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**Objective.** Shared decision making (SDM) tools can help implement guideline recommendations for patients with atrial fibrillation (AF) considering stroke prevention strategies. We sought to characterize all available SDM tools for this purpose and examine their quality and clinical impact. **Methods.** We searched through multiple bibliographic databases, social media, and an SDM tool repository from inception to May 2020 and contacted authors of identified SDM tools. Eligible tools had to offer information about warfarin and  $\geq 1$  direct oral anticoagulant. We extracted tool characteristics, assessed their adherence to the International Patient Decision Aids Standards, and obtained information about their efficacy in promoting SDM. **Results.** We found 14 SDM tools. Most tools provided up-to-date information about the options, but very few included practical considerations (e.g., out-of-pocket cost). Five of these SDM tools, all used by patients prior to the encounter, were tested in trials at high risk of bias and were found to produce small improvements in patient knowledge and reductions in decisional conflict. **Conclusion.** Several SDM tools for stroke prevention in AF are available, but whether they promote high-quality SDM is yet to be known. The implementation of guidelines for SDM in this context requires user-centered development and evaluation of SDM tools that can effectively promote high-quality SDM and improve stroke prevention in patients with AF.



# Why PEG?

## *Risk versus Benefit Perspective*

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Survival

Nutritional Support “Prevention of Starvation”

Comfort

Decrease aspiration risk

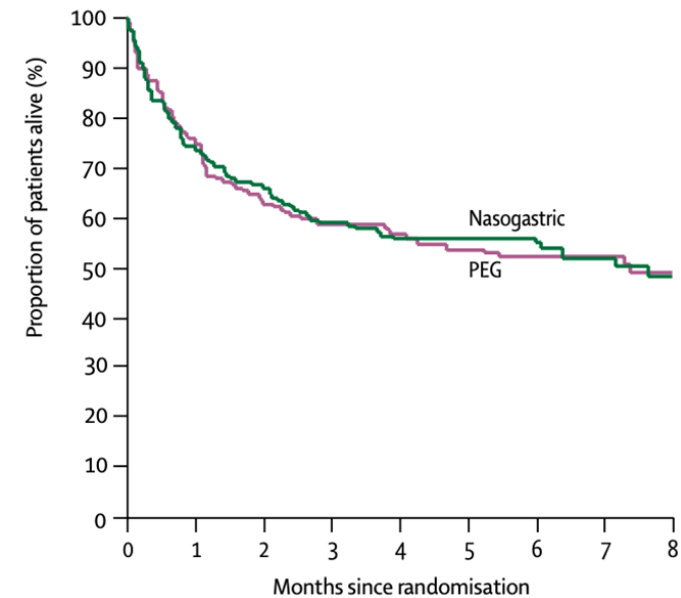
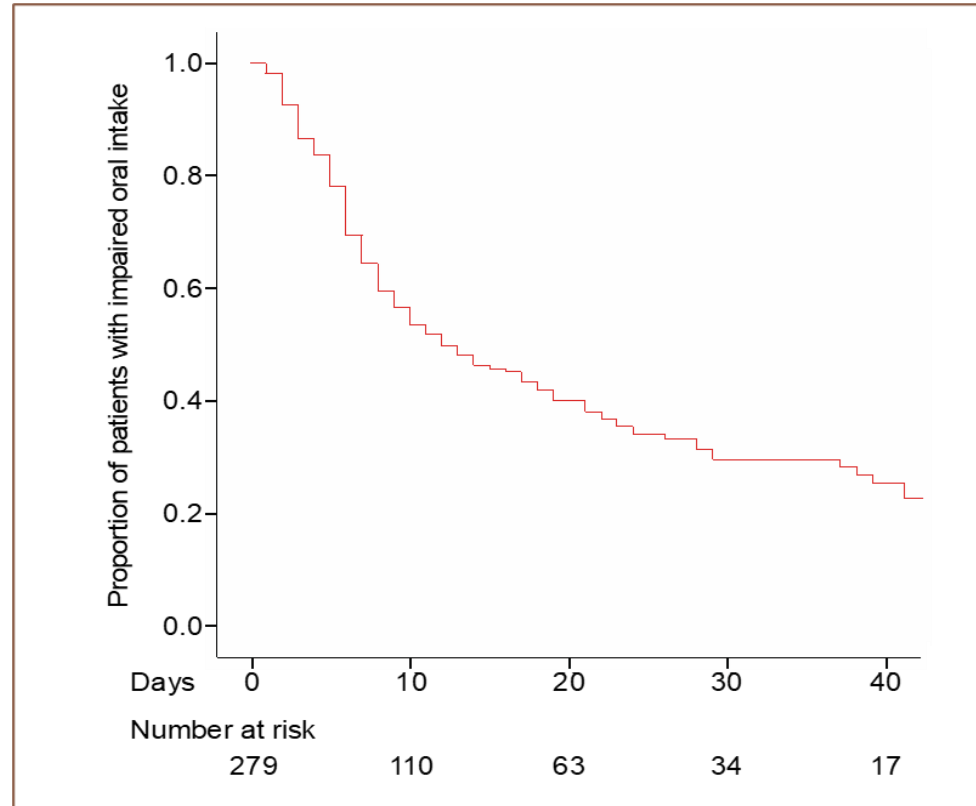
Reversibility

Collateral decision made in context of other decisions

Logistics



# Swallowing Recovery and PEG Placement



**FOOD Trial:** PEG associated with 7.8% ( $p=0.05$ )

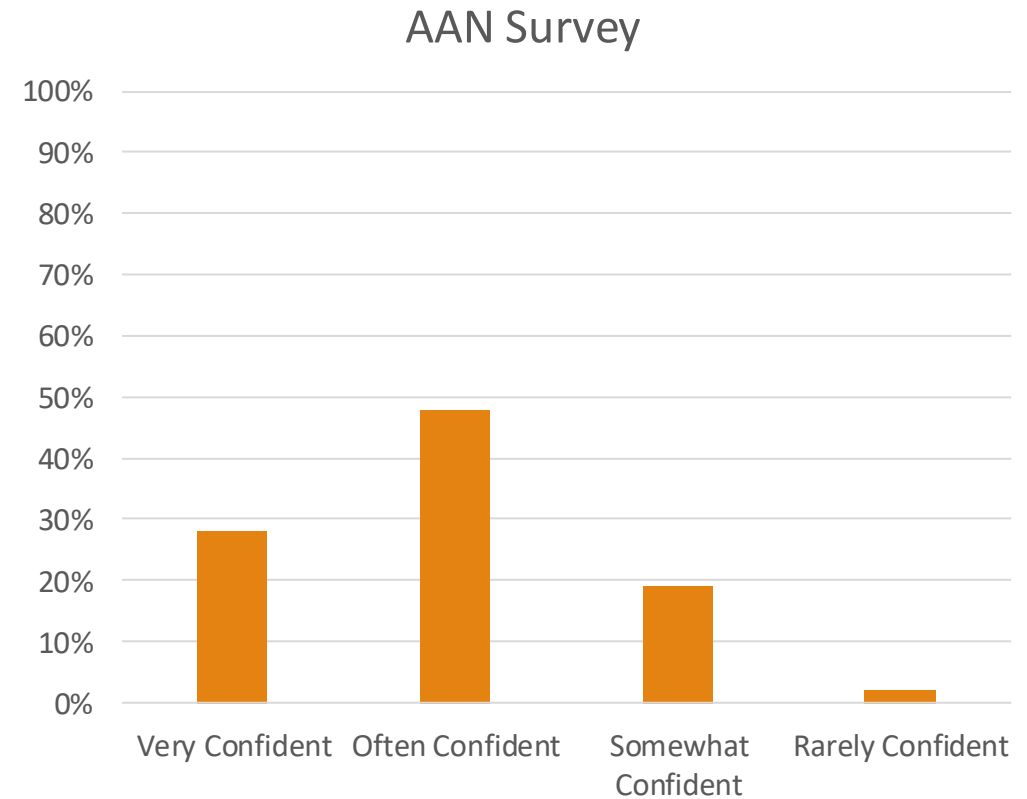
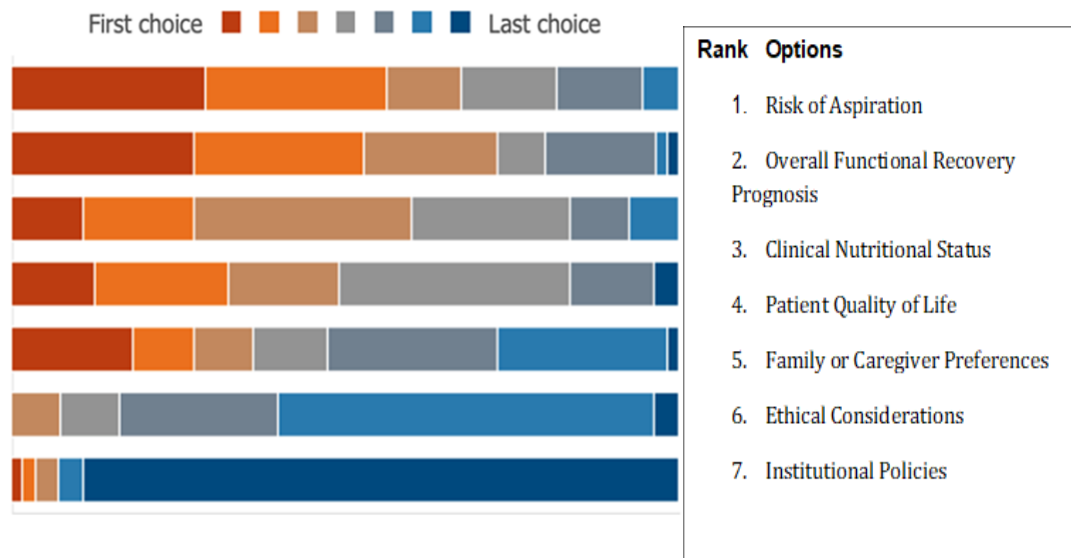
increased risk of death & poor outcome

PEG: increased risk of pressure sores

NGT: increased risk of GI Hge

No difference on QOL (EUROQoI)

# Physician Perceptions on PEG Decision Making



***Decisions are often made before a conversation occurs.  
PEG are supposedly reversible but not often in reality***

# Shared Decision Making-A Potential Framework

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Build Therapeutic Alliance/Partnership

Thoughtful semi-structured conversations

Active listening

Be aware of decision-making biases

Expect and manage conflicts

Communicate prognosis (evidence and experience synthesis)

Elicit patient's valued life activities

How does intervention intersect with valued life activities

Alternatives

Consider time-limited trials

# Interactional Approach to Decision Making:

*Shared Information, Shared Deliberation, Shared Mind*

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## TRANSACTIONAL CARE

### *Information Exchange*

- Knowing about the patient
- Understanding the illness
- Information based on typical needs
- Focus on information provision
- More information is better
- Removing affective components of information

## INTERACTIONAL CARE

### *Shared Knowledge*

- Knowing the patient-as-person
- Understanding illness-in-context
- Information tailored to individual need
- Focus on relevance, comprehension and meaning
- Quantity of information depends on patient needs
- Acknowledging and adjusting for affective components of information

# Interactional Approach to Decision Making

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## TRANSACTIONAL CARE

### *Negotiation*

Elicitation of preferences

Negotiation and compromise

Contractual relationship

Removing affective influences

Focus on quantification of risk

## INTERACTIONAL CARE

### *Shared Deliberation*

Mutual discovery of preferences

Collaborative cognition

Collaborative “medical friendship”

Affective engagement

Use of gut feelings and risk quantification

# Interactional Approach to Decision Making

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## TRANSACTIONAL CARE

### *Decision-Individual Choice*

Focus on individual autonomy

Obtaining consent

Delivering care

## INTERACTIONAL CARE

### *Decision-Shared Mind*

Focus on relational autonomy

Articulating and confirming  
consensus

Engaging in care

# References

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