

Editorial

FACING CHANGE: WHEN TO EMBRACE, WHEN TO RESIST

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Change is happening everywhere, in all aspects of our lives, and with blinding rapidity. Some of us seem to be wired to seek out and embrace change. Others find our daily lives in health care to be challenging enough that we do not need more change; we tend to be more comfortable managing our complex patients, or doing our research, with our feet firmly planted on a stable platform. We would like to focus this editorial on 3 major areas where change is occurring and share with you our perspectives on the following: (1) change in scientific evidence leading to modification in practice, (2) changes in the health care system structure and how it affects our daily lives, and (3) our thoughts regarding the recent changes in national political leadership.

Change As It Relates to the Evidence

Given the editorial mission of *AJCC*, new evidence that leads to changes in practice is something about which we feel quite strongly. As discussed in one of our previous editorials, the average time from publication of a relevant research article to an associated change in clinical practice can be on the order of a decade or more.¹ But, as we have also pointed out, some agents and protocols—with significant evidence behind them—turn out to be less helpful than initially thought. Examples of this include activated protein

C and early goal-directed therapy for sepsis.^{2,3} Results from other studies, such as the ARDSnet protocol, appear to have better stood the test of time.⁴ But these interesting controversies lead to the crucial focal point of our discussion. This is why we rejoice in the scientific method!

If we take an evidence-based approach to caring for patients, then change should be a fully expected part of the routine. We view evidence-based practice as one of the aspects of our profession that keeps it stimulating, and we remain enthusiastic about the role that *AJCC* plays in that process. Looking out for new guidelines, new data, and new definitions is a routine part of the scientific method, and this should be an integral part of the career of anyone who cares for patients.⁵⁻⁷ But what we find meaningful, and paradoxically reassuring, about this approach is that the concept of change, debate, discussion, and subsequent further refinement is deeply ingrained and incorporated into the entire process. The focus is a scientific one. The focus is on facts.

Regardless, as we have discussed previously, there are challenges and limitations to the practice of evidence-based practice. There are many areas where the literature may not be robust enough to fully, or even partially, answer a question. There are times, especially in critical care, where there can be 2 particular areas of shortfall: one is where a specific technique, piece of equipment, or even an overall management style seems to take hold with minimal

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evidence behind it, and the other is when a regulatory agency may start to measure certain processes with limited data and use them as markers of a quality intensive care unit. The former occurs primarily because of the great challenges of performing high-quality research in critical care, and a reliance on our personal experiences with individual patients. Problems with the latter include changes to the literature where regulatory agencies may lag behind the evidence, sometimes forcing clinicians to continue to implement certain practices that they know may be out of date.

A crucial point that we wish to make around implementing and performing evidence-based practice is that, with all of its limitations, we feel that this is the most reasonable, rational, time-tested, and reliable approach to providing the best care for our patients. It is not surprising that this approach can sometimes lead to heated debates—let us not forget the important work of Semmelweis on hand washing.⁸ But it is equally important that we constantly try to bring the discussion back to the data and to what practices the current data actually support. Where the data is lacking, practitioners should then use liberal amounts of emotional IQ and develop consensus-based guidelines (and/or follow preexisting ones) wherever possible. But in terms of the change process itself, we would embrace change based on evidence.

Change As It Relates to the Health Care System and Its Organization

Another area of change has been the manner in which the health care system is organized. Through continued efforts to ensure that our health care system not only provides quality but provides it in a cost-effective manner, our jobs are being monitored and scrutinized more than ever before. It can sometimes be disheartening when we are told that because of a new quality improvement project, someone will be evaluating our workflow pattern,

or perhaps we are asked to take part in a new committee to help improve communication within our unit. Or, potentially, we may be reassigned to a different job or role within the hospital altogether. We are not here to tell you that this kind of change always works out for the best, but we do want to help you take another perspective.

More than ever, none of us work in a vacuum, and none of us can provide comprehensive care to our patients alone. Though the concept of the lone clinician battling by himself or herself to save lives is a quaint and somewhat charming one, the reality of health care in 2017 is that we are all working as part of a large, complex, highly dynamic health care system. Our perspectives are not that this change is either inherently good or bad, but rather that it is inevitable. For those of us who wish to help care for patients, the system in which we work today may be—nay, most likely will be—extraordinarily different from the system we practice in tomorrow. But rather than being looked at as a challenge to be overcome, this kind of change can and should be reimagined as a terrific opportunity.

One of the central facets of quality improvement techniques, such as Toyota-Lean, is that ideas come primarily from people working on the front lines.⁹ These practitioners—we!—are the people who best understand how to prioritize improvement at the bedside, when it is appropriate to apply additional resources, and the best ways to enhance workflow issues. This kind of change, organic and spearheaded by bedside clinicians, is, again, the kind of change we would embrace.

Political Change at the National Level

We wish to conclude by making some comments on the political transformations that have occurred at the national level. Given how deeply divided the nation is currently, whatever points we bring up will inevitably be regarded as controversial. However, writing about the national political landscape is not new for us; a previous editorial reflected on the changes accompanying the early days of the Obama administration.¹⁰ We begin by clearly stating what we stand for at the *American Journal of Critical Care*. The American Association of Critical-Care Nurses (AACN) “is dedicated to creating a healthcare system driven by the needs of patients and families where acute and critical care nurses make their optimal contribution.”¹¹ As the national research journal for

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the AACN, we stand for caring, compassion, inclusiveness, and research. As editors of a national research journal, we state unequivocally that care for patients should be based on truth, truth distilled from knowledge gained through the scientific method. This journal has been, and remains, a platform for the highest quality critical and acute care nursing research.

We believe that the United States was founded on making decisions based on facts, that our country has been and remains a country of immigrants, and that it is a country with deep foundations built upon respecting others—even if they look, pray, or love differently from us. There is no question that the current administration won by election, but the manner in which they have acted since taking office has tended to lean unnecessarily towards fear, autocracy, intimidation, and bullying. We believe that an atmosphere of chaos, uncertainty, confusion, mistrust, and deep division is not good for any of us on a personal level, is not good for our patients and health care systems, nor is it good for us as a nation.

The current administration has made it clear beyond any shadow of a doubt that they wish to make profound, sweeping changes to the policies and practice of our country; but we would implore them, with great gravitas, to make these changes while still respecting the norms, structure, and traditions of our current government, and to take into account our deeply held respect for the rule of law, our system of checks and balances, as well as the sanctity of the Constitution. When decisions are made regarding health care policy and resources, we appeal to them to do so in a manner that is respectful of both patient needs and the relevant scientific evidence.

We conclude by stating to each and every one of you that change is here to stay. We do not recommend a single approach to change. Every one of us reading this article right now is a member of 2 sacred organizations: we are all healers and we are all people of science. As such, we beseech every single one of you to approach changing situations with your

minds fully open and engaged. You must determine *for yourself* whether to embrace or resist the change you face.

The statements and opinions contained in this editorial are solely those of the coeditors in chief.

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None reported.

eLetters

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