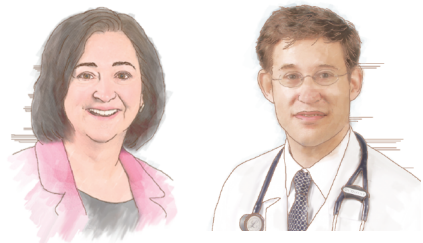


## BALANCING ACT: OPTIMAL CARE IN THE REAL WORLD

By Cindy L. Munro, RN, PhD, ANP, and Richard H. Savel, MD



The landscape of critical care has changed substantially since the first intensive care units were developed in the 1950s, and recent times have been the most tumultuous. Our ability to intervene in critical illness has vastly improved, but expansion of interventions and care processes has led to new challenges. Ethical, legal, and social quandaries impact care decisions.

By definition, what is *optimal* is “most desirable or satisfactory.”<sup>1</sup> Many stakeholders and decision makers are now involved in determining what is optimal care, including patients, families, health care providers, health care institutions, regulatory agencies, legislative bodies, courts, and others. In an ideal world, the needs of all stakeholders would align and optimal care would be easy to define and achieve. In the real world, clinicians must balance competing definitions of what care is most desirable. There are often ongoing tensions in finding coherence among multiple viewpoints of optimal care, including patient and family preferences, evidence of best practices, regulatory requirements, and other considerations that may not converge.

The recently enacted Patient Protection and Affordable Care Act (ACA) adds an additional layer of uncertainty and complexity to the immediate future of critical care. The ACA included a requirement for establishment of a National Strategy for Quality Improvement in Health Care (the National Quality Strategy, or NQS).<sup>2</sup> The NQS was charged with setting priorities for health care quality improvement and developing a strategic plan. The NQS framed its aims around 6 initial priorities:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.<sup>2</sup>

Optimal care is embedded in balancing these 6 priorities in the real world.

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doi: <http://dx.doi.org/10.4037/ajcc2014612>

# “ Collaboration among providers is an essential feature of optimal care. ”

## First, Do No Harm

Above all, optimal care must be safe. “First, do no harm” is a tenet founded in medicine but embraced by all health care professions. Patient safety has become an integral driver of improvements to systems of care. The move to value-based payments adds financial incentives to improve patient safety and quality.

Engagement of patients and families as partners in care is important, but several factors can make this engagement difficult in critical care. Critically ill patients are often unable to directly engage with providers. Critical illness, medications, and interventions such as mechanical ventilation can contribute to decisional impairment and communication difficulties. Families often struggle to understand the patient’s problem, the prognosis, and the risks and benefits of treatment options. In the absence of advance directives from the patient, families may be unsure about what care the patient would want to receive. Stakes and emotions are high, situations are dynamic, and some decisions must be made quickly.

Family dynamics are complicated, and decision making within a family is a process that may involve multiple family members. Although the focus is often on the formal surrogate decision maker in the family, an ethnographic study by Quinn and colleagues<sup>3</sup> identified many informal roles for family members that were incorporated into the group’s decision making process. These roles included a primary caregiver, primary decision maker, family spokesperson, out-of-towner, patient’s wishes expert, protector, vulnerable member, and health care expert. Our understanding of the complexity of family decision making is incomplete, and deserves additional study.

The NCQ noted that a lack of necessary understandable information impedes patients (and families) attempting to partner with health care providers in making decisions about their care. In a recent high-fidelity simulation study of physicians’ rapid decision

making for a simulated intensive care unit (ICU) patient and caregiver spouse, most physicians moved beyond providing information to engaging the caregiver in the decision-making process.<sup>4</sup> The most common physician decision making pattern was facilitative (providing information + eliciting preferences/values + guiding surrogate to apply preferences/values, used by 49%). Collaborative decision-making (information + eliciting + guiding + making a recommendation) was used by 37%. Only 12% of physicians made an independent treatment decision without involving the caregiver.

## A Critical Role for Nurses

Nurses have a critical role in ensuring that families receive necessary, understandable information. In a recent survey of family members of ICU survivors,<sup>5</sup> 75.8% of respondents identified the nurse as the member of the ICU team who was their main source of information during the patient’s hospital stay; physicians were identified as the main source of information less frequently (attending, 16.9%; residents, 8.9%; fellows, 4.8%). In the same survey, a quarter of the respondents reported feeling that they had received inconsistent messages from providers, particularly in the first 48 hours of the ICU stay.

No matter how well presented, the information families need to make decisions about the critically ill patient is complicated. Clinicians must apply the evidence available about communicating with families, and we are wise to remember that our choice of words matters. Curtis and colleagues<sup>6</sup> provided examples of phrases that may convey negative messages or be confusing to patients and families (for example, “There is nothing we can do”), and suggest alternatives that more correctly convey our intent (for the previous example, substituting “We will focus our efforts on keeping the patient comfortable”).<sup>6</sup>

Collaboration among providers is an essential feature of optimal care. There is a growing body of knowledge about interdisciplinary teams, with much of the focus centering on nurse-physician relationships as a central underpinning to effective interdisciplinary teams. In a study of nurse-physician leadership, Clark and Greenawald<sup>7</sup> found that collaboration was enhanced by (and diminished without) behaviors in 4 areas: positive interpersonal relationships (in contrast to problem solving, goal-directed relationships); organizational structure and support; shared expecta-

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tions about team member roles and team goals; and respectful, timely, honest communication. This issue of the *American Journal of Critical Care* includes a scoping review of ethnographic studies of interprofessional care in the ICU and how team processes affect patient safety and quality. The authors note that “interprofessional interactions in the ICU do not happen in a historical, social, and technological vacuum.”<sup>8</sup>

## Conclusion

There are times when providers and families disagree about what optimal care should entail. If disagreements cannot be resolved, additional stakeholders may become involved. Unfortunately, determination of optimal care can devolve into a power struggle that undermines communication and trust among family members, providers, and health care institutions. In extreme cases, optimal care is impeded by forces outside the control of patients, families, or providers. Intrusion of well-meaning but ill-advised legislation into family decision making with unintended consequences is particularly egregious. As these scenarios drag on into judicial action, optimal care for patients is jeopardized.

As researchers, we must continue to move forward building the knowledge that will support optimal care in the real world, including research on patient safety, quality, communication, decision making, collaboration, and improving effectiveness of interdisciplinary teams. As clinicians, we must stay focused on providing optimal care in the real world. Doing so is sometimes difficult and involves balancing many (sometimes competing) interests, but our patients and their families deserve no less.

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

## FINANCIAL DISCLOSURES

None reported.

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