

REFLECTIONS ON MAKING DECISIONS

By Kathleen Dracup, RN, DNSc, and Christopher W. Bryan-Brown. From the School of Nursing, University of California, San Francisco, San Francisco, Calif (KD), and the Department of Anesthesiology, Albert Einstein College of Medicine, Bronx, NY (CWB-B).

It's 3:00AM and the patient in bed 8 is not looking good. George Benshaw, a 64-year-old recently retired contractor, was admitted to the intensive care unit (ICU) early this morning following a cardiac arrest at home. He was successfully resuscitated by his son and arrived at the hospital awake and alert. His acute myocardial infarction symptoms had started yesterday, but he waited more than 24 hours to come to the hospital, long past the window of opportunity for reperfusion. He has smoked cigarettes for over 40 years and has chronic lung disease. At 5'9" and 220 pounds, he is overweight and diabetic.

Mr Benshaw's wife has elected to spend the night in the waiting room. She is anxious and hovers at the ICU door. You know that she has questions, but the few times that she has come into Mr Benshaw's room, she does not seem to be able to put them into words. Her questions hang in the air, unspoken and unanswered. Your concern for both of them is compounded by his poor color, his restlessness, and pulse oximeter readings that reflect a gradual desaturation over the past hour. There is no particular reason to think that an emergent situation is brewing—his blood pressure remains stable and the cardiac rhythm unremarkable—and yet you wonder if you should call his physician at home. If called, the physician must make the decision to come into the hospital or wait until morning—critical decisions made in the middle of the night that can mean life or death.

So many of the decisions that nurses and physicians make in hospitals are based on intuition and judgment. Unfortunately, when someone is critically ill, multiple decisions must be made quickly, often emergently. To intubate or not. To call a consult or not. To perform surgery or not. To encourage the spouse to stay over night or to go home. To withhold or to administer a medication. To put in a pulmonary artery catheter or rely on

physical assessment. All of these decisions and a hundred others must be made in the course of a single day, and few can be supported by scientific data, despite all our enthusiasm for evidence-based practice. Even when scientific data are available, patients bring individual preferences and unique characteristics that often make the evidence-based choice not appropriate or applicable.

Changing Paradigms in Making Decisions

Two decades ago, most of the decisions about clinical treatment would have been made by a physician without any discussion with the patient, family, or nurse. But then a dramatic change in the public's perception of their personal role in healthcare decisions occurred. One of the champions of this change was Jay Katz, a Yale physician and ethicist, who wrote a book in 1984 that was a devastating critique of the way decisions about healthcare were made.¹

Katz argued that decisions not only could but also should be made by the patient involved. He portrayed the philosophy held by physicians in regard to decision making as paternalistic and even unethical. He made his case using actual stories of real patients. The stories were compelling and ultimately created a dramatic shift in the way we looked at decision making in healthcare. Patient autonomy became a mantra in medical and nursing schools across the United States.² Today, a physician who made a decision about whether to perform a lumpectomy vs. mastectomy in a female patient diagnosed with breast cancer without consulting the patient could be accused of malpractice or worse. Patients come to appointments armed with Internet printouts and lists of questions. Second opinions are encouraged for the new insight they bring to difficult decisions.

The change in philosophy in medical decision making had a precursor in religion. In the Middle Ages, priests gave weekly sermons, which were the only opportunity the members of a congregation had to learn the tenets of their faith because they were illiterate. The esteem with which priests were held

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was based on their unique access to the sacred texts. As people became literate, they had access to much of the same information as priests. Religious leaders then had to learn how to encourage, inspire, and motivate, and not just dictate behavior.

Similarly, the involvement of patients, family members, and other healthcare professionals has placed the onus on physicians, as well as nurses, to learn the skills required to guide individuals through various treatment options and to communicate with the key members of the team to build a consensus about treatment directions. What happens when the physician dictates, rather than effectively communicates, treatment to the nurses caring for the patient? Increasingly, a growing body of studies supports the fact that poor physician-nurse communication leads to negative patient outcomes.

Minimizing the Learning Curve

An excellent example of the power of effective communication between healthcare professionals is provided in a book titled *Complications: A Surgeon's Notes on an Imperfect Science*.³ The author, Atul Gawande, writes from his vantage point as a resident in a surgical training program and reflects on the uncertainty that accompanies the learning of new surgical techniques. In discussing patient care errors, he describes the experience of a group of Harvard Business School researchers who examined the learning curve associated with minimally invasive cardiac surgery.⁴ This type of surgery allows for only a small incision between the ribs rather than the usual sternotomy. Minimally invasive cardiac surgery has been a boon to patients, but it minimizes the visual field for the entire surgical team. To make the transition from traditional techniques to those using a minimally invasive approach requires that the surgeon conquer new skills. However, Gawande notes that the surgical nurses, anesthesiologists, and perfusionists also have new roles and skills to master when using this new method. Unfamiliar things happen during and after surgery, and new solutions need to be manufactured quickly.

The Harvard researchers identified this change in practice as a unique opportunity to study the factors that positively and negatively affect the learning curve, ie, how quickly new techniques can be mastered. They focused on the amount of time it took to perform minimally invasive cardiac surgery for each of 18 surgical teams during their first 50 cases, using an assumption that patient morbidity would be related to the time required for surgery. All 18 teams received the same 3-day training, and all came from highly respected institutions with extensive experience in adopting surgical innovations. In the course of the 50 cases, some

teams halved their original operating times (which for some were as high as 18 hours!), while others failed to improve their times.

Richard Bohmer, the one physician on the research team, visited the 2 hospitals with the best and worst operating times. The surgeon on the team that had achieved the best reduction in operating time was relatively inexperienced, being only a few years out of a surgical residency. However, he had picked team members with whom he had worked well before the innovation and kept them together throughout the 50 cases. He scheduled 6 operations in the first week so that they would have an opportunity to refine their skills quickly. Before every surgery and immediately after, the team convened to discuss the case. All results were carefully tracked and reviewed in the group. When being interviewed by Bohmer, the surgeon offered the following observation, "The surgeon needs to be willing to allow himself to become a partner (with the rest of the team) so he can accept input."³ In contrast, the surgeon from the team with the poorest learning curve did not put a team together. The members of the team varied for each surgery. He held no pre-briefings, no debriefings, and did not track the data. Although he was by far the more experienced surgeon of the 2 teams, he did not value the power of teamwork to influence patient outcomes, and he brought little appreciation for the importance of the entire team to the new challenge.

How We Teach

How can communication skills and interprofessional teamwork be taught? New recruits to our professions learn these skills from the days of their first clinical rotations by modeling the behavior that they see in the staff. We know the importance of such modeling. In a recent article⁵ in a university student newspaper, a first-year medical student wrote about a troubling conversation that took place ". . . between a doctor and nurse who had been arguing about the care being given to a patient. 'Do you see my name on the door?' the doctor inquired. 'Yes,' answered the nurse. 'Can you read the letters after it?' 'M.D.' 'That's right, M.D. You know what that stands for? Makes Decisions!'"⁵ The student author reflects on the culture of medical training, where trainees are encouraged in subtle ways to feel shame when they do not know the answer to a question (even when no answer may exist) and to hold tenaciously—even arrogantly—to a decision (even when the decision is revealed to be inappropriate or wrong).

Improving Patient Outcomes

The findings of several studies conducted over the past 2 decades suggest that one of the most powerful

predictors of optimal patient outcomes is good communication between physicians and nurses when making patient care decisions. In an early study by Knaus and colleagues,⁶ the mortality rates in various ICUs differed dramatically based on the communication between nurses and physicians. Similar to the findings of the Harvard researchers related to learning a new surgical technique, patient survival in the ICU was best when the communication between physicians and nurses was characterized as excellent and worst when relationships between members of the intensive care staff were strained. As nurses and physicians, we are often dealt bad hands (patients with multiple diseases who bring little to the table by way of internal and external resources). We work in a healthcare system that focuses far too often on the bottom line to the detriment of patients and the professionals who care for them. Our ability to be empathetic and to talk effectively with

patients, families, and each other can become the key to an optimal clinical outcome.

We are not sure how the nurse responded to the physician in the dialogue reported earlier, but we can only hope that she revealed the secret meaning of RN, namely, "Rejects Nonsense."

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