

The Unlearned Environment

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Another day on the wards. I am working with 3 internal medicine residents, a medical student, and a pharmacist. We have 20 patients to see including 4 patients that were admitted overnight. Due to the full capacity of the hospital, our patients are in the ER, an intermediate care unit, and 3 separate hospital wards. Our goal is to finish rounds in 3 hours. Otherwise, orders and consultations will be delayed, and discharges will occur late in the day.

A quick calculation gives us approximately 10 minutes to spend with each patient. So, we begin. Because the first few patients are relatively straight forward, we do spend 10 minutes with each. But as we go to see the next patient, a family member is present. She inquires if other family members can listen to the presentation and ask questions on a cellular phone. Of course, we agree. After the resident's presentation, which is clear to the medical team, there is a barrage of questions, all fair, emanating from the family's concern for the patient. We have to make a choice, interrupt the flow of rounds and remain in the patient's room, or tell the patient and her family that we will come back later in the day after we finish rounding.

We choose the latter and finish rounds in 3.5 hours, later than planned but acceptable. The team then begins the work of the day, including writing progress notes and discharging patients.

What about the patient and her family whom we told we would return? Because of the unpredictable nature of the day, we did not give them a specific time. We assumed that they will be present whenever we return. We also did not relate how much time we would be able to spend.

In the middle of the afternoon the resident gets a text message from the nurse taking care of the patient. She is asking for the patient and her family when will we return. Almost simultaneously the resident is paged to admit a new patient in the ER. So, another choice has to be made. Go see the patient and her family as promised. This will delay admitting the patient in the ER. Or go see the patient in the ER and hope there will time later in the day for the patient-family discussion. This time the choice feels more difficult, in that there will be a significant downside for one of these patients.

This type of day is typical in teaching hospitals across the United States. It has been well documented there are untoward effects of this atmosphere on patient care. Perhaps most important is that patients and their families are frustrated by the unpredictable and too brief interactions with the care team. I think my team is aware of this and take some of the responsibility. They are more than willing, time permitting, to participate in ongoing structural

efforts to correct the problem including a reduction of team size of patients, better geographic localization, and improvements in the EMR.

What my team is not so cognizant of is how handicapped we as care givers are by this milieu, and how this is impeding patient care. In their training, this has not been discussed sufficiently.

How is the care team handicapped by this environment?

First, care teams are immersed in an environment where they lack control. They have to constantly adapt to the complexities of patient care, including time needed for each patient, new admissions, and unexpected patient events. Loss of control has been studied in both animals and humans. The results are similar. Loss of control results in increased anxiety and stress, and impaired problem solving. Loss of control is also a major factor in physician burnout. In one report in a health maintenance organization, loss of control was the major factor that predicted physician burnout (1) These findings have also been found in other health care professionals.

Another consequence of such an emotional environment is impaired decision-making by the care team. This is often referred to as, "Decision fatigue", the notion that one's ability to make decisions declines in proportion to the number of decisions previously made. In the AMA series, "What Doctors Wish Patients Knew," Lisa Maclean, a psychiatrist and chief wellness officer, describes this phenomenon. Dr. Maclean notes the complexity of decisions made by physicians, the resultant fatigue, and the cumulative worsening of decision-making over time. (2)

A third factor is a decline in performance due to the inherent tension in this environment. Jerome Groopman, in his book, "How Doctors Think," discusses the effects of emotions on thinking. (3) He describes work by Yerkes and Dodson on the relationship between performance and tension. Their research shows that at low to medium levels of tension there is a positive effect on performance. The peak is referred to as productive anxiety. However, with further increases in tension, performance declines to a very low level.

As the attending for the group, I feel a responsibility to make them aware of these handicaps, this unlearned environment. This takes time. And as described there are many other things competing for time. But I think it is worth it and I plan to do so with the hope that our discussion will tell these learners that I am aware of the difficulties they face and how appreciative I am of their dedication.

I also hope that calling out these handicaps will lead to a national discussion among medical educators resulting in some creative solutions to be applied to all training programs.

I realize that this is a difficult task. Physicians are dedicated to their patients. They will persist even in the face of barriers and may not feel that they have the time to make any changes. But mitigating these handicaps will be needed if the goal of outstanding patient care is to be achieved. Without solutions, proposed structural changes can only partially help.

References

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