

From Context Comes Expertise: How Do Expert Emergency Physicians Use Their Know-Who to Make Decisions?

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Study objective: Decisionmaking is influenced by the environment in which it takes place. The objective of our study was to explore the influence of the specific features of the emergency department (ED) environment on decisionmaking. In this paper, we specifically report on the way emergency physicians use their knowledge of their collaborators to make their decisions.

Methods: We conducted a qualitative study on emergency physicians recruited in 3 French hospitals. Physicians were equipped with a microcamera to record their clinical activity from their “own-point-of-view perspective.” Semistructured interviews, based on viewing the video, were held with each physician after an actual clinical encounter with a patient. They were then analyzed thematically, using constant comparison and matrices, to identify the central themes.

Results: Fifteen expert emergency physicians were interviewed. Almost all of them reported using their knowledge of other health care professionals to assess the seriousness of the patient’s overall condition (sometimes even before his or her arrival in the ED) to optimize the patient’s treatment and to anticipate future care.

Conclusion: Emergency physicians interact with many other health care workers during the different stages of the patient’s management. The many ways in which experts use their knowledge of other health care professionals to make decisions puts traditional conceptions of expert knowledge into perspective and opens avenues for future research. [Ann Emerg Med. 2016;67:747-751.]

Please see page 748 for the Editor’s Capsule Summary of this article.

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SEE EDITORIAL, P. 752.

INTRODUCTION

In the decisionmaking literature, the environment in which physicians make decisions is referred to as “context,” which encompasses the setting of the encounter, its circumstances, and its specific features.^{1,2} In an effort to better understand how the emergency medicine context affects decisionmaking, we performed a qualitative study of a small number of patient-physician initial history and physical examinations. Results about the way that emergency physicians generate and evaluate diagnostic hypotheses have previously been reported in this journal.³

One of the characteristics of emergency medicine is its horizontal division of labor, which requires that physicians interact frequently with multiple health care workers in the process of patient care.⁴ These interactions are likely to affect physicians’ decisionmaking, rendering it particularly complex.¹

As Gruppen and Frohna⁵ wrote in their critique of the literature on clinical reasoning, “[t]oo often, studies

of clinical reasoning seem to take place in a vacuum. A case or scenario is presented to subjects, usually in written form, stripped of any ‘irrelevant’ noise.... The traditional methodology of providing clinical cases that are decontextualized and ‘clean’ may not be particularly valid means of assessing the full range of processes and behaviors present in clinical reasoning in natural settings.” This is a significant threat to the external validity of these findings, ie, in terms of transferring them to real-life clinical practice. To address this, we specifically set out to study clinical reasoning in real clinical situations occurring in the participants’ natural setting.

This article reports on how emergency physicians use the knowledge they have of other members of the health care team in their decisionmaking process.

MATERIALS AND METHODS

We provide a brief overview of our methods, which have been previously described in more detail.³

Editor's Capsule Summary

What is already known on this topic

Many efforts to characterize physician decisionmaking do so with artificial scenarios and other techniques that are less complex and less context-dependent than reality.

What question this study addressed

This qualitative study used lapel cameras to videotape 15 emergency physician encounters with patients and then had the physicians watch the tapes and, as best they could, articulate what they were thinking. Qualitative techniques were used to develop a matrix of ideas about how context, including knowledge of coworkers, affected medical decisionmaking.

What this study adds to our knowledge

This study is an early step in understanding how physicians actually make decisions in the complex environment of the emergency department (ED).

How this is relevant to clinical practice

This article adds to the small but growing literature on how physicians make decisions in the ED.

Study Design

Investigating decisionmaking is an extraordinary challenge because the thought processes that interest us are, by definition, not observable and occur partly unconsciously, which explains why practitioners find it very hard to articulate them. To meet these methodological challenges, we used a qualitative approach based on a focused ethnographic design, whereby data are collected on a targeted aspect of a community's activity during a limited time. The targeted community was that of expert emergency physicians.

Selection of Participants

We used a range of criteria stemming from research by Ericsson⁶ on expertise and reasoning in other fields to identify "experts" within a population of emergency physicians.³ To diversify the sample as much as possible, these experts were recruited in the emergency departments (EDs) of 3 hospitals: a large urban hospital, a university hospital in a large provincial town, and a regional hospital in a medium-sized town. Potential participants were contacted with the help of contact person at each site. All participants provided their informed consent before taking part in the study, and all physicians provided written consent to their interview data's being anonymously included in publications. Ethics

committee approval for this study was granted by the Education and Social Sciences Research Ethics Committee of the University of Sherbrooke, Quebec, Canada and the Committee for the Protection of Persons Northwest 2, Amiens University Hospital, France.

Data Collection and Processing

Focused ethnography involves data collection in authentic environments. For each participant, we collected data on 1 actual encounter between the physician and a patient who was spontaneously seeking care. The patient encounter was filmed from physicians' own-point-of-view perspective, using a high-definition microcamera mounted on the practitioners' temple or on one of the arms of their glasses, at eye level. This technique, unique in the investigation of decisionmaking in medicine, is a powerful tool for the people concerned in the action to assist retrospective articulation on the thought processes used.⁷ The video recording was stopped when the physician had completed the history and physical examination and left the patient's cubicle. The video was used as support to retrospectively articulate physicians' reasoning in the semistructured, head-mounted video, cued-recall interviews,⁷ carried out with each of the practitioners by an investigator (T.P.) after treatment of the patient. The median time between the end of the patient encounter and the interview was 110 minutes (interquartile range [IQR] 80 to 180). Open questions were asked of the experts to understand what they were thinking as the patient encounter unfolded. The videos were deleted immediately after these interviews. These were continued in series of 5. A total of 15 interviews took place between May 2011 and April 2012, 5 in each of the 3 hospitals, separated by several months.

Primary Data Analysis

The data collected were processed as part of an interpretive approach based on thematic analysis with constant comparison.⁸ The aim was to identify central themes, using an iterative, gradual process of data analysis and structuring. The interviews were fully transcribed by secretarial staff. The transcriptions were checked and anonymized by T.P., C.A., and C.B. first performed blind coding of the transcribed interviews with NVivo 9 (QSR International, Melbourne, Australia) to facilitate coding. Intercoder agreement reached 96% after discussion.

In line with recommendations of Miles and Huberman,⁹ data condensation matrices were then constructed for each participant, within a context of constant back and forth between verbatim reports and the results of the primary coding. These matrices crossed each of the patient treatment stages horizontally with what was happening in

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