**What if a patient lacks DMC?**

1) Deal with any life or limb-threatening medical concerns
2) See if you can restore DMC
3) Look for prior wishes
4) Find the appropriate substitute decision-maker
5) Reassess frequently
6) Document your assessment and all steps taken

**Discussing Life-sustaining Treatments**

**ASK – LISTEN – TALK**

1) Clarify understanding
2) Ask about prior wishes
3) Focus on goals – what can be achieved
4) Match treatments with goals
5) Finish strong – clarify and document the decisions made

**Problems that arise during DNR discussions, and suggestions for addressing them:**

**1) "What aren't they telling me" syndrome** - patient/family (p/f) feel blind-sided - Start the discussion by asking what they know/have been told so far

**2) The ER effect** – p/f have unrealistic expectations of recovery - Educate patients/families as to the actual likelihood of benefit and possible risks

**3) Resuscitation fixation** – p/f demand intervention regardless of relevance Explore the significance of the treatment – move conversation from treatments to goals

**4) "Who is the patient?"** - family requests interventions that do not appear to be in patient's best interests - Get help (nursing/social work) to explore family motivations and address guilt or fears.

**5) Reader's Digest Syndrome** – p/f have hope for recovery based on isolated/ anecdotal evidence - Explore family motivation and address reasons why this situation is different from others

**6) Deer in the headlight phenomena** - families are so overwhelmed they can not make a decision. - Be proactive, make specific recommendations based on family/patient goals. Reassure that they are not responsible for outcome, and that comfort care will be provided

**7) "Come Hell or High Water"** - p/f have deeply held beliefs that determine what they want no matter the clinical situation or discussion - Get a second opinion, involve administration, ethics services, patient services, and even legal assistance, consider transfer

**21 Selected CDRs (Cognitive Dispositions to Respond)**

**Anchoring:** focusing on vivid, salient features in a clinical presentation early in the diagnostic process, and failing to adjust this first impression later as more information becomes available

**Ascertainment Bias:** when thinking is unduly influenced by prior expectations (e.g. stereotyping and gender bias)

**Availability:** options appear more likely when they are readily brought to mind (e.g. a subarachnoid hemorrhage diagnosis is given more consideration on the differential for headache if it was seen a week ago)

**Blind Spot Bias:** the general belief people have that they are less susceptible to bias than others, due mostly to the faith they place in their own introspections. This bias appears to be universal across all cultures

**Commission Bias:** the idea that something always needs to be done to the patient, instead of letting things take their course – more common in overconfident physicians; things get done that were unnecessary

**Confirmation Bias:** looking for things to support your hypothesis/diagnosis, rather than looking for disconfirming evidence (which is usually a more effective strategy)

**Contrast Effect:** when interpretation of a particular case is influenced by adjacent cases – even though they are independent of each other e.g. going from a multiple trauma to an ankle sprain

**Diagnosis Momentum:** when diagnoses gather momentum without gathering evidence

**Fundamental Attribution Error:** judging and blaming particular patients (e.g. obese, borderline personality disorders, addicted patients) for their illnesses by focusing on their disposition (character, personality, intelligence) rather than considering their situational circumstances (socio-economic, upbringing, history of physical/sexual abuse)

**Hindsight Bias:** learning from past experience is hindsight. However, hindsight bias occurs when, knowing the outcome, people either make themselves look good or look bad, thereby distorting any chance of realistic learning

**Omission Bias:** the tendency towards inaction and not to intervene. Error arises from things not getting done that should have been done

**Overconfidence:** the general belief that we are better than we really are - a misplaced belief in the efficacy of one's thoughts and actions

**Playing the odds:** also know as **frequency gambling**, is the tendency in equivocal or ambiguous presentations to opt for a benign diagnosis on the basis that it is significantly more likely that a serious one

**Premature Closure:** shutting off thinking before there is sufficient evidence to support a particular diagnosis - when the diagnosis is made the thinking stops

**Psych Out Errors:** a variety of errors occur with psychiatric patients; they are vulnerable to fundamental attribution error, they are seen as less credible, their complaints don't get taken seriously enough, co-morbid illnesses get missed, and serious medical conditions may be misattributed to their underlying psychiatric condition

**Representativeness Restraint:** we tend to look for prototypical manifestations of disease - atypical presentations are more likely to get missed

**Search Satisficing:** reflects the universal tendency to call off a search once something is found. Co-morbidities, second foreign bodies, other fractures, and co-ingestants in poisoning all might be missed

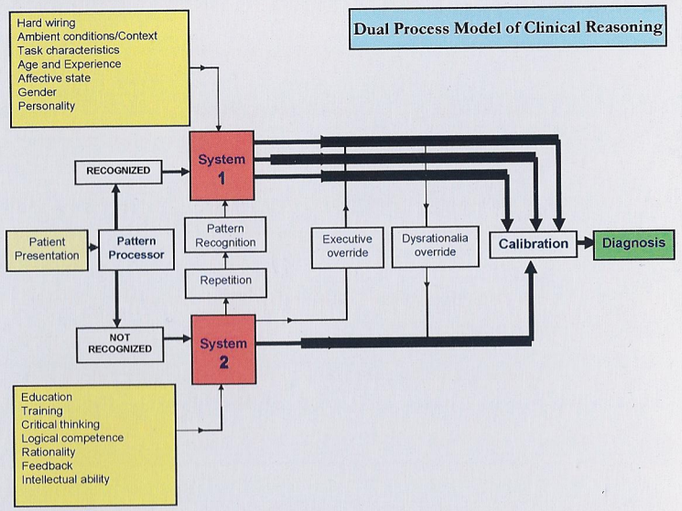
**Triage Cueing:** the tendency to inherit the abbreviated thinking that occurred at triage – patients in the minors area are seen as having only minor complaints. Many CDRs are initiated at triage

**Visceral Bias:** when emotions overly intrude into decision making. Countertransference may result in feeling unduly negative or positive towards patients leading to suboptimal decisions about their diagnosis and management

**Yin-Yang Out:** the outlook that once patients have been worked up the Yin-Yang, further effort will be futile

**Zebra Retreat:** backing away from a rare diagnosis for reasons other than it being rare: thinking that you will attract a reputation for being esoteric, unrealistic, or a wastrel of resources and time

For more CDRs and more complete descriptions, see: Chapter 32 in Patient Safety in Emergency Medicine pp 220-223




## Main Features of the Model

- System 1 is fast, autonomous, reflexive, and inexpensive but vulnerable to error
- System 2 is slow, deliberate, methodical but costly; it makes few errors
- CDRs, ADRs, and affective responses are all in System 1
- Repetitive activations of System 2 can get something into System 1
- System 2 can override System 1(executive control)
- System 1 can override System 2 (dysrationalia)
- Cognitive Miser function – the brain always tries to default into System 1

For ordering this card and information about Clinical Decision-Marking in Emergency Medicine, go to the Canadian Association of Emergency Physicians at **www.CAEP.ca**

CAEP | Canadian Association of Emergency Physicians
ACMU | Association canadienne des médecins d'urgence

CAEP | ACMU

# RISKY BUSINESS

Clinical Decision-Making in Emergency Medicine

**Consent, Capacity and Refusal of Care**

**Elements of an Informed Consent:**

1) Decision-making Capacity

2) Disclosure

3) Understanding

4) Voluntariness

**Elements of Decision-Making Capacity (DMC):**

1) Knowledge of the options

2) Appreciate the consequences of the decision

3) Consistent connection to Reality and Values

**An Approach to Capacity Assessment**

1) Clinical assessment

2) Provide information to the patient

3) Assess patient's knowledge

4) Ask why

5) Set the threshold

6) Make a decision