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# Stop hiding the uncertainty

A grassroots approach to creating a culture of openness in Emergency Departments.

## Uncertainty at handover time

Handovers in an emergency department (ED) from one clinical team to the next often occur in a rushed and pressured environment. Time and resources are limited, test results can be delayed and admission rates hard to manage, all of which may contribute to uncertainty at the time of handover.

While it is tempting to hide this uncertainty, studies have shown it can contribute to errors in diagnosis and poorer outcomes for the patient and the clinical teams. Although the overall incidence of diagnostic error in EDs is unknown, for certain conditions, such as subarachnoid haemorrhage, up to 51% of patients may be misdiagnosed in ED (see Graber 2013, The incidence of diagnostic error in medicine).

Misdiagnoses in ED have been associated with communication factors such as inadequate handover, and systems factors including excessive workload and clinician fatigue. These factors are exacerbated during night shifts where clinicians have even fewer system resources, and where fatigue is likely to affect clinical performance, thus contributing to an environment that is conducive to diagnostic errors. Morning handovers, therefore, are crucial patient safety checkpoints, as care and knowledge about patients is transferred from night to day staff.

A ‘cognitive huddle’ at the Royal Victorian Eye and Ear hospital

Research has shown that handovers can be marked by frequent hesitation, tentative and vague language and such linguistic features have been described as detracting from the efficiency of the handover. Hesitation or ambiguity in handovers can jeopardise the quality of exchanged information, trigger miscommunication and increase clinical and medico-legal risks. Thus, acknowledging and openly communicating uncertainty is a critical part of the diagnostic process.

Communicating openly about uncertainty can improve relationships between clinicians and patients, increase patients’ trust and confidence in their doctor’s abilities, open avenues for shared decision-making and, in turn, improve long term patient outcomes and the quality and safety of care.

## A grassroots approach

Putting this into practice, however, may prove a challenge for some teams and individuals. Clinicians can make uncertainty explicit during handovers, but, depending on personal characteristics, some might be apprehensive and find it challenging to disclose diagnostic uncertainty. This reluctance to acknowledge and discuss uncertainty can negatively impact clinician wellbeing.

In particular, junior doctors and those with limited practical experience in hospital settings >

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may experience anxiety due to uncertainty. Emergency clinicians who are reluctant to openly discuss and disclose uncertainty maybe also be at greater risk of burnout. Instead of focusing on the individual clinicians, a cultural shift in ED as a whole is needed to normalise and promote tolerating risk and uncertainty through the actions of all clinicians across hierarchies.

In a grassroots approach, Dr Carmel Crock was instrumental in introducing a comprehensive morning handover—or 'cognitive huddle'—at ED at the Royal Victorian Eye and Ear hospital. In this huddle the overnight clinicians can discuss particularly challenging or uncertain cases with incoming staff. In fact, the night team are encouraged to present all overnight cases, including those patients already discharged home. The entire day team is present and are active participants in the cognitive huddle, questioning, challenging and cross-checking all overnight diagnoses and management plans.

## Diagnosis as a team sport

Diagnosis becomes a team sport, with the day team not just supporting the night team, but acting as a safety net. The team appreciates that clinical decision-making degrades at night. Discussion of diagnostic uncertainty is modelled by the more senior doctors and is normalised. Often overnight patients are told that their case will be reviewed in the morning and that they will be contacted by the day team.

The power of admitting uncertainty, acknowledging it openly, sharing it with colleagues and with patients should not be underestimated. A culture is created where there is more openness in communication and where clinical reasoning can be constantly examined and refined.

These handovers involve participants across all hierarchies: including clinicians, managerial and clerical staff and on occasion even the Hospital's CEO, which sends a very powerful message to the staff of being valued. One of the main benefits of this approach has been an eroding of hierarchies between junior and senior clinicians, as well as between clinicians and non-clinicians. All members of the team have an equal voice. Patient safety and staff wellbeing are paramount.

Making uncertainty in medicine explicit allows clinicians and patients to remain open in their thinking about diagnostic possibilities. And creating a culture of openness in medicine can only contribute to safer diagnoses for our patients. ha