the importance of the user voice in clinical decision making: a reflective account

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**Abstract**

Effective clinical decision making is crucial to patient safety. A tripartite case decision was analysed with the hope to find learning points to improve clinical decision making. The case decision was analysed using the Dual Process Theory and the Intuitive Humanistic Model. The place of individual thinkers was analysed and their use of ‘System One’ and ‘System Two’ thinking was considered. The impact which the diversity of individuals and their skill levels had on the clinical decision was analysed. It was concluded that a team consisting of both ‘System One’ and ‘System Two’ thinkers as well as individuals at different places on the novice to expert continuum would be beneficial in creating a balanced choice. The importance of the patient voice in clinical decision making was highlighted.

**Key words**

* Decision making
* Midwifery
* service user
* Dual Process Theory
* Intuitive Humanistic Model

**Reflective questions**

* Reflect on whether women and people are always viewed as members of the team in clinical practice. What can be enhanced to develop this in your clinical role?
* How often have you experienced ‘freedom’ within your clinical teams to encourage individual views and planning, regardless of clinical seniority?
* How diverse are the clinical skill-sets and skill-levels in your clinical teams and what are the potential benefits if this were to be increased?
* reflect on a recent clinical situation where you have found it beneficial to make quicker, intuition-based decisions?
* Reflect on a recent clinical situation where you have found it beneficial to make slower, analysed decisions?

Decision-making can be seen as a process of choosing between different options, where each option would yield a different outcome (Marshall, 2005). The growing autonomy and specialised skill sets now expected and held by midwives increases the need for effective decision-making (Zolkefli, Mumin and Idris, 2020). Evermore so, it is crucial for women’s safety and wellbeing that the multidisciplinary team are considering, reflecting on, and learning from processes of decision-making (Ockenden, 2022, Kirkup, 2015). This tripartite decision between Sarah (pseudonym), a student, and an anaesthetist about which pain relief option would be best to use in labour is used as a basis for reflection and analysis (Figure 1). The context of decision-making theory is a large one, with a range of different theories and models. These can be broadly categorised as normative, descriptive, or prescriptive (Bell et al, 1995), or those looking at optimised decision-making, recommendations to improve decision-making, and descriptions of decision-making processes (Standing, 2017). To aid in the examination of this decision, two descriptive models have been chosen to add insight into the processes involved within the decision made. Through the Dual Processing theory (Evans, 1989) and the Intuitive Humanistic Model (Benner, 1984), the effect on risk taking, personal bias, and teamwork of different skill levels and categories of thinking are considered with the role of the midwife, professional accountability, and the importance of being woman centred examined.

Figure 1: Case decision

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| A midwife and a student midwife cared for Sarah (Pseudonym) throughout her induction of labour. Sarah’s cervix was assessed as 4cm dilated and she was using Entonox as pain relief, as per Patient Group Directives. Sarah was becoming increasingly uncomfortable and requested a stronger pain relief. On discussion with the student, it became clear that a choice was to be made between Remifentanil or an epidural. Sarah expressed fears surrounding having an epidural: she had heard that there was a risk of paralysis and long-term effects. The student bleeped the anaesthetist who came to see Sarah to discuss the risks and benefits of both options and provided evidence to support their clinical recommendation to have an epidural. Sarah showed no signs of wanting to question this perspective hence the student expressed Sarah’s concerns and fears surrounding having an epidural. This facilitated space to talk through her fears following which Sarah opted to have an epidural. |

When reflecting upon the factors affecting the decision-making process, it is useful to consider the decision through the lens of decision-making theory. The Dual Processing theory suggests that thought process can be distinguished as either intuitive or analytical. This was originally refined into one theory by Evans (1989). Evans divided the analytical and intuitive thoughts into separate groups: System One (intuitive, fast, unconscious) and System Two (rational, slow, conscious) (Kahneman, 2003). This is relevant to the tripartite decision being examined, as the individuals within the decision can be divided between these two systems. System One thinking is often defined by habit and governed by internalised precepts (Evans, 2008). Within the case decision, the anaesthetist demonstrated characteristics of ‘System One’ thinking. He quickly formed a view on which choice would be the most appropriate, prior to discussing it with Sarah. For him, this was a routine decision which did not engage ‘System Two’ thinking. This has benefits. It relies on easily accessible thought, creating pattern recognition and enabling faster thinking (Kahneman, 2003) and limits the amount of mental effort needed to be exerted, meaning that it will not be disrupted by effortful tasks (Pashler, 1998). However, the safety of using ‘System One’ thinking relies on the skill of the thinker (Kahneman, 2003) especially as it does not allow for the consideration of other individuals’ perspectives prior to a decision being made. An increase in skill will increase the accessibility of useful and safe responses in intuition (Kahneman, 2003), which ‘System One’ relies on using. For these fast responses to be monitored, ‘System Two’ needs to be engaged (Kahneman, 2003). This can lead to potential safety issues especially in healthcare such as anchoring or ‘confirmatory bias’, if the thinker does not engage ‘System Two’ thinking thereby not regulating or reconsidering their immediate and most accessible responses. It is reasonable to assume that the anaesthetist was skilled, due to his experience, training, and grade implying that his decision-making was safe. This is further supported by Klein (2003) who asserts that for decision makers who are skilled, using ‘System One’ thinking will often produce better results than ‘System Two’.

In this case decision, the student and Sarah demonstrated attributes of ‘System Two’ thinking, in that their decision-making process was slower and more considered which also has strengths and limitations. Doubt is a concept only present in System Two thinking (Kahneman, 2003) and it creates a process of decision-making which is deemed safer, especially to a thinker not well skilled in that area, as it creates opportunity for self-moderation. The benefit of deliberate control can be outweighed by the disbenefit of a heavy cognitive load, being unable to multitask, being distracted from task by other high cognitive decisions, and a decrease in speed. In an emergency setting, this potentially jeopardises safety. Whilst this tripartite case decision was not time critical and there were no other pressing decisions to be made, a ‘System Two’ way of thinking was deemed safer than using ‘System One’ process.

There are limitations to dual processes as a concept. Firstly, some of the dual process theories differ over their presentation of how the two systems interplay, making it hard to apply to the case decision with ease. Frankish (2007), suggests that ‘System Two’ thinking has intentional control over ‘System One’ thinking whereas Wilson and Dunn (2004) suggest that ‘System One’ thinking has the control over our behaviours and, without realising, we use ‘System Two’ thinking to justify these. This could suggest that both the student and Sarah had already made a choice, using ‘System One’ thinking and were simply using ‘System Two’ thinking to justify it. If so, this could suggest that initial perceptions of decisions, guided by System One thinking, could cause an anchoring bias (Lieder et al., 2017) from which all other opinions are skewed. In a healthcare setting, where it is important that personal biases are recognised to prioritise the need of the patient (NMC, 2018), this bias could be mitigated by engaging ‘System Two’ thinking.

 A further suggested limitation of dual processing theory, and the terminology determined by Evans (Evans and Stanovich, 2013) is that it does not allow for complexity. In using the term ‘system’ and not ‘systems’, one may overlook the multiple neurological pathways being used in both intuitive and analytical thinking (Evans and Stanovich, 2013). Some critics (Osman, 2004) go further and suggest that the theory fails by even defining the systems as a dichotomy and not a continuum. Stevenson (1997) suggests that systems one and two thinking are poles at either end of this continuum. This could be applied to the decision being examined, with ease as it creates flexibility when defining which system the individuals fall into. Sarah could be defined as being close to the ‘System Two’ pole and the student would also fall close to the ‘System Two’ pole as she was quick to assume which pain relief would be best but then reconsidered and spent time deliberating. It does bring into question where the anaesthetist would fall between the two poles. There is no evidence in the literature to show that someone skilled in a routine task cannot carry it out with speed, even when utilising ‘System Two’ thinking. As such, the point could be considered that the anaesthetist was analytically considering options, just faster than the other two individuals, as he had more experience. This presents the option that he would also fall close to the ‘System Two’ pole. As seen, the idea of a continuum provokes more consideration and perhaps more accuracy than a dichotomy approach.

Another limitation of the theory is that it was not designed with healthcare in mind and does not acknowledge the context of the individual or how this could influence thinking. Personal biases, time pressures, fatigue, pain are examples of factors which could affect the tripartite decision. Osman (2004) acknowledges biases to some extent by suggesting that initial experiences will impact on how information is encoded and how accessible it will be in future. ‘System One’ reasoning is influenced by the accessibility of information (Kahneman, 2003), and as such personal experiences could affect the judgements made, but this is the extent to which the experiences, personality, or context of the thinker is considered. The voice of the patient is central to all healthcare decisions (NMC, 2018) and as such, professionals rarely make decisions in isolation. The inputs of other professionals and the voice of the patient is another factor which is overlooked by the dual processing theory

Similarly, the Intuitive Humanistic Model with the novice to expert continuum was originated outside of a healthcare setting (Dreyfus and Dreyfus,1980), through the study of chess players and pilots (Benner, 1982). However, it has been adapted to fit a nursing background (Benner 1984) and so fits with more ease into the case decision. The theory suggests that the expert utilises intuition in their judgements, setting them apart from the novice who relies predominantly on guidelines and principles to navigate situations (Thompson, 1999). Benner (1984) outlined a definition of different states on the novice to expert continuum and whilst this was considered in a nursing context, this application includes the voice of Sarah in an attempt to modernise its use (Figure 2). Within this tripartite case decision, Sarah falls into the novice category, the student into the competent, and the anaesthetist into the expert. Intuition has many different definitions; however, one way of viewing it is as an ‘understanding without a rationale’ (Bennner and Tanner, 1987; p23). Kahneman (2003) suggests that, through ‘System One’ thinking, the brain presents the thinker with only one option and does not present the rejected ones. This could be seen as synonymous with intuition, as the thinker would come to conclusions without having consciously thought through the options. As such, the thinker would not fully know why they have reached their conclusion. This would support the idea that, in this tripartite case decision, the anaesthetist, being the expert, was using System One thinking, or even intuition, to come to his conclusion as opposed to using System Two thinking quickly. Conversely, the novice, who was relying on principles to navigate her decision, was using System Two thinking.

Figure 2: Novice to Expert Definitions and application to case decision (Benner, 1984)

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| Novice  | Limited ability to foresee events. No flexibility in approaches to situations. Dependence on guidelines.  | Sarah fits into the category of novice in her clinical understanding. She was reliant on the information and processes provided to her by the others involved in the decision. It can be noted that she should be classed as ‘expert’ in the understanding her own body. |
| Advanced beginner  | More experience allows for recognitions of common situations. Lack of in-depth experience.  | None of the members of the tripartite decision were an advance beginner.  |
| Competent  | Have a range of experiences and can plan detailed patient care. Can recognise patterns and the development of situations.  | The student fits into this category in that they had had a number of previous experiences in this area and could recognise the basic patterns which they had experienced. They could not yet view the situation holistically or adapt to developments in their surroundings.  |
| Proficient  | Can view the situation holistically. Can readily modify and adapt plans to developing situations.  | None of the members of the tripartite decision fit into the proficient category.  |
| Expert | Have a depth of knowledge and experience. Have an intuitive understanding which covers many situations. Can use analytical thinking to approach unencountered experiences.  | The anaesthetist can be classed as an expert as they had a deep knowledge base underpinning their judgment of this situation and could use this to approach the case decision analytically.  |

Similarly to the Dual Processing Model, the Intuitive Humanistic Model has its weaknesses. Both the model and the expert to novice continuum (Benner 1984) are only supported by dated qualitative research. More recent research in a greater breadth of methodologies would be a benefit in supporting this theory in a contemporary context.

The Nursing and Midwifery Council (NMC) Code (NMC, 2018) states that midwives must work to ‘identify and reduce risk’ and priorities the needs of the women in our care. In the case decision being analysed, Sarah needed to find a pain relief choice that not only met her need but which she felt safe receiving. To reach that decision, Sarah needed to discuss the risks of both options and discuss her fears surrounding an epidural. As midwives, we need to be advocates for women, and so the student voiced Sarah’s fears to the anaesthetist, and he was able to provide the information Sarah needed to make an informed decision. The anaesthetist presented these risks after making a judgement, using ‘System One’ thinking or intuition. ‘System One’ thinking does not engage analytical thinking (Kahneman, 2003) and therefore will not analyse risk in the way that ‘System Two’ thinking would. In forming a judgment, he could have overlooked some risks as justifiable without analysing if Sarah would feel the same way. In presenting the information, after forming this intuitive judgement, there is a potential that it was presented in a biased way.

This potential for bias could also be carried across to documentation. Midwives are accountable for the decisions they make (Cooke, 2005; Tilley and Watson, 2004). With documentation consuming a significant portion of time for healthcare professionals (Penoyer et al., 2014), it could be easy to slip into ‘System One’ thinking, allowing for multitasking while documenting. Yet, in order to respect accountability, it is essential that midwives engage ‘System Two’ thinking and document events free from bias where possible. Clear documentation of the decision-making process will enable midwives to justify decision-making after the event has happened to tell women’s narratives in the future.

A further consideration is that of teamwork. The Department of Health (2004) highlighted the importance of multi-professional teamworking in delivering safe care. From analysing this tripartite case decision, it is clear that multi skilled level teams are beneficial in meeting care needs. Having a team comprising a range of individuals on different points of the novice to expert continuum (Benner, 1984) aims to produce thinking from both ‘System One’ and ‘System Two’ thinking approaches. This will provide the benefit of quick and intuitive thinking, while also allowing for reasoning to promote safety, consider risk, and suggest alternatives. The outcomes of a literature review looking at teamwork efficiency found that a diversity of experience can increase productivity and outcomes (Zhou and Rosini, 2015). One can postulate that differing positions on the novice to expert continuum (Benner, 1984) equates to a range of experiences, thus supporting the need for diversity of skill in teams. This fits with the human factors body of evidence and safety tools such as ‘Teach or Treat’ (RCOG, n.d.). Healthcare should be patient focused (NMC, 2018) and in order to achieve this, the patient should be considered as part of the team and is key within the new pre-registration education standards for midwifery (NMC, 2019). While Sarah was a novice clinically, value should be placed on this, as it increases the team diversity, ensuring there is always a System Two thinker; she can also be seen as an expert in her own self and so is a valuable member of the team looking at her individual care needs.

In this tripartite case decision, Sarah was in pain. The ethics of individuals’ making decisions when in pain should be considered. Interestingly, the research surrounding ethics in pain management (Carvalho et al., 2018; Cohen and Jangro, 2015) do not consider the patient as part of the team and make recommendations for health care professionals only. Similarly, the research supporting the Dual Process Theory does not consider how context can influence thought processes. It could be considered that pain could pressurise the woman to make decisions quicker, reducing her analytical thinking and leading her to use ‘System One’ thinking. In this case decision, it is the role of the midwife to analytically present benefits and disbenefits of each pain relief option, in an evidence-based manner (NMC, 2018).

The program of care and the NICE guideline (2020) state to offer all women pain relief, as they report their need to be, regardless of their stage in labour. Ethically, this should never change (Carvalho et al., 2018), as women have a human right to access the pain relief they need and be well informed about it (NICE, 2020). The potential for a biased presentation of evidence was noted in this case. To mitigate this potential for subconscious bias, practitioners could ensure they engage ‘System Two’ thinking before to discussing options with a woman. ‘System Two’ thinking can moderate ‘System One’ assumptions and intuitions (Kahneman, 2003), ensuring that the practitioner has not overlooked any information or risks, which they deem justifiable, but which should still be presented to the woman. Another consideration for practice would be the benefit of having a wide skill range when forming teams and the importance of seeing the woman as part of the team. This will mean that individuals on the team are at different points on the novice to expert continuum (Benner, 1984), increasing the likelihood that both ‘System One’ and ‘System Two’ thinking will be used. This may create a team responsive to a variety of situations with both speed and rationality. Including a System Two thinker will add a level of safety, if the System One thinker is unskilled, by adding a level of monitoring to actions made. However, the role of the midwife is largely autonomous, and while it is in the woman’s best interest for the midwife to recognise her sphere of competence and the times when she needs to engage other members of the team, there will be many decisions which the midwife will make on her own. In these cases, it is still important to engage both System One and System Two thinking. The safety of their decision-making is a midwife’s responsibility and so they must actively analyse their initial assumptions and decisions. This will also increase the consideration of the needs of the woman, as an individual (Ockenden, 2022).

The woman’s needs should always be central to all decisions (NMC, 2018; Ockenden, 2022; DH, 2010). If the woman is in too much pain to advocate for herself or analytically consider her options, it is the role of the midwife to support her. This is made easier through a continuity of carer model (Royal Collage of Midwives, 2020), as the midwife can be familiar with the woman’s wishes through discussions antenatally. From considering the tripartite decision through the view of the Dual Process Model Evans (1989), the Intuitive Humanistic Model (Benner, 1984), and the novice to expert continuum (Benner 1984) a number of considerations can be made. Firstly, a parallel can be drawn between the intuition which experts use (Benner 1984) and the traits of System One thinking (Evans 1989). Experts will often use intuition or System One thinking in decision-making. This has benefits in a health care setting; it will increase the speed and reduce the cognitive load of decision-making. However, the decision will not have been analytically thought through and will have been based on previous experiences, not the specific current situation. People closer to novice on the continuum are more likely to engage System Two thinking. This will mean they approach the decision analytically and can make the decision more tailored to the exact situation they face. System Two thinking also reduces the potential for bias when presenting choices or evidence to women. It is suggested that teams are made stronger for using a mix of the two systems and utilising their benefits in response to different situations. System Two should always be used when considering women’s wishes, as a way to reduce personal bias.

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