LETTER FROM THE EDITOR-IN-CHIEF

Stepping Outside Yourself

Until recently, I've had the rare luxury of working in busy urgent care centers where I was virtually always working side-by-side with another provider. However, with changes in my career and UC staffing models in the wake of the pandemic, I find myself working in single coverage situations the majority of the time nowadays. While I do miss the camaraderie of multi-coverage practice, I miss the unfettered access to a second clinician's brain the most.

Have you ever found yourself caring for a patient and uncertain about what the best thing to do was? As clinicians we find ourselves facing such dilemmas every shift. The landscape of medical decision-making in urgent care is endlessly treacherous in its complexity and is studded with the various landmines of hidden bias and cognitive traps. There are, however, simple strategies we can use to protect ourselves from these pitfalls.

Asking for advice and input from other clinicians is often the default response to situations where we are unsure of how to proceed. We have a patient with an issue germane to a specialty outside our own, we call a consultant. We need a second opinion on a patient within our specialty, we curbside a colleague. They can often give us dispassionate, objective advice about what we should do given the situation.

How are they able to be so objective? The answer is simple: distance. They don't know the patient and weren't affected by the interpersonal dynamics of the interaction. They simply know the salient facts of the case. This distance limits many sources of bias that can arise from being the person who greeted, interviewed, and examined the patient. Conversely, we are at greater risk of many types of cognitive errors the closer we are to the patient. And when you're caring for the patient directly, you're about as close as you can get.

So, why not just present every case to another doctor or clinician like a resident or trainee might? This is an excellent option when the circumstances allow for it. In fact, this method has been studied specifically with compelling results. A group of French researchers found that emergency physicians who presented their cases to colleagues made a remarkable 40% fewer errors than those who went it alone.[1] So, yes, by all means, present patients to your colleagues as often as is practical. Take advantage of the insights which can only manifest among those with the luxury of distance from the case when they are willing to share their time and thoughts.

However, on most shifts, this is simply not practical or even possible. Many of us work in single coverage situations or are physically isolated from our colleagues. Even if you have other physicians working around you, the pace of patient care rarely allows for two clinicians to both stop what they are doing and take 5–10 minutes to discuss a patient's presentation.

But what if we could achieve this distance (and consequently improved objectivity) without having to rope a coworker into listening to us? Turns out we can through the use of a technique psychologists call *self-distancing*. Self-distancing refers to the process of creating psychological distance from your own subjective experiences. Numerous studies have shown that rational decision-making improves with greater self-distancing.[2,3]

Achieving self-distancing can be done through a variety of simple mechanisms, but most center around the use of language. For example, a 2012 article in *Psychological Science* references a series of studies demonstrating that multilingual people can make better decisions when they hear the same problem stated in multiple languages.[4] And if you do happen to speak more than one language, there's no reason this technique couldn't be used to create psychological distance when you're stuck on a case. This creation of distance is predicted by Construal Theory, which suggests that distance in one domain (eg, language) creates distance in other domains (eg, more holistic perspective).

When considering linguistics, a more universally practical strategy, however, involves simply changing the point of view when telling the patient's story. A number of social psychology studies have demonstrated that the perspective of self-talk matters. Self-distancing can be effectively achieved, therefore, by simply switching from the first person (ie, I and me) to the second (ie, you) or third person (ie, she, he etc.).[5] So rather than presenting the patient to a colleague, you simply change the pronouns and present the patient to yourself.

I know this might seem a bit odd at first, but it's actually elegant in its simplicity and power. Rather than thinking to yourself, "I don't know what to do with this dizzy 64-year-old woman," say to yourself, "You're seeing a 64-year-old woman who presented with dizziness that resolved. Her vital signs are

normal. You've checked her neuro exam and an EKG. What does that still leave on your differential?"

By self-distancing, you will be able to get a more objective assessment of how high-risk the patient is. But if you're a bit too self-conscious to actually talk to yourself in front of your staff, there's another powerful tool for creating psychological distance we can use. In fact, we all spend at least 1/3 of our time using it on any given shift already; I'm speaking of our documentation. Many of us understandably look at our charting obligation as a nuisance; however, this attitude causes us to miss the opportunity the EMR provides in forcing us to consider the patient's presentation from a different perspective. By converting our thoughts from nebulous internal chatter rattling around our noggins into an organized written narrative, we give the patient's story form. In charting, we are compelled to observe our thoughts from an outside vantage point as they are splayed out on the virtual page. Psychological distance has been created.

Imagine you are caring for a young, otherwise healthy woman with a fever. You collect her history and sit down to quickly start her chart while you have her story fresh in your mind: "3 days of subjective fevers, body aches, intermittent headache, abdominal cramps." As you type and reread her HPI, you realize you forgot to ask about associated diarrhea, travel, and vaccination history. She was well-appearing, but her answers to some of these questions might significantly alter your risk assessment. As these questions arise, you realize you need to collect more history and that you may need to order more than just the urinalysis and COVID swab you were initially planning.

So, whether it be through more intentional use of the medical record, presenting patients to yourself, or both, consider self-distancing on your next shift. You may find that much of the insights arising from objectivity that you've been seeking were within you all along. ■

References

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