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The Art of Conscious Practice: Mastering Medicine

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ABSTRACT

It is said that about 90% of what people routinely perform daily, stems from the subconscious mind. This can be comparable to the state of unconscious competence (provided you have achieved competence). For the more junior professionals who may not have achieved this, there may then be a need to make them more focused and conscious in their practice. This may need to involve behavioural change. Behavioural change is linked to three different elements: motivation, ability and a trigger. The conscious mind is logical. It is able to think, reason, select, discriminate, plan and perform many more functions. The important thing to note is that the conscious mind can only perform one thing at a time. It cannot do two things simultaneously. The subconscious mind on the other hand, is the “feeling” mind and thus the source of love, hatred, fear, jealousy, anger, fear, and other emotions. Doing anything with the conscious mind requires energy and effort. Learning to do something for the first time takes effort but as it becomes a habit, the task can be relegated to the subconscious mind. The subconscious mind can perform all the task without mental effort. This article discusses how to attempt to make medical personnel more conscious of their actions in order to reduce the chances of errors happening. This is in the context of an Emergency Department which is fast paced and busy 24 hours a day. The suggested strategic framework is shared.

Keywords: *Conscious mind, Subconscious mind, Behaviour, Motivation, Focus*

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Introduction

Physicians practice and learn in a complex clinical environment and context where the relationship as well as interaction with patients is more intricate than just a face or a name they recognise. After years of practising medicine and educating medical students and doctors, I have come across a multitude of errors. Some errors may be due to inadequate or insufficient knowledge, but often they arise from a lack of focus or

cognitive concentration. At times, the latter happens to very good and conscientious doctors. For example, a doctor may have noted that a patient has an allergy to a certain drug and has documented this as well. However, when it comes to ordering a prescription, the doctor orders that same drug the patient is allergic to. It can also be ordering a drug from the same or related family of drugs that a patient may be allergic to. The other observation made is that these errors tend to be made by certain staff only

and yet not others. Those who made the errors also tended to make them repeatedly. Could there be a reason or underlying causes for these errors to occur?

The Mind and Behaviour

It is said that about 90% of what people routinely perform daily, stems from the subconscious mind (1, 2). This can be comparable to the state of unconscious competence (provided you have achieved competence) (3). For the more junior professionals who may not have achieved this, there may then be a need to make them more focused and conscious in their practice. This may need to involve behavioural change. Behavioural change is linked to three different elements: *motivation*, *ability* and a *trigger* (4, 5).

Motivation can wax and wane. It is important to be able to harness the motivation wave when it is at its highest level so that the desirable behaviour can be effected. Sustainable motivation would be optimal, but often, impossible to achieve at all times.

Ability is about how easy or difficult it is to perform the behaviour. Ability is also directly linked to simplicity, with reference to the task or behaviour. The whole idea is to make the new behaviour automatic so that it no longer depends just on motivation, or the motivation wave, in order to be executed or to succeed.

The *trigger*, in our context, will be the clinical case or the patient that the professional encounters or interacts with. It is the person who will form the relationship with the healthcare professional (4, 5). There are two ways that may have an impact on long term behaviour change:

1. A change in the external environment (that affects the execution of the behaviour directly)
2. Making the behavioural change in small, gradual steps

The objective would be to programme our brains to make the new behaviour automatic, so that it no longer depends on motivation to succeed.

The Conscious and Subconscious Minds

The whole idea of conscious practice being proposed, is to have things done and decision made more consciously and with focus. Practising consciously is about being aware of everything that has a bearing on our actions, purpose, values and goals. The conscious mind is logical. It is able to think, reason, select, discriminate, plan and perform many more functions. The important thing to note is that the conscious mind can only perform one thing at a time. It cannot do two things simultaneously, e.g. give instructions to a nurse and read the patient's charts, at the same time. Scientists have also found that the brain has a finite amount of space for tasks requiring attention. Learning to drive is a good example of how difficult it is for the conscious mind to do many things, all at once (2, 6–8). The conscious mind has will and has a sense of awareness. Will, is the ability of the conscious mind to direct a thought or action.

The subconscious mind on the other hand, is the “feeling” mind and thus the source of love, hatred, fear, jealousy, anger, fear, and other emotions (8, 9). Doing anything with the conscious mind requires energy and effort. Learning to do something for the first time takes effort but as it becomes a habit, the task can be relegated to the subconscious mind. The subconscious mind can perform all the tasks, without mental effort (2, 8–10).

The conscious mind represents only the tip of the iceberg, but it has understanding. Our subconscious mind receives information, many of which we may be aware of, and stores them. When we receive information, even at high speed and frequency, such as in the emergency department, the information

will dwell in our minds and become an important part of who we really are. Our realisations have conscious understanding and insight. Thus, to live our realisations, we may need to programme our subconscious mind with the present conscious understanding. This may take time and will need understanding and awareness of our thought patterns (2, 9, 10).

Going back to the initial example on the wrong order of drug, this may have something to do with the use of the subconscious mind, over the conscious one. As it was also noted that many of these errors tended to be made by the more junior staff. It could be that they have not learnt and developed their capabilities, to the state of unconscious competence (3, 10).

One of the ways to inculcate positive behavioural change is to use protocols and templates. However, these as well as other tools can only be as good as the persons using them. To develop more conscious practice, we may have to get routine out of our vocabulary. We need to function at a higher than the “spinal level”; to be aware of the “here and now”. It is about being alert and conscious in the immediate moment. This is also known as being mindful (11, 12).

There are at times, certain portions of our tasks which we may feel can be quite routine, such as passing a standard set of information, explaining risks versus benefits, sharing on certain medical conditions and their prognosis. However, despite appearing routine, there is a need for customisation of these messages and tasks to each trigger, clinical situation, or patient. We need to also add in the elements of humanity and empathy. Making wise and appropriate decisions consciously in any circumstances can shape and affect outcomes and lives of our patients. This will be “conscious practice”, that is being proposed. If we can develop this within each individual, it may be possible to enhance the level of safety in an institution.

Cognition and Conscious Practice

We have a choice to conscious practice. It is the choice of the level and depth at which we practice. Each choice will have its consequences and limitations, which we must be aware of. If we do not choose consciously we may then drift into errors and may even encounter dangerous, life threatening or adverse outcomes in our practice of medicine.

Conscious practice also means paying attention to oneself and others so as to do no harm. It will enable us to have a better understanding of ourselves and others and enhance self-esteem. When we are faced with mistakes and errors, or are dominated by fear, we must use the situation as an opportunity to examine our practice and make the relevant changes. This act of re-examining and reflection of our practice is also a part of the conscious practice, being proposed.

Reducing cognitive errors involves complex steps like perfecting performance through regular and frequent feedback as well as improving skills in metacognition (ability to monitor, understand your thought processes). It is also linked to reflective practice (11).

The Practical Approach

Therefore, in handling our initial problem, what were our interventions?

As the conscious mind has the ability to:

1. Direct our focus, and
2. The ability to imagine that which is not reality

We have to tap on this knowledge to plan our interventions. To create the change required, the staff concerned will need to learn to control what they consciously focus on. To assist them in doing this, the following strategic framework was implemented:

1. Pop ups on the computer system to disallow progression to the next page or screen without actually doing certain task and documenting it. This enable the staff to consciously think about the issues when it appears on screen.
2. Prominent reminder messaging and signage at the computer points and stations to reinforce the stimulus to users. These act as visual reminders.
3. Each staff that has committed the error has to have a face to face interview session with the Director of Quality. This is to explore their thought processes and make them more aware of what is going on. If they commit repeated errors, this interview will have to be done for each error. This is easy to track with the use of an error reporting system online.
4. These errors and issues are also discussed and highlighted at the weekly teaching programme. The sharing is done not to “shame and blame” but for the purpose of learning and promoting an open and just culture.
5. The use of compulsory two identifiers for all doctors and nurses performing tasks and delivering drugs and medications to patients.

With these strategies, qualitative observation seems to have a positive impact and the staff involved appears to be thinking more consciously of their orders and actions. For example, when they meet the Director of Quality at other platforms (following their initial interview once the error has been reported on the online reporting system), they will come up to specifically state they have not committed any new errors. This shows they are consciously thinking about this and aware of it. In the end, what counts is our patients’ safety.

References

1. Journal Psyche. Freud’s model of the human mind [Internet]. Authors & Journal Psyche. c1994–2015 [cited 2016 May 26]. Available from: <http://journalpsyche.org/understanding-the-human-mind/>
2. Diffen. Subconscious versus conscious mind [Internet]. Seattle: Diffen. [cited 2016 Feb 11]. Available from: http://www.diffen.com/difference/subconscious_vs_conscious_mind.
3. Cannon HM, Feinstein AH, Friesen DP. Managing complexity: applying the competence model to experiential learning. *Development in Business Simulation and Experiential Learning*. 2010;37:172–82.
4. Bundy C. Changing behaviour: using motivational interviewing techniques. *J R Soc Med*. 2004;97 Suppl 44:43–7.
5. Ryan RM, Deci EL. Intrinsic and extrinsic motivations: classic definitions and new directions. *Contemp Educ Psychol*. 2000;25(1):54–67. doi:10.1006/ceps.1999.1020
6. Custers EJ, Regehr G, Norman GR. Mental representations of medical diagnostic knowledge: a review. *Acad Med*. 1996;71 Suppl 10:S55–61.
7. Carpenter HW. The genie within: your subconscious mind and how to use it. c2016 [cited 2016 Feb 20]. In: The genie within [Internet]. [place unknown]: The genie within. Available from: <http://www.thegenewithin.com/lesson-2>.
8. Baddeley AD. Is working memory still working? *Am Psychol*. 2001;56(11): 851–64.
9. Thomas J. The human mind-How does it work? [cited 2016 May 26]. In: *Mindset habits* [Internet]. New York: Magazine Po Theme on Genesis Framework. c2016. Available from: <http://www.mindset-habit.com/conscious-subconscious-unconscious-mind/>

10. Royal K, Hardie L. Making thinking visible. Book review. *Can Med Educ J*. 2015;6(2):e78–80.
11. Staik A. Four steps to rewire your brain with conscious-mind action. 2013 [cited 2016 Feb 12]. In: Psych Central [Internet]. Massachusetts: Psych Central. c1995–2016. Available from: <http://blogs.psychcentral.com/relationships/2012/05/four-steps-to-rewire-your-brain-with-your-mind-and-conscious-action/>
12. Charlin B, Boshuizen HP, Custers EJ, Feltovich PJ. Scripts and clinical reasoning. *Med Educ*. 2007;41(12):1178–84.

