NARRATIVE
ESSAYS

Choose Your Battles

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When I first started residency, I always listened and executed the attendings', nurses', or pharmacists' patient care plans, never questioning them. I felt like I didn't know enough, and even if I did, I was scared of creating conflict. As I progressed through residency though, my fund of knowledge and my confidence grew, and I began to challenge care plans that were not evidence-based. My approach was to place the patient at the center and come from a place of curiosity. I used phrases such as "Oh, I thought I had seen something different. Let's look at it together," "That's a good point, but let's ask the patient and see what s/he would like," or "I may be wrong, but this is what I was thinking…" I learned to do this to cope with a repeated discomfort that I experienced in residency, stemming from the cognitive dissonance I felt when I knew the suggested care plan for the patient contradicted evidence-based medicine. Usually, it was effective. Although I felt like I had a framework for *how* to approach conflict within teams providing care, I had not understood the importance of knowing *when* to trigger conflict to improve patient care.

At the beginning of one of my obstetric shifts, a new attending advised that I give IV low-molecular weight (LMW) iron dextran instead of IV iron sucrose for a patient. Before making the decision, I reviewed the evidence. I realized she was right. IV LMW iron dextran was as safe as IV iron sucrose and required fewer infusions. I decided to place an order for the iron dextran quickly before heading to labor and delivery for a possible delivery.

The pharmacist paged me soon after. He wondered if it was a mistake, an accident by a new resident. I was closely monitoring the fetal heart rate of a labor that I was particularly worried about when I was interrupted. I had to restrain my initial, impatient thoughts—I was doing something more important and didn't have time for this! I was almost a third-year resident, not an intern, and he was challenging my decision-making?

My better self prevailed after a deep breath. I knew the pharmacist had prevented numerous medications errors this way. I began, "Thanks for the page and checking in. I was thinking it might be better for the patient because…" and I continued to explain why I had ordered it, reviewed the evidence that I had consulted, and restated that's what I had wanted. He complied reluctantly.

The nurse paged next. She said it was about safety. She had never given this form of iron, and it was an unusual choice. I listened, but I was preoccupied. The fetal heart rate for the labor I was monitoring continued to worsen. I responded, "Well, this formulation is just as safe and it's quicker for the patient. I talked to the attending and this is what we decided." It was a curt response that she didn't deserve. The nurse acquiesced. Half an hour later, I received another page. The patient had had a minor infusion reaction. It was not an allergic reaction or a life-threatening reaction. The nurse disagreed. A complaint was filed.

The new attending continued to order IV LMW iron dextran, and as she became comfortable at our hospital, she incessantly created conflict with her colleagues and the staff to change a number of non-evidence-based institutional practices. The number of disgruntled nurses and pharmacists grew. Another attending gave me a word of advice during this period: "Choose your battles." He suggested that trust was a finite resource that can be misused, and the new attending had challenged new working relationships too much by pushing for every change she believed in.

Distrust between the staff and the attending grew and began to affect patient care. Every decision by the attending was doubted, and miscommunication led to patient errors. She was not seen as a colleague but rather as an adversary. This was especially apparent during periods of

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high stress. In one instance, when she had made a difficult decision to attempt a vaginal delivery leading to an emergent cesarean section, the nurses began to question her medical competency—although it could have been equally attributed to bad luck.

I wish I could change culture and processes quickly as evidence mounts and practice evolves. I didn't want to "choose my battles." At the same time, I realized how poorly I had managed my interaction with the nurse, who was concerned for the safety of our patient, due to my stress. I observed how fragile working relationships can be as our new attending attempted to change current practices. As I reflected, it seemed deciding on *when* to challenge colleagues or staff involves answering these questions for myself: (1) Do I believe this change is important for patient safety? (2) Is this the right time to address this issue? (3) Is my relationship with this person strong enough to withstand this conflict? (4) Am I putting my emotions, fear of conflict or desire to be right, above the patient's well-being? In hindsight, if I had answered these questions for myself, I would not have chosen the battle of the IV iron. It did not affect patient safety, I did not have time to communicate clearly to other team members, and I did not even know the name of the nurse caring for the patient. Lastly, I had not discussed it with the patient to elicit her desires, but I, by myself, had decided that it was the right decision. These questions are neither algorithmic nor all-inclusive, but they helped me see that sometimes it is okay to yield to institutional non-evidence-based practices and choose my battles to build and maintain working relationships. Hopefully, as I become part of a community and foster trusting relationships, conflicts can be embraced as an inevitable part of change to providing better care for the patients I serve.

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