The Curse of Knowledge

“Could I have made the mistake of asking a question in the climate of my patient’s sudden car accident?”

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Caring Transitions

“I can’t believe Robert was in that nursing home for a week without an INR [international normalized ratio] being done – even if INRs were not ordered. He had just started warfarin and was on antibiotics. Everyone knows that all patients need INRs done! His bleeding just wouldn’t stop when he arrived at the emergency department.”

“I can’t believe Mary came back from the hospital with a feeding tube inserted! Didn’t they know she never wanted that? Everyone here at the nursing facility knew her wishes.”

“I can’t believe John came back to the hospital from the nursing home with Clostridium difficile! Everyone knows treatment for a urinary tract infection should be short term. Didn’t they know he was only supposed to be on the antibiotics for 2 days, not 2 weeks? What could they have been thinking?”

How often have we spoken – and heard – these types of comments in our post-acute/long-term care world? A patient suffers harm, often due to a knowledge gap when the patient moves from one site of care that knows a patient well to another where the patient is new and less well known.

Facts about our patients and their care may appear to be so obvious to caregivers that it must seem absolutely impossible for all involved not to know them. Communication of timely, appropriate data in a format that best suits the receiving site of care has been, and always will be, the commonly acknowledged engine that drives good transitions of care. With this in mind, the question must be asked as to why gaps and deficiencies appear and are perpetuated – repeatedly and regularly – by caring, experienced clinicians. Gaps that result in hospital readmissions.

One insightful book goes to the heart of our communication issues. “Made to Stick” (Random House, NY, 2007), written by Chip and Dan Heath, is an essential book to read when dealing with interpersonal communication. This entertaining volume explores why some messages can never be remembered, whereas others can never be forgotten, and also what elements compose strongly delivered, sustainable messages.

One concept in the book particularly applies to care transitions: how good providers, working hard to provide relevant data in transitions, still inadvertently omit key information. Despite outstanding intentions, ultimately we are all human. Once we throw some-thing, we find it hard to imagine anyone else does not also know it. Thus is it difficult – if not impossible – to share knowledge with others in a logical, linear, comprehensive fashion because we cannot re-create the listener’s state of mind. The writers refer to this as “the curse of knowledge.” What information does a receiving care site already have, and what clinical information does that site need to truly understand the plan of care intended? Is it impossible for the sender to accurately know?

That clear, clean order set from the clinician at the sending site to the care team at the receiving site is an integral step in the clinician-to-clinician conversation that defines the gold standard in transitions.

Barriers to Communication

The Heath brothers provide an example of this barrier, called “tappers and listeners.” The “tapper” taps out a well-known song, such as Happy Birthday, and then asks the listeners to identify the tune. The tapper cannot avoid hearing the song in his mind as he taps out the tune. This theory implies the message sender cannot comprehend that the listener may not know the same tune. It is impossible to put oneself into the mindset of someone who does not know what we know. This injects a fatal flaw into all communication with the next site of care:

▶ Why worry about ordering INRs for John when he moved to a nursing home? Doesn’t everyone know every patient on warfarin needs regular INRs?
▶ Why would the hospital need all that advance directive paperwork? Everyone knows Mary’s feelings against feeding tubes in others and herself.
▶ Why would it be necessary to provide an ending date for John’s course of antibiotics? Doesn’t everyone know treatment for a UTI would be no more than 7 days?
▶ So how do we minimize this data exchange prejudice? The best solution is to craft an order set based upon communication with the average teenager. Seasoned parents have all experienced the frustration of this exchange:
Parent: “Billy, please take out the trash.”
Billy: “Sure.”

Parent (2 hours later): “Billy, did you take out the trash?”
Billy: “Sure.”

Parent (another 2 hours later): “Billy, have you taken out the trash?”
Billy: “Sure. Oh, did you want that done today?”

The only chance of a completed plan of care: “Billy, please take the trash out right now as we have company coming for dinner at 5 o’clock and I need to have the house clean for them” (with, of course, the implied threat of imminent discipline if the trash is not removed). This encompasses the elements of the desired action: what is wanted, when it is wanted, why it is wanted, and the consequences of not accomplishing the task.

The same completeness is necessary for writing an order set during a transition. Examples:
Not: “Amoxicillin 250 mg PO TID.”
Instead: “Amoxicillin 250 mg PO TID for 5 days for UTI.”

Not: “CT scan in 1 week.”
Instead: “CT scan of the lungs at We Care Hospital 1 week after admission to evaluate right lung mass. Call results to Dr. Bill Smith at 212-555-1234.”

Not: “Warfarin for anticoagulation per facility policy.”
Instead: “Warfarin 2 mg PO daily for atrial fibrillation. Adjust warfarin to INR of 2.0 to 3.0. INR the day following skilled nursing facility admission and every other day until seen by SNF clinician.”

And, as with the conversation with Billy, there is an implied consequence. A tightly completed order set with no room for interpretation puts the next site of care on notice that liability for mishandled tasks will rest with the accepting site of care.

Order Set Just a Start

It might be tempting at this point to relax about transitions, consider the problem solved, and believe all that is necessary for a good transition outcome is an excellent order set. Unfortunately, transitions are complex, and even a meticulously crafted order set cannot ensure all the knowledge gaps are closed. However, a number of transition programs have demonstrated they will reduce 30-day readmissions, including the BOOST Program, Project RED, INTERACT, the Care Transitions Intervention, and the Transitional Care Model hospital.

Each program has a package of mutually supporting actions to be accomplished with transitioning patients. For each program, the bundle in its entirety is effective, but no single intervention has proven to be the key, much less the answer, to reduce unnecessary hospital readmissions.

The order set written with your teen-ager recipient in mind will not close all transition gaps. It will not prevent all misunderstandings in care. It will not prevent all harm. Nonetheless, it is a powerful springboard to invoke an antidote for the curse of knowledge. That clear, clean order set from the clinician at the sending site to the care team at the receiving site of care is an integral step in the clinician-to-clinician conversation that defines the gold standard in transitions. It opens the process to determine the level of knowledge the receiving site has about the patient, and then relates the key information that will close the gaps for the new care team.

Identification of items, such as length of antibiotic administration, advance directive wishes, and anticoagulation program guidelines helps enable true patient-centered care.

Chip and Dan Heath did not write “Made to Stick” intending to improve health care. However, the implication for excellence in health care could not be more on point. Experienced clinicians accumulate a gift in their patient interaction. The relationship we achieve with our patients reaches an astonishing level of intimacy. It occurs so effortlessly and so rapidly that we cannot believe that all others involved in the care of a given patient do not have the same depth of knowledge of that person’s wishes, needs, and plan of care. We cannot allow our gift to be a “curse.”

Please (mentally) begin your next order set for a patient transfer with:
Dear Billy ...

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A past AMDA president, Dr. Lett chaired the AMDA workgroup that created the clinical practice guideline “Care Transitions in the Long-Term Care Continuum” and currently is chairman of the AMDA Transitions of Care Committee.

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