Thought Leadership, Ghost Writing

The Need

This physician-led Emergency Room management group is responsible for the delivery of care and quality metrics at several hospitals, across multiple states. With hundreds of physicians and processes, the need for comprehensive education, across multiple channels is key. For this project, the client requested our support in identifying an educational opportunity, organizing the content, and crafting it into a thought leadership piece.

Our Solution

At Jessica Ovadia, we know that communication is only successful if it meets the specific needs of the audience. For this client, with thoughtful organization and creative word choice, we chose story-telling to communicate the company's message.

The first piece, “Bring the Magic to Medicine,” cloaks the company’s philosophy of patient care in the magic of Disney. The second article, “Avoid the Bias,” uses a real-world example of clinical decision making, showcasing the pitfalls to avoid.

The Results

In an otherwise cerebral and tactical industry, the client was able to offer their physicians creative educational content to inspire improved patient care.

Bring the Magic to Medicine

Recently, I returned from a trip to Disney with my family. It had marked my third time at the parks, but this trip was different. My wife and I were thrilled to have brought our three children, son in law, and most importantly, our two grandchildren. Seeing my three-year-old grandson, Sam, greet each experience with awe and excitement certainly left me smiling.

Of course, wherever I go, I'm still a doctor and found myself taking advice from the magic around me - and applying it to my hectic life in the ED.

Here is what I learned:

Each experience is new for our patients

According to Sam, meeting Mickey was the most exciting part of our trip...unforgettable. Sam was expectedly star struck, but what was most surprising was Mickey's reaction. As soon as we approached, Mickey turned to Sam and shared how long he had been waiting to see him. With a hug and shared memories from Mickey Mouse Club House, Mickey made Sam feel like the only kid in the world. As the adult, I knew better. I knew that the moment we left the room, Mickey would turn to the next child in line and engage him, as he did Sam. This cycle would continue throughout the day, and yet, it was Mickey's job to maintain excitement, poise, and dedication with each child that came through his door.

How many chest pain cases come into our ED's each day? 10? 15? Yet, despite this frequency, we must treat each patient with the same dedication we would treat our first. Our patients, many of whom are experiencing these symptoms for the first time, are looking for empathy from us. The circumstances are irrelevant. Whoever the patient, whatever the symptom, we must learn to greet everyone with the same enthusiasm and dedication that Mickey had for Sam.

Setting expectations

At Disney, we spent a lot of time waiting. Not surprisingly, though, Disney figured out a way to make these waits more manageable. First, before entering the park, we downloaded the wait time application. This allowed us to set expectations for the day – at the start. Once we developed our schedule and made our way to ride number one, we were greeted by the wait time sign. Again, here was an opportunity to reset expectations as we prepared for the wait. Interestingly enough, as we approached the end of each line, we were surprised at how fast it had moved. Disney had added time to their wait estimate… under promise and over deliver.

In the ED, we have many opportunities to set expectations. Our patients spend most of their time waiting…waiting to be triaged, waiting to see a doctor, waiting for test results. Certainly, there are many components of our patient's experience we cannot control, however, much of these wait periods are predictable. We must do a better job of setting expectations. When we leave a patient's room and order a test, let's consider how long the typical wait time is, build in time for delays, and share next steps with our patients.

Stay in character; we are providers first

Disney World is quite an operation. Trash cans are never emptied in front of people, spills are cleaned up the moment they occur, and never will you see uniformed character acting out of place. There is a reason that each Disney employee is called a cast member… everyone has an impact on the guest experience. We met Mickey, Donald, Pluto, Buzz Lightyear, and more; Everyone remained in character as long as they were in view. The "magic" Disney offers their customers is not an accident. From the moment they step into costume, every cast member assumes their role completely.

In the ED, we are on stage. We may have outside interests, enjoy socializing with our colleagues and do deserve a break from the hectic moments of our job. However, regardless of all that, in our patient's

eyes, we are providers – offering the medical care they need. As our patients are waiting for test results, anxiously wondering what their diagnosis will be, our focus must remain. In our personal life, and even in the break room, we are people, but at the nurse station or in the hall, we are providers, being watched. Let's work together to keep character and remind our patients they are in good hands.

Safety First

A typical day at Disney is full of potential risks. However, with checks and balances, potential accidents are avoided. I was reminded of this as my children and I waited to ride "Tower of Terror." As our turn approached, a recording above announced the safety rules. Once we got closer, a Disney cast member repeated the same rules. After being secured in our seats, we were reminded to keep our hands inside as the cast member confirmed our belts were locked. A final "thumbs up" signaled we were ready. As the ride began, I felt secure – knowing that Disney was protecting me.

Over the past several years, the provider community has begun to reconsider the cause of medical errors. What used to be "acceptable but unfortunate" has transformed into "never events." Here, at Bob Health, we take this seriously and have even instituted checklists and time outs across our campuses. Studies have shown that the patient handoff consists of a series of risky moments. After a long stay – with care given by nurses, advance practitioners, providers and more, our patients could be at risk when they are discharged or admitted. We know our providers are excellent, however, when stressed, mistakes may occur. We must address documentation errors, duplicate testing, inaccurate reporting, and miscommunication—realistic concerns that exist in all ED's.

Acknowledging these risks, we have launched "Diagnostic Discharge Time-Out." This time out creates a forced pause in the natural discharge momentum – offering an opportunity to reflect on clinical decisions and identify questions. The time out process includes a review of triage

notes, vital signs, test results and diagnosis. These steps help providers ensure the safe delivery of care throughout the patient experience. The “magic” Disney creates is not an accident and in our line of work, patients deserve the same level of dedication. Bob Health aims to deliver excellence in patient care and by joining our team of esteemed providers, you are part of this mission. Together, let’s bring a little Mickey into our ED’s and bring the “magic” to medicine.

Avoiding the Biases

Emergency clinicians are faced with a challenging task. During a busy shift, there can be significant pressure to evaluate and treat patients quickly, without giving each case the care it warrants. Therefore, to deliver care efficiently, physicians often categorize patients early into a specific diagnostic pathway. At some point however, with each evaluation we must pause to assess the individual and ensure we are providing not only efficient care, but effective care as well. Relying on diagnostic categories and past experiences can be useful, however, as I recently learned, it can also lead to careless errors.

"**Cognitive Biases** are tendencies to think in certain ways that can lead to systematic deviations from a standard of rationality or good judgment and are often studied in psychology and behavioral economics." – Wikipedia

Cognitive Bias has become an increasingly popular topic of discussion in medical literature and one we have begun to explore at Bob Health. Recently, this concept became even more relevant for me. I would like to share my story.

A 72-year-old female patient presented to the Emergency Department with abdominal pain. After an initial exam, which included a history and physical, I suspected a kidney stone. Subsequential blood work, urinalysis and a CT Scan were ordered. Blood work was normal, urinalysis did not reveal any signs of infection. As suspected, the CT Scan revealed a 2 ml UVJ stone. The patient was given pain medication and improved. So, following normal protocol, I wrote up the discharge paperwork. As the nurse began the discharge process she noticed the patient had a sudden Tachycardia episode (up to 140). The nurse informed me, and I reassessed the patient. I considered common causes of Tachycardia including infection and pulmonary embolism however, there was no evidence to support those causes. The patient

showed no signs of infection and her blood pressure was normal. The Tachycardia was sinus, so I proceeded to treat her with a small amount of IV beta-blocker thinking that this episode was stress induced. Eventually, her heart rate decreased to 105 due to the beta-blocker, and since she was feeling fine, she requested a discharge. I sent her home with instruction to follow up with a primary care physician and cardiologist.

A few days later, I realized I had made a mistake. It is not my usual practice to give a beta-blocker for an unknown Tachycardia. Her Tachycardia was a symptom of a larger issue and I failed to use it as a clue to uncover the cause. When I called to check on her progress, I learned she had been admitted to the hospital two days after the initial discharge with an infected kidney stone. She ended up in the ICU for 24 hours with bacteremia and hypotension. She recovered and I am very lucky the story ended like this.

“Tachycardia is our friend.”

This is a phrase we have started repeating at our peer review meetings. I know that Tachycardia is a classic sign of infection. But, because previous tests had shown no infection, I dismissed that as an option completely. This was uncharacteristic of me. What happened?

Enter: Cognitive Bias

Our peer review process allows practitioners the opportunity to critique decisions and identify potential clinical errors made. However, to truly avoid future mistakes, we must understand why the errors were made in the first place. I believe, in this case, the answer lies with cognitive bias.

Anchoring – *describes the common human tendency to rely too heavily on the first piece of information offered (the "**anchor**") when making decisions.*

When the patient's urine did not reveal an infection, I dismissed the notion that she could still be at risk for infection. She had a classic presentation of kidney stone and that was my anchor.

Availability – *relying on a past case or situation that was memorable, thus making it available in your mind – despite the differences it may have from the current case.*

As physicians, it is good practice to rely on lessons learned while making clinical decisions. However, we must also identify anomalies. Perhaps, here, I relied too heavily on past cases and failed to treat based on the facts in front of me.

Confirmation – *ignoring contradictory data to make the pieces of the puzzle fit neatly into a presumed picture.*

When I treat patients, I like the symptoms to “line up” – to make sense. In this case, Tachycardia didn't fit neatly into the mental box I had built and so - rather than address it as a symptom of a larger issue - I tried to explain it away.

Momentum – *This can be in the form of diagnosis or discharge momentum. Diagnosis momentum is accepting a previous diagnosis without sufficient skepticism. This can lead to discharge momentum when a clinician is likely to continue discharging the patient – despite conflicting information becoming available.*

Once I had evaluated the patient and confirmed my diagnosis, I didn't deviate from my plan. I had begun the discharge procedure and began treating new patients. In retrospect, admitting her to observation may have been the better choice.

So, now that we know what some common cognitive biases are, how can we avoid falling victim to them in the future? What can we do to ensure our patients remain safe?

In our line of work, it can be challenging to find a few minutes to regroup. However, it is incredibly important to break the momentum – and consider our patient's specific story – and that is the reasoning behind the Discharge Time Out. It was created to give our busy practitioners the opportunity and permission to take a step back, review the chief complaints and reevaluate the differential diagnosis. Other methods include one minute in the break room to physically step away from the monotonous routine, listing the biases we've reviewed as a reminder to combat them, and considering the observation unit as a tool to gather more information before deciding to discharge or admit.

What are some other ways we can challenge ourselves to avoid these pitfalls? Let's hold each other accountable to not only offer efficient care but effective care as well!