BACKGROUND: Complexity, duress & uncertainty confront LTCPs admitting patients to the SNF. Patients & families (PFs) may have low expectations of quality of care & lack of trust. These conditions make errors more likely.

PURPOSE OF ARTICLE: Explore the causes of cognitive errors during this transition. Discuss 5 cognitive principles as root causes & 6 contextual factors underlying these errors. Describe methods of gaining trust with PF’s.

PSYCHOPHYSICS: The study of the relationship between the physical value and the psychological value of a relationship.

UTILITY THEORY: Reasonable people give maximal weight to the physical value of any choice (e.g. EBM) with little or no consideration to the psychological value of that choice (e.g. avoiding conflict with PFs regarding a change in plan on admission to a SNF → should Diazepam be continued). Dominated the study of decision-making before 1979.

PROSPECT THEORY: Reasonable people are frequently & predictably influenced by the psychological value of choice. Early application in medicine: physician prescribing practices based on marketing of drug reps.

FRAMING AFFECT: Alternative descriptions of an identical treatment elicit different preferences among patients.

NOCEO EFFECT: an undesirable effect induced by unreasonably pessimistic expectations

TRANSITION RULE: Irrational beliefs make humans poorly able to predict adaptation to achieve future happiness. Irrational beliefs usually abate within months if we do nothing to make matters worse.

TWO SYSTEMS OF THINKING (Cognitive Psychology): System 1 and System 2

SYSTEM 1: works rapidly & below the level of awareness. Considered “lazy & reckless,” preferring to consider information it readily understands while ignoring the rest that requires more effort

SYSTEM 2: Monitors System 1, scans results & looks for cues that it should override System 1. System 2 is methodical but tires quickly & is easily distracted.

Example: PF’s enter the NH as a decision of last resort, expecting poor care based on the way SNF’s are presented in the media (System 1). A discussion of EBM will fail to engage System 2 unless LTCPs demonstrate caring & trust.

FIVE COGNITIVE PRINCIPLES THAT IMPACT TREATMENT DECISIONS:

SOCIAL INFLUENCE: making decisions that differ from opinion leaders can lead to feelings of insecurity

POWER DISTANCE INDEX: The lower the number, the higher the predisposition to speak up to those of higher rank
THE BYSTANDER EFFECT: caring observers become progressively more reluctant to provide assistance to a person in distress as the number of persons in attendance increases: possibly due to performance anxiety, diffusion of accountability or an error of inference that if something should have been done it would have been done by somebody else.

THE TREADMILL EFFECT: humans adapt to new circumstances (e.g. in the SNF LTCPs quickly adapt to a lowered standard of excellence when suboptimal care is widely tolerated (results in clinical inertia & undertreatment)

THE FUNDAMENTAL ATTRIBUTION ERROR: THE FATAL FLAW OF JUDGMENT BY PROTOTYPE: System 1 overvalues personality-based or physical characteristics of the PF while avoiding the harder work of analyzing situational factors that could explain the observed characteristics of the PF (snap decisions & thin slicing)

CONTEXTUAL FACTORS: similarity between dysfunctional communication among cabin crews involved in air disasters & dysfunctional initial family meetings at the SNF.

UNCERTAINTY: absence of credible evidence regarding the utility of EBM in elderly outliers

TIME CONSTRAINTS: driver of mental effort & mental fatigue

UNFAMILIARITY: why PFs/LTCPs would be inclined to select an inferior option suggested by a familiar physician over a superior option suggested by an unfamiliar one

MISTRUST: adds stress to the process of decision making

FATIGUE: contributes to medical error

MISSING CLINICAL INFORMATION: endemic to transfers from the hospital to the SNF

METACOGNITION: Thinking about thinking.

REFLECTIVE PRACTICE: thinking about decisions made in the more distant past. Triggered by a cue to System 2 to wonder whether he has made an error in the management of a patient.

MENTAL EFFORT: complexity of tasks; time constraints & switching back & forth among tasks (e.g. reviewing complex medical records & orders while deciding whether orders match the PFs needs or goals while answering multiple phone calls/pages, switching back & forth among activities racing to get to the next task)

"Experienced LTC physicians cannot rely on heightened vigilance to resist System 1’s bad advice. They will require a programmed method of automatically overriding System 1’s preference for the path of least resistance."

PART OF THE SOLUTION:

1) WINNING THE TRUST OF THE PF;
2) MANDATORY FEEDBACK FROM THE IDT TO THE PHYSICIAN