

# Thinking Out Loud... Contagious Ideas

*“Why is it that some ideas or behaviors or products start [social] epidemics and others don’t? And what can we do to deliberately start and control positive epidemics of our own?”*

—from *The Tipping Point - How Little Things Can Make a Big Difference*, by Malcolm Gladwell<sup>1</sup>

**Elizabeth A. Evans**

*Elizabeth Evans is CEO of Health Informatics, Inc., Richmond, Virginia, the parent company of AMI Healthcare Systems Group, which has been providing clinical and financial software solutions for dialysis facilities and physician practices since 1981, and of HMG, which provides outsourced billing capabilities to dialysis facilities, physician practices, and emergency rooms.*

---

There is a book that business colleagues recommended to me over a year ago that I just read last week. I wish I had read it sooner. The name of the book is *The Tipping Point - How Little Things Can Make a Big Difference*.

What does “Tipping Point” mean? It means that change comes dramatically, not gradually as would be expected. The Tipping Point is essentially that one instant in time when everything can change all at once. It’s almost as if an invisible hand puts a brake on what’s happening and steers the course it wants. Although the Tipping Point has three characteristics—first, contagiousness, second, relationship to small things that bring big changes, and third, absence of gradual change—it is the third characteristic that imbues the other two with meaning.

Gladwell passionately supports his Tipping Point thesis with facts and studies that cut across the disciplines of epidemiology, anthropology, psychology, and criminology. Sound tedious? Amazingly, *The Tipping Point* is an entertaining book. It is also one of the most thought-provoking and compelling books I’ve read in a long time. I still find myself

mulling over its ideas and discussing them with colleagues. When taken to its logical conclusion, the Tipping Point theory can explain fashion trends, crime waves, fads, best-sellers, teenage smoking, human behavior, and the use of information technology to care for patients.

The Tipping Point may provide insight into some of your own musings. For example, have you ever wondered why some of your colleagues become involved in a situation and others don’t, why some remain bystanders and others do not? Have you rationalized the reasons why excellent clinical practices seem to consistently take place in one of your facilities and not in another, almost as if no one is in charge and nobody cares? Gladwell highlights the *bystander problem* and the *broken glass theory*, respectively, to explain these social phenomena.

## **The Bystander Problem**

A particular incident within the book caught my attention because it not only occurred in the city where I was living, but because I am a native of that city, having been born and bred there. The incident was the stabbing death of Kitty Genovese in 1964.

At the time the event took place, murders were almost a daily event in the New York City environs of which Brooklyn is a part, though they were almost unknown in our neighborhood. What was so unusual about this particular murder is that Kitty Genovese was chased and attacked three times by her assailant for half an hour while 38 witnesses watched... without one of them calling the police for help. How could this happen? Were New Yorkers (and I, by default) so desensitized by city living that we had lost our humanity? Our neighbors seemed friendly and caring. We believed ourselves to be the same. Surely we would have responded differently. But how could we really know unless faced with the same situation?

To make sense of what occurred, Gladwell cites a study conducted by two psychologists, Bibb Latane of Columbia University and John Darley of New York University. To understand what they referred to as the “bystander problem,”<sup>2</sup> they staged emergencies to uncover the kind of circumstances that engendered intervention by the witnesses. What they found was that the overriding circumstance that determine

whether a witness intervened was the number of individuals who witnessed the event. If an individual believes there is only one witness, that person will intervene 85% of the time. When, however, an individual believes there are four others also witnessing the event, that person will intervene only 31% of the time. In other words, the higher the number of witnesses, the lower the intervention rate. Latane's and Darley's conclusion was that none of the 38 witnesses to the Genovese murder called the police because there were 38 witnesses. The *power of context* ruled their behavior, as it most likely does ours.

### **Broken Windows Theory**

To illustrate the point that the minor quality-of-life details are the Tipping Points for behavioral change, Gladwell directs our attention to the "broken windows theory."<sup>3</sup> The broken windows theory is the creation of two criminologists, James Q. Wilson and George Kelling, who postulate that disorder is the cause of violent crime; hence, their use of the broken window to symbolize its reality.

As mentioned before, my birth city is Brooklyn, New York. At the time the Genovese murder took place, Brooklyn was known for its shallow neighborhoods—that is, there were a few blocks of pristine, carefully cared for homes and apartment buildings, followed by a few blocks of neighborhoods marred by graffiti and broken windows, followed by a pristine neighborhood, and so on. This always baffled me. After reading the broken windows theory and peering into the past, recalling those who inhabited both environments, it became clearer.

The broken windows theory speculates that when someone sees a broken window, they assume that it is left unrepaired because no one cares and no one is in charge. As a result, other windows will be bro-

ken and disorderliness will spread. This is what eventually happened in Brooklyn. In a sense, the environment caused the disorderliness.

### **Tipping Points in Renal Care**

What relevance does the bystander problem and broken windows theory have for us within the renal community? For starters, consider the Dialysis Outcomes Quality Initiative (DOQI). When the DOQI guidelines were introduced, concern emerged about their becoming the standard of care rather than becoming an agreed-upon jumping-off point in search of excellence—that is, the creator of context for the quality-of-life details to take seed. "Band-Aid solution" became a pejorative catchphrase of their detractors. Many advocates, however, thought of them as a laser-focused starting point to inject discipline into renal care rather than as a standard for substandard care. The questions are: "Were they an attempt to fix a broken pane of care? Was the intended result to eliminate bystandering?"

When I began my tenure as a project leader with our company, Health Informatics Inc. (at the time known as AMI Healthcare Systems Group), I quickly learned that each dialysis facility had its own way of providing scientific services to its patients. At the time this seemed curious. Looking back on that experience and then forward to today, perhaps the DOQI guidelines will be seen as a Tipping Point in nephrology.

In a similar way, perhaps the electronic "continuous care record" (CCR)—under joint construction by the American Society for Testing and Materials (ASTM) International, the Healthcare Information and Management Systems Society (HIMSS), and the Massachusetts Medical Society—will become a Tipping Point in medical informatics. Encompassing the patient's demographic information, allergies, medication list, a summary of care provided, and a short-term

care plan with recommendations for the next step in care, the CCR is intended to be created and updated at the end of (not *during*) each encounter so that the next provider has the necessary medical information for treating the patient wherever the next treatment takes place.

While not a full-blown electronic medical record (among other things, test results are absent), should we look at the CCR as a cave-in reaction or as a laser-focused Band-Aid that has the potential to unleash the power of context, thus becoming the Tipping Point in medical informatics?

### **A Call to Arms**

You have read many times in this journal my deep-seated belief that the practice of medicine is becoming the practice of information. Our responsibility as workers in the renal community may be to push the technology envelope so that information gaps in care become a thing of the past and educated guessing is obsolete because we have succeeded in integrating complete, up-to-date clinical data into the process of patient care wherever it takes place.

Will the CCR fix a broken window of care so that those caregivers, who have their noses pressed against the electronic medical record window-pane, can stop being bystanders and start actively enjoying the benefits of real-time, information-rich electronic patient care? The answer may be irrelevant in the future when the scenes are played out. For today, we must keep the momentum going forward, keep connecting the electronic healthcare dots, so that the power of the electronic medical record overtakes us all and assumes the *power of context*. When we do, we stop being bystanders and become Tipping Points.

### **References**

1. *The Tipping Point - How Little Things Can Make a Big Difference*, by Malcolm