In this op-ed, Greg Wright, MD, discusses the importance of achieving continuity of care at Children's.

Hobgoblins

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A foolish consistency is the hobgoblin of little minds… To be great is to be misunderstood." (Emerson) (To be fair, the entire quotation is a bit more nuanced; Google it.)

The test of a first-rate intelligence is the ability to hold two opposed ideas in mind at the same time and still retain the ability to function. (Fitzgerald)

In response to these two esteemed American authors, I quote an even more highly regarded Englishman: *Bah, humbug!* (Dickens)

Since my arrival at Children's in 1986, and, Dr. Kibort tells me, even since the ancient 1970's, we've had a persistent problem, although I am sure Children's is far from unique. We endanger safety, damage trust, and adversely influence family satisfaction due to a lack of consistency. A few scenarios (if you recognize yourself, keep reading):

1) A long term neonate is failing to feed adequately. The neonatologist most familiar with the child discusses options with a pediatric surgeon, and over a weekend they agree that a gastrostomy and a Broviac line would be the best option, given the uncertainty of intestinal function. The parents, communicating through an interpreter, reluctantly consent. During the week, a new attending surgeon indicates (s)he will put in the gastrostomy, but the central line is unnecessary. After the procedure the child's enteral feedings continue to fail, and a few days later the neonatologists find themselves returning to the already distrustful, and now angry, family to explain the need for a second trip to the OR in order to place a Broviac for TPN.

2) A child with failure to thrive is admitted 6 times over a few months for evaluation. In a retrospective review, the child's primary physician indicates that (s)he may want to keep the child on an inpatient feeding regimen for 3-4 more days, but the new hospitalist attending may decide the child should go home sooner. Another admission ensues when the child continues to fail to gain weight at home.

3) A consultant tells a child and family that the child's condition appears to be improving, but before discharge the next day, the consultant will re-evaluate one more time. The next morning, the hospitalist writes discharge orders. A different consultant from the same service but unknown to the family stops by to provide discharge information a little different than what the family thought they had heard from the original

consultant. A few days later, the child is readmitted, probably unavoidably, but the family expresses anger and frustration that "their"

consultant did not re-evaluate the child before the previous discharge and a new consultant gave them seemingly different instructions. They do not want to pay any of the costs of readmission.

And so on… The common thread in these and many scenarios is the failure of the care teams to maintain consistency, to stick with the plan. Of course, circumstances may dictate changes in plans, but often plans appear to depend less on the clinical course and more on the personal preferences or opinions of an attending physician or consultant. Optimally, these changes should be discussed with those most familiar with the patient and with those who formulated the original plan. Families should be included in discussions involving a change in direction, if only to maintain their understanding and, therefore, their trust. The tendency for some hospital courses to lurch in one direction and then another generally reflects a failure of adequate communication among the consultants, attending, nurses, and other involved personnel. Given that 60-70% of serious harm events in hospitals involve breakdowns in communication, our cultural lack of consistency and careful team-wide communication creates greater risk that we endanger our patients and make families unhappy with and distrustful of Children's .

So what can be done? We already have examples and pockets of success at Children's: scripted handoffs, which can be not only for shift changes but for transitions from one consultant to another; protocols, such as the ECMO protocols which elevated our results from average to world class as everyone began to manage complex ECMO patients in a standardized way; creation of "primary" intensivists or hospitalists for long term or frequently admitted patients, so that one person filters the entirety of a child's course. We know how to do this.

Whatever your clinical position, you can develop plans to improve the consistency of care for patients (substitute "communication between and within services" for "consistency", if you prefer). Give it some thought. We could use a few more hobgoblins around Children's.