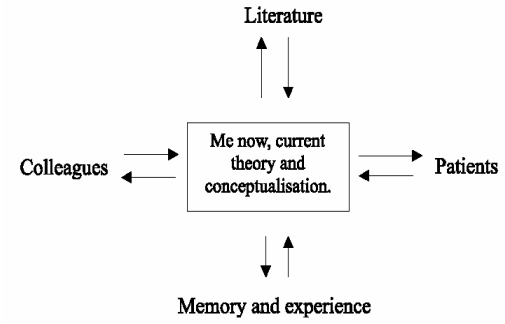
‘Knowledge Management’ for Health

- Framework and tools: First look
- Background
- Action in social and educational context
- Cognitive dissonance and schemata
- Tools for learning
- Overcoming barriers
- Articles



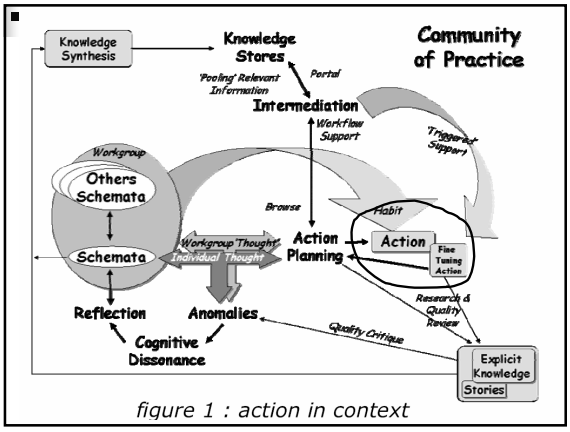
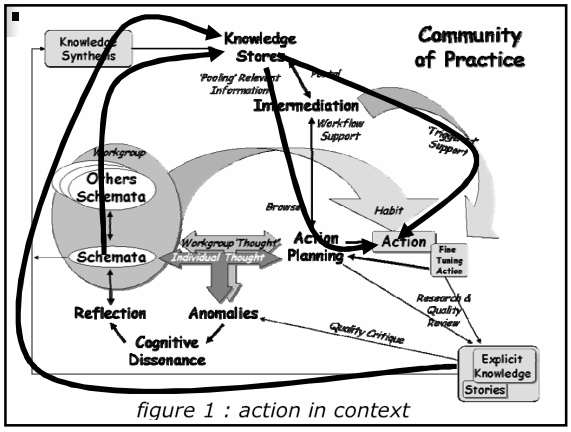


figure 1 : action in context



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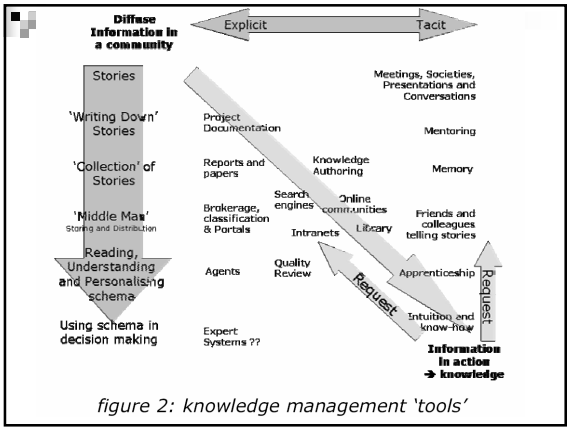


figure 2: knowledge management ‘tools’

- “knowledge cannot be managed”, but “technical, human and organizational ‘tools’” can help learning

Main problem

- Current Knowledge Management solutions not in tune with
  - Complexity of encounter
  - Habits of experts
  - Narrative structures
- At the same time, individuals can't keep up with the rate of new knowledge and need tools to help them

Emergent understanding I

- Evaluation methods too simple to capture complexity
- Research-Practice Gap
  - Dissemination of knowledge not perfect
  - Resistance or rejection by practitioners
  - Mismatch (cognitive and value):
    Research results VS Experience, intuition

Emergent understanding II

- Decision making – what sort?
  - Clinicians rely own experience (too much)
  - When using research based knowledge, they should still not disregard their intuition
- Complexity theory (about emergent characteristics) – the thing is more than the sum of its parts
- Habits: Most skilled actions are automatic.

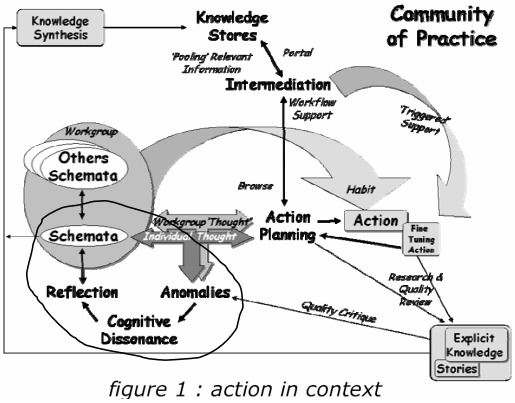
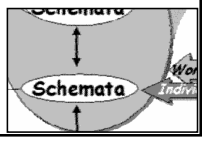


figure 1 : action in context

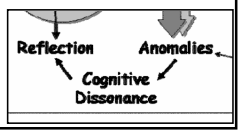
Schemata

- Organised knowledge about the world centred around past situations [2] (this is only one of several different knowledge models in memory, learning and teaching theory)
  - Person schema: How is he/she
  - Event schema: How I should act in this situation
  - Role schema: How will others act



Cognitive dissonance

- Cognitive dissonance: A difference between
  - what we've experienced before, and
  - new information.
- We either
  - dismiss it as unimportant or untrue, or
  - adjust our mental schemas



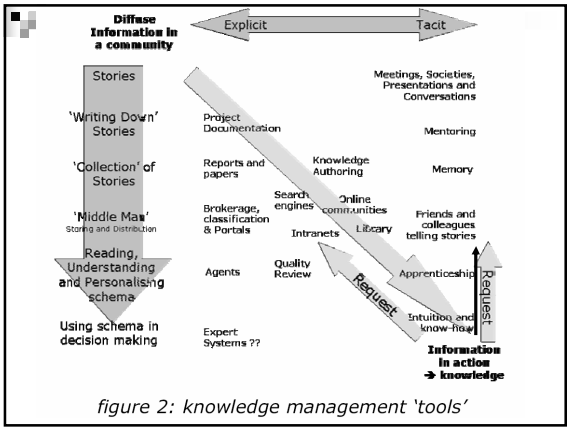
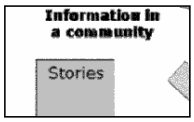


figure 2: knowledge management 'tools'

Stories

- General stories should be provided to let physicians compare their own patients to the general cases
  - during the patient encounter
  - after the fact, to learn outside the encounter, when dissonance feelings do not affect the patient



Overcoming barriers for formal knowledge

- Getting the rational, research-based information into the consultation. Records used as after-the-fact rationale.
  - Solution: Dynamic user interfaces. Guiding the process without hampering it.
- Contribute without the physician asking a question?
  - Solution: Close integration with the record.

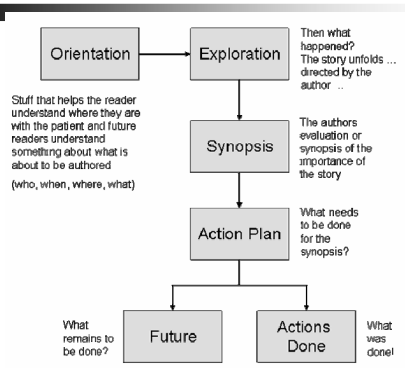


figure 3: the clinical process

The case for the narrative

"the EHR should carry narrative"

- They argue that we shouldn't pick apart the chronology, remove the narrative and loose the time dimension

Articles

- Pensum: [1]: I. Purves, P. Robinson: *Knowledge management for health: what 'tools' can improve the performance of workgroups, clinicians and patients? (peker til rapport lik Medinfo-paper)* Medinfo. 2004;2004:678-82

▪Ikke pensum: [2]: Robinson P, Purves I. Learning support for the consultation: information support and decision support should be placed in an educational framework. *Medical Education.* 2003; **37**: 429-433.