Hierarchies: the Berlin Wall of patient safety

M M Walton

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Hierarchies and patient safety

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Hierarchies: the Berlin Wall of patient safety

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To maximise patient safety considerations the medical hierarchy needs to be balanced in favour of teaching and learning rather than the exercise of power

Reporting and preventing adverse events is the theme in two papers in this issue. In their commentary, Murff and Dittus[1] suggest that nurses and pharmacists could report medication errors and equipment failures during clinical research, and Seiden et al[2] identify a role for medical students in recognising and preventing errors during their clinical attachments.

While I agree with their recommendations for improved reporting, enhanced communication and acting ethically, I remain sceptical that change will occur without significant examination and understanding of the role of hierarchies in our healthcare system.

UNDERSTANDING WHERE WE HAVE COME FROM

The word "hierarchy", first found in 1380 in the Oxford English Dictionary, referred to priests in relation to God. Today the term has broader application and refers to a group of individuals ranked according to authority, capacity, or position. At the turn of the 20th century hospitals were organised into hierarchical structures with the medical hierarchy at the pinnacle.[3] Typically, this involved ever increasing power with each rank subject to the authority of the next level up. This arrangement has endured despite increased complexity and costs and significant changes in technology. Hospital patient populations, clinical pathways, and workforce have radically changed over the last three decades, yet the organisational structure for doctors remains substantially unchanged since the 19th century.[4] New areas (specialties and subspecialties) have been accommodated by adding to existing structures, creating departments and hierarchies often without reference to the needs of patients.

Nineteenth century medical apprentices were legally bound to their surgeon (master) for 7 years, during which time they worked as a servant in return for the acquisition of skills to enable them to practice.[5] Surgeons had no more than two apprentices at any one time, thus allowing them an intimate knowledge of their trainees. Today interns, residents, and registrars work with many health professionals and seniors on a day to day basis and are required to understand and implement instructions from doctors above them. Registrars work for five or more consultants. They are expected to follow the usually unwritten rules of each of their "bosses" and to take instructions. This results in inadequate communication, fragmented supervision, inadequate instructions, and more frequent suboptimal patient outcomes.[6]

The medical hierarchy, a natural derivative of the apprenticeship model, is today best characterised by the power relationship between a superior and a subordinate rather than the relationship between teacher and learner. The good ingredients of the apprenticeship model—mentoring, coordination, and constant observation—only survive in temporary situations such as a teaching session between a clinician and trainee. Instead, what has survived is the unhealthy obsequiousness shown by a substantial portion of health professionals, medical students, and junior doctors to senior clinicians.

HOW THIS IMPACTS ON CAREER PROGRESSION

Medical students, interns, and residents are low in the hospital and medical hierarchies and remain dependent upon clinical supervisors for their instructions and learning. Their progress up the hierarchy depends on favourable reports from supervisors about their competence, performance, and professional development. Maintaining a good relationship with those higher up the ladder understandably becomes a prime focus, often at the expense of other priorities such as reporting on errors or on poor patient care. Calling attention to a supervisor's mistakes or potential mistakes may have repercussions for the junior. Medical students, interns, residents and registrars tell me about their fears (real or imagined) that disclosing mistakes—even reminding a senior about a protocol—may lead to an unfavourable report, decreased employment opportunity, reduced chance of access to training programs, or all three.

The unequal power relationship means that novices will be silent when they should speak up. This is not because we are training unethical or bad doctors. They do what they do because they have no option. Raising a potential problem or error with a senior or contradicting their decisions becomes still more problematical if the clinician practices in the area of medicine which interests the junior.

COMMENTARIES

SENIOR MEMBERS OF THE HIERARCHY RARELY REPORT OR TALK ABOUT ERROR

In addition to career fears, junior doctors say they rarely see their seniors report or act on errors—their own or those of others.[7] One explanation for this may be that many clinicians are still not familiar with patient safety concepts and do not have the knowledge and skills to practise safety principles. Perceived medicolegal fears and unwarranted administrative intrusions into practice also inhibit error acknowledgement.[8] But notwithstanding many of the cultural barriers, some clinicians are using innovative teaching methods designed to encourage individual assertiveness. One clinician I know conducts assertiveness training of the ward staff by intentionally making a prescribing or treatment error and expecting the medical and nursing staff to speak up when he does so. He tells them before the round that he will be deliberately making an error, and that during the round members of the team are to speak up to avoid him acting on the error.

THE VOID IN UNDERSTANDING ERRORS

Although a widely used and popular way of learning is the use of narrative, it is not the best way to learn about errors. The common use of the words ''stuff up'' or ''screw up'' to describe an adverse event suggests a lack of knowledge about errors and reinforces the personal circumstances and impact of mistakes instead of a multifactorial analysis. Narrative experiences are not easily translated into professional discourse unless clinicians practise what they teach.

During the preparation of a patient case presentation to a medical ward meeting by a team of medical, nursing, physiotherapy and occupational therapy students participating in an interprofessional learning project, the students told me the patient had an adverse event from a wrong medication order. As a result the patient had been transferred to ICU for a few days before returning to the ward. They wanted to know whether they should include this in their presentation. The medication error was a reportable incident but, until the medical student discussed it with the nurse unit manager, no report had been done and no discussion had taken place with the ward team. The students presented the case including the information about the medication error to the ward team which, on this occasion, included the doctors. They used neutral language focusing on what happened and how the patient was treated. They focused on the patient and made no reference to ''who'' was involved in the incident. It was obvious that the staff were not used to such a comprehensive case discussion. I explained to the students during the debriefing that the language for discussing and learning from errors is still underdeveloped, with many health professionals unable to shift from the ''who did it'' to ''what happened''. I congratulated them on their presentation.

CONCLUSION

Murff and Dittus[1] and Seiden et al[2] emphasise that adverse events in research and clinical care can be minimised when health providers (pharmacists, nurses and medical students) identify and report errors and potential problems. This will only happen when the positive attributes of the medical hierarchy govern—such as leadership, promotion of shared team responsibilities, and respect for all members of the healthcare team. From a patient's perspective, why shouldn't everyone caring for them play such a role? We need to change the framework for thinking about patient safety: to move away from the ''discipline'' hierarchy approach to a patient centred one in which the competencies for patient safety are designed for everyone depending on their level of responsibility for patient care. The authors identified two key patient safety activities—namely, the need for appropriate assertiveness and honest and timely reporting. These are important competencies. Everyone—receptionists, cleaners, students, health professionals working under supervision, supervisors and managers—should be able to demonstrate them. A ''whole of system'' approach focuses on personal and team responsibilities, not hierarchies. When the hierarchy is balanced in favour of teaching and learning rather than the exercise of power, everyone will become a resource.

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