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Review

Challenging hierarchy in healthcare teams – ways to flatten gradients to improve teamwork and patient care

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Abstract

In healthcare, mistakes that are potentially harmful or fatal to patients are often the result of poor communication between members of a team. This is particularly important in high-risk areas such as operating theatres or during any intervention, and the ability to challenge colleagues who are in authority when something does not seem right or is clearly wrong, is crucial. Colleagues in oral and maxillofacial surgery recognised the importance of this as early as 2004, and it is now well known that failure or reluctance to challenge others who might be wrong can severely compromise a patient's safety. The Royal College of Surgeons of Edinburgh runs popular regular courses (Non-technical Skills for Surgeons, NOTSS) that teach how to ensure safety through good communication and teamwork. In this paper we introduce the concept of hierarchical challenge, and discuss models and approaches to address situations when problems arise within a team.
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Introduction to hierarchy in medicine

In the past, medicine, and surgery in particular, were seen predominantly as male-dominated professions, and they often attracted people with strong personalities, courage, and high levels of expertise. These times have thankfully been confined to history, but some negative aspects of medical practice, such as a lack of candour or lack of insight into one's own attitudes and behaviour, can still have a damaging effect on our workplace culture.

There is a potential risk of unintentional harm in 3%–16% of inpatients[1,2] as a result of human error and other factors such as organisational complexity, lack of systematic communication, poor teamwork, and a reliance on highly technical equipment.[3,4] The operating theatre can be a stressful place and is one of the main areas where this can happen.[5,6] The Kennedy inquiry into cardiac surgery at the Bristol Royal Infirmary, UK, in 2001[7] showed that some clinicians lacked insight, and their behaviour was perceived as being flawed. The report concluded that a few colleagues had too much control, and this had resulted in an imbalance of power and a steep hierarchical gradient.[7]

Another example is the well-known Elaine Bromiley case, in which a healthy woman died from hypoxic brain injury after attempts to intubate by two anaesthetists had failed during a routine elective ear, nose, and throat (ENT) operation.[8] Two of the nurses involved subsequently reported that they had known what should have been done but had not asserted themselves because of the hierarchy in the operating theatre. Instead, they had used passive and indirect statements,

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which had had no effect during the crisis. A steep hierarchical gradient, whether perceived or real, can also be linked to other issues in the workplace, and one study found that 38% (421/1100) of staff had been bullied.[9]

A flat hierarchical gradient at a senior level can also cause problems. In this situation, the team leader lacks self-confidence, is constantly unsure, and usually relies on the rest of the team to make decisions. These individuals are poor leaders and role models. In the armed forces, leadership skills are taught at an early stage, as they are vital in battle. In hospitals, a rapid change in gradient is sometimes needed – for example, when an inexperienced surgical trainee causes a major haemorrhage and is unable to deal with it, and the senior clinician must rapidly take control. Debriefing after such an event is an invaluable part of a trainee's education.

Hierarchical gradients in aviation

During the 1970s and 80s several serious aircraft accidents resulted from the failure of the co-pilot to challenge the incorrect and dangerous decisions of the captain.[10] Airlines quickly realised that human factors were an important feature in these accidents, and they rapidly identified and adopted remedial measures to allow crew to challenge each other about anything that could compromise safety, without fear of retribution.

This changed the culture in aviation, and the use of Crew Resource Management (CRM) training programmes, which included communication, situational awareness, problem-solving, teamwork, and decision-making, levelled out the hierarchical gradient between the captain and co-pilot on the flight deck (Fig. 1). Instruction was based on case studies of fatal accidents with video reconstruction, and it concentrated particularly on situations when the co-pilot did not speak up despite realising that something was seriously wrong. Senior pilots were concerned about cultural change and were reluctant to admit to making mistakes, but gradually it has become more acceptable for co-pilots to speak up. Today, captains can be disciplined if they fail to listen to, or act upon, a concern of the co-pilot, irrespective of seniority or experience. The CRM programme has created a strong safety culture, an awareness of human error, and the need for reliability.[10] The principles involved are increasingly being used in healthcare.

Fig. 1. A gentle hierarchical gradient on the flight deck of an Airbus A320. This practice should be commonplace in healthcare as well as in aviation.

Following rules and regulations

In addition to these training programmes, standard operating procedures (SOPs) were introduced in aviation, and simulation was developed to improve teamwork and further facilitate a gentler hierarchical gradient (rather than the historical model in which the "captain knows everything and is always right").

Flight decks are now fitted with voice recorders, and despite some early opposition, airlines adopted SOPs from which any deviation requires detailed justification. An example of such a procedure in healthcare is the WHO preoperative checklist.[11]

In many organisations, particularly in aviation, high-fidelity simulation is used for training in teamwork.[10] This can also benefit medical teams, as it allows them to rehearse and practice events that rarely occur. In any simulation it is important is to remain aware of what is happening around you, as loss of "situational awareness" has a considerable impact on the clinical environment and can potentially affect a patient's safety.[8]

Hierarchy in healthcare

Human error is as old as humanity itself and we all make mistakes, but errors can often be prevented. The publication in 2000 of *To err is human: building a safer health system* was instrumental in improving the recognition of human error on both sides of the Atlantic,[3] but there is still much more to do. It reported that up to 98 000 deaths/year in US hospitals were caused by human error, and many were related to problems within a team. Better teamwork can prevent error, or at least minimise risk, and is therefore crucial if we are to improve patient care.

Many factors can affect a person's position within the hierarchy of a team. These include the medical or surgical specialty, sex, personality (introvert or extrovert, passive or aggressive), and education outside of the country of practice. They also include increased responsibility, the hierarchy within and between professions, and professionalism. A study from Denmark[12] described how a flat hierarchical gradient between medical and nursing staff enabled effective communication and better patient care. Unfortunately, in some healthcare systems, nurses can be seen as subservient to clinicians, and this creates a potentially steep hierarchical gradient between them. Regular use of the simple expression "there is no I in team" quickly focuses attention on the importance of good teamwork and one's own role within it.

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