Social Science & Medicine 71 (2010) 1683–1686

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Short report

Overcoming gendered and professional hierarchies in order to facilitate escalation of care in emergency situations: The role of standardised communication protocols

Nicola Mackintosh*, Jane Sandall

NIHR King's Patient Safety and Service Quality Research Centre, King's College London, London, WC2R 1HH, United Kingdom

ARTICLE INFO

Article history:
Available online 26 August 2010

Keywords:
Standardised communication protocol
Boundary object
Division of labour
Interprofessional working
Failure to rescue
UK
Cardiac arrest
Power
Nurses

ABSTRACT

It has been suggested that as many as 23,000 in-hospital cardiac arrests in the UK could be prevented with earlier detection and intervention (Hodgetts et al., 2002). Cases of 'failure to rescue' are often linked with difficulties relaying and interpreting information across occupational and professional boundaries. Standardised communication protocols have been recommended as a means of enabling the transmission of concise, salient information, licensing and empowering the individual to overcome established hierarchies in speaking out and asking for help. This paper critically examines the current discourse around such protocols. We find that there is a paucity of evidence regarding the complex relationship between social contexts, individual applications of these protocols and short- and long-term impact on safety and 'failure to rescue' rates. The paper highlights the complexities of the underlying power dynamics that are located within gendered and occupational hierarchies and explores the role of standardised communication protocols as a potential boundary object. The paper discusses the potential for these protocols to inter-relate and act as a mediating boundary object between nursing and medical staff, enabling understanding and sharing of cultural context.

Introduction

UK patient safety policy documents acknowledge that managing escalation of care at a professional and organisational level is a key issue in distributed care systems (NCEPOD, 2005; NICE, 2007). Changes in physiological vital signs (notably respiration, pulse, blood pressure, oxygenation, and mental function) often occur in the period six to 24 h before patients clinically deteriorate on general wards (Hillman et al., 2002). However, these changes in clinical signs are often 'missed, misinterpreted or mismanaged' (McQuillan et al., 1998; Hodgetts et al., 2002) resulting in the concept 'failure to rescue' (FTR). Delays in treatment or deficient care of these patients can result in unanticipated admissions to intensive care units (ICU). These unanticipated admissions are twice as likely to develop cardiac arrest and are associated with an increased ICU and hospital mortality (McGloin, Adam, & Singer, 1999; McQuillan et al., 1998).

UK policy response to FTR has been to focus on individuals' knowledge, attitudes and skills (e.g. improving recording of observations, skills of recognition and patterns of communication). A recurring theme noted amongst FTR cases is inter and intra-professional difficulties in speaking out and asking for help; this has been linked with power relations underpinning medical discourse (Allen, 2004). Currently, a nurse alerted to a patient whose condition is rapidly deteriorating will refer the patient to a junior doctor who in turn may then need to call for help from a medical superior thus increasing delay. The contribution of occupational and hierarchical boundaries, a culture of secrecy, fear and autocratic leadership to failure to articulate and listen to concerns has been documented (Healthcare Commission, 2007; National Patient Safety Agency, 2007).

In this paper we examine the social development and utilisation of these communication protocols. We conceptualise their potential role in overcoming gendered and professional hierarchies. We suggest that the standardised communication protocol could be considered as a 'boundary object', structuring relations between nursing and medical staff. We examine this construct and aim to generate new insights into the potential for standardised narratives to maintain coherence across intersecting social worlds.

The problem – gendered and professional hierarchies

Relations at work in healthcare settings intersect at the crossroad of gender, profession and hierarchy (Davies, 2003). Unequal relationships exist in healthcare work, the everyday practice of 'doing dominance and doing deference have been part and parcel of how nursing and medicine were historically constructed in relation

* Corresponding author. Tel.: +44 (0)20 7848 7153.
E-mail address: nicola.mackintosh@kcl.ac.uk (N. Mackintosh).

0277-9536/$ – see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.socscimed.2010.07.037

to one another' (Davies, 2003, p. 728). A problem long recognised within sociological understandings of patient safety is that those in subordinate positions are often 'repositories of critical information', yet unable to persuade those in more senior positions in the organisation of either 'the credibility of their knowledge or relevance of their perspectives' (Silbey, 2009, p. 361). Nurses' relationship with patients puts them in a relative position of strength in relation to the doctor who may be unaware of any changes in the patient's condition (Svensson, 1996) Yet nurses are confined within existing relations of power and knowledge that position them as persons whose concerns need *not* be taken seriously (Ceci, 2004). Underlying gendered ideologies have been found to fashion medical responses to nurses' means of raising the alarm (Porter, 1992). Public display of anxiety and concern for the patient may be perceived as 'over reactive' and dismissed accordingly on account of underpinning masculinist ideals which value rationality, objectivity and self control (Davies, 1995). Whilst nurses lay claim to jurisdiction over activities they are routinely expected to do, such as take observations, assess the patient and report back any concerns, their claims on the interpretations of their findings are pitted against social norms that determine whose testimony is credible or authoritative, whose testimony is to be distrusted or discounted (Anderson, 1995).

Gender is but one factor (albeit an important one) in inter-occupational interaction. The doctor – nurse relationship can be perceived as dominant – subservient, mostly in terms of the division of labour according to gender but also by the fact that doctors have both a monopoly over diagnosis and treatment (Gjerberg & Kjølsrød, 2001). However, a changing negotiation context, new nursing knowledge and new organisational conditions in the hospital context have strengthened the voice of nursing (Svensson, 1996). Hierarchical relations between doctors and nurses have seen important changes in recent years (including increasing numbers of women in medicine) (Gjerberg & Kjølsrød, 2001). Yet traditional relations still hold sway; those lower down in the hierarchy, regardless of gender are subservient to those higher up (Davies, 2003).

Other aspects of status difference also have considerable influence. Factors such as formal prescriptions about occupational roles (Johnson, 1972), or reflections of the immediate situational context within which interactions take place (Hughes, 1988), can either reinforce or countervail against the influence of gender (Porter, 1992). One of the greatest differences between nursing and medicine presents in their temporal – spatial occupancy of the modern hospital (Snelgrove & Hughes, 2000). Differences in ordering of medical and nursing work (ward based nurses versus directorate/department based doctors) create different perspectives and priorities which are a source of strain (Allen, 2004). Nurses frequently have to raise the alarm regarding patients' deteriorating conditions outside normal working hours. They hold a weak negotiating position in their relationship with on call doctors where 'contacts are superficial and temporary' (Svensson, 1996, p. 396).

The solution – the communication protocol as a boundary object

Standardising the referral process has been offered as a solution to this problem (JCICPS, 2006). Standardised communication protocols are constructed as a useful mnemonic for nurses in emergency situations to help them to articulate their concerns to the medical staff (who are often not co-located on the same ward). They are constructed as situational briefing protocols, designed to 'eliminate excessive language' and 'convey, in less than a minute, vital information needed by the doctor or next caregiver' (Denham, 2008, p. 39). It is difficult to assess the impact of standardised communication protocols on patient safety in high risk care settings as there is a general paucity of research and high level evidence to support these strategies (Riesenberg et al., 2009). Data showing evidence of changes in communication and 'speaking out' is lacking. A need for economic analyses (O'Bryne, Weavind, & Selby, 2008) and assessment of the impact of these protocols on outcome data (Riesenberg et al., 2009), such as 'failure to rescue' rates has been documented. However, there is evidence of their acceptability and utility (Haig, Sutton, & Whittington, 2006) as well as reported improvements in patient safety attitude scores (McCarthy & Blumenthal, 2006).

Current policy discourse suggests that the communication protocols can determine a form of social interaction, guiding nursing and medical staff to act in a particular way. Likewise care pathways and technologies have generated opportunities for remapping of professional boundaries between nursing and medicine (Pinder, Petchey, Shaw, & Carter, 2005; Tjora, 2000). Care pathways have been identified as a classic example of a boundary object (Allen, 2009). Boundary-work has been utilised as a useful concept to articulate the social organisation of scientific knowledge (Lamont & Molnár, 2002). In contrast to studies that conceptualised boundaries as markers of difference, Star and colleagues perceived boundaries as interfaces *facilitating* knowledge production (Star & Griesemer, 1989). The concept of the 'boundary object' expands understanding beyond boundaries as conditions for separation and exclusion, to communication, exchange, bridging and inclusion (Lamont & Molnár, 2002). The boundary object is used to describe those interfaces that are key to developing and maintaining coherence across social worlds (Star & Griesemer, 1989). 'Boundary objects are objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites' (Star & Griesemer, 1989, p. 393). It is precisely because of their vagueness that they facilitate communication and cooperation between members of distinct groups without requiring members to give up the advantages of their particular social identities (Allen, 2009).

Standardised communication protocols could be perceived as an object inhabiting several intersecting social worlds and fulfilling a role in structuring relations between them (Star & Griesemer, 1989). Utilisation may enable nurses to gain authority and 'symbolic capital', improving their social position (Bourdieu, 1993; Gieryn, 1983) in order to accumulate the resources they perceive as important to improve patient care. To explore this further we will consider a case study example of a communication protocol.

An example – SBAR

One protocol, 'SBAR', uses the terms '*situation*', '*background*', '*assessment*' and '*recommendation*'. In identifying the 'Situation', the nurse is prompted to foreground the purpose of her call; 'I am calling because…'. Next the nurse provides a 'Background' to the patient's condition illustrating this with physiological parameters such as vital signs. For the 'Assessment', the nurse is required to state what is suspected to be going on with the patient. Lastly, the nurse is prompted to make a 'Recommendation', suggesting treatment options to the listener (see Fig. 1).

SBAR has been adapted from a protocol utilised in the US Navy Nuclear Submarine Service to facilitate urgent transfer of information and flatten hierarchies between junior and senior officers (Kaiser Permanente of Colarado, 2009). In the US in less than five years this particular protocol has not only entered healthcare vernacular, but is now considered best practice for use in rapid transmission of information in hospitals (Carroll, 2006; US Institute for Healthcare Improvement). Within the UK, SBAR is increasingly