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Clinical Research in Practice: The Journal of Team Hippocrates

Volume 3 | Issue 2 Article 7

2017

Quality? Safety? Stop Being Naïve.

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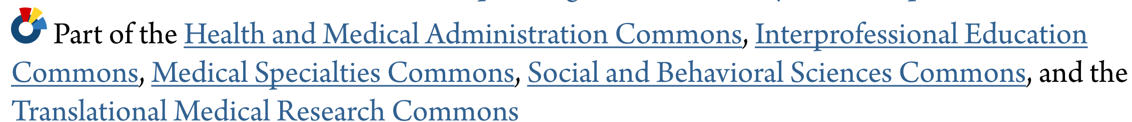

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Recommended Citation
ZABAN RK, ISTEPHAN S, SERMAN J. Letter to the editor: Quality? Safety? Stop Being Naive. Clin. Res. Prac. 2017;3(2):eP1515. doi: 10.22237/crp/1498867620

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Clinical Research in Practice
The Journal of Team Hippocrates
VOL 3 ISS 2 / eP1515 / AUGUST 23, 2017
doi: 10.22237/crp/1498867620

LETTER TO THE EDITOR:

Quality? Safety? Stop being naïve.

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The first day of our inpatient medicine rotation, the Emergency Department (ED) admitted a patient to a general medical floor without notifying our rounding team. We used the institution's system improvement tracking software to draw attention to this communication breakdown in the interest of patient safety.

Two days later the Residency Program Director asked us to return ED pages quickly because the ED submitted an incident with the same software, claiming we were not responding to calls from the ED in a timely way. Upon investigation, the miscommunication was a missed sign-out between ED physicians. We asked others, and apparently these tit-for-tat quality improvement reports are common in other areas of the hospital, the updated version of turf wars.

Today, the ED called about a patient known to our intern because she was a continuity patient from his clinic. The intern evaluated the patient in the ED and the symptoms of panic attack completely resolved. The intern went to the ED and told her that lorazepam completely resolved the patient's symptoms. We arranged follow up for the next day with her the primary care physician—the intern who knew her previously, saw her in the ED, and was to see her again the next day. The ED attending asked the intern if he had cleared that decision with our attending. When the answer was "yes" the ED attending commanded, "Document that," turned briskly, and walked away.

Approximately an hour later, we were paged to admit a patient that seemed like a "soft admission." As a warning, the Physician Assistant told us the ED attending was "really pushing for this one to be admitted." The evaluation of the patient wasn't even complete when the intern said that he would talk to our attending and the ED attending responded, "Do whatever you have to do but she's already admitted." This was startling because there had been no formal sign-out for the admission—the same problem that started this series of events.

While relaxing and sharing stories about how difficult inpatient medicine was, our attending asked if we thought these were stories of retribution. "Yes." "Of course." Afternoon didactics that week contained a lot of social theory.

Our attending conceptualized the whole episode as power structures within social institutions, and told us about Marcel Mauss, who identified gifts as imbued with power that circulates through societies.[1] James Scott describes "weapons of the weak" where oppressed people retaliate economically using social behaviors.[2] Institutions maintain and replicate power structures and are resilient to change.[3]

We thought we were trying to improve quality and safety, but there was an unseen social structure that resists change. We talked about the opportunity cost of spending time and energy on patients who shouldn't have been admitted in the first place—the really sick patients get ignored; worse, "soft admissions" are exposed to iatrogenic harm if hospitalized.

Our attending told us to stop being naïve. Unless we understand social dynamics, we won't achieve improved quality and safety.

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