Future leaders Communiqué

VOLUME 4. ISSUE 2.
April 2019 Edition
ISSN 2207 - 0451

CONTENTS

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65 Kavanagh Street,
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Next Edition: July 2019

GUEST EDITORIAL

Bronwyn O'Gorman

Welcome to the April edition of the Future Leaders Communiqué. As return readers will know, each edition of the Future Leaders Communiqué presents cases of preventable health care-related deaths and explores the systemic issues and errors identified in the ensuing coronial investigations. All junior medical officers (JMOs) working in a hospital setting will relate to these issues – I'm sure we can all recount a 'near-miss' situation that has stuck with us and informed our day-to-day work. Similarly, the aim of these discussions is to raise awareness of the potential failures or gaps in our system and provide some tools for which to overcome them. The overall goal being to improve patient care and safety in all settings of healthcare.

This edition will explore the concepts of compartmentalisation and subspecialisation in medicine and their impact on inter-specialty relationships and collaborative care. These issues are implicit in the case of a young woman's avoidable death due to ventriculoperitoneal shunt dysfunction. This fatal pathology went unrecognised over several presentations to a tertiary teaching hospital despite the relevant investigations being reported as abnormal. Specialty bias led to misinterpretation of the imaging findings, while miscommunication between specialties resulted in a missed opportunity for the appropriate involvement of a neurosurgical specialist.

We are working in the era of an increasingly complex healthcare environment. The achievements of the past 50 years have led to improved health outcomes globally and an ageing population. As a consequence, we are often caring for patients with complex medical issues for which we have a multitude of treatment options and pathways. This has in turn necessitated our healthcare system to become ever more subspecialised and compartmentalised. In his 2012 TED talk Dr Atul Gawande summarises this evolution: in the 1970s inpatient care consisted of the interaction of only two clinicians – one nurse and one doctor. Thirty years later the same patient episode would involve at least fifteen clinicians and subspecialists. As Dr Atul Gawande puts it, 'we've reached the point where we've realised, as doctors, we can't know it all. We can't do it all by ourselves.'

It is therefore inevitable that while working as individuals and in teams, we will reach the limit of our experience, skill-set or scope of practice. This is especially relevant to JMOs rotating frequently through various specialties or moving into roles of greater responsibility. As a resident doctor learning to assess patients independently I would always run through the issues list with my supervising registrar, just to be sure I hadn't missed anything. Different experiences and perspectives might result in something being glaringly obvious to one clinician but completely missed by another. This is the focus of the cited article published in the Harvard Business Review which highlights the importance of creating environments that 'support perspective sharing and effective communication'. However, this is easier said than done.

The increasing compartmentalisation of healthcare has caused a change in the relationships and cultures within and between specialty teams of doctors. I was interested to find a growing commentary on this topic, particularly regarding the impact of 'tribalism' on collaborative patient care. Tribalism refers to strong bonding within a group which maximises team loyalty and identity. While this can be beneficial within teams, Hewett et al found that strong specialty-based identity often created conflict and tension between specialty units, and can significantly impact the quality of patient care and safety.

GUEST EDITORIAL (CONTINUED)

Emergency physician Dr Victoria Brazil described her experiences working in the 'tribal jungle of healthcare' in her presentation at the 2018 Social Media and Critical Care (SMACC) conference. This is highly recommended viewing and provides some tips on changing this dynamic.

Finally, I would like to thank two of our expert colleagues for their fantastic contributions to this edition of Future Leaders Communiqué: Melbourne-based Neurosurgeon Mr Bhadu Kavar and Dr Eve Purdy, an Emergency Medicine Trainee who is also completing a Master of Applied Anthropology.

FURTHER READING / RECOMMENDED MEDIA

1. Gawande, A. How Do We Heal Medicine? *TED*; 2012. Available from: https://www.ted.com/talks/atul_gawande_how_do_we_heal_medicine?

2. Frimpong JA, et al. When Health Care Providers Look at Problems from Multiple Perspectives. *Harvard Business Review*; 2017 June 23. Available from: https://hbr.org/2017/06/when-health-care-providers-look-at-problems-from-multiple-perspectives-patients-benefit.

3. Brazil, V. Timing, Tribes and STEMIs [audio/video]. *SMACC*; 2018. Available from: https://www.smacc.net.au/2014/06/brazil-timing-tribes-and-stemis/.

EDITORIAL

We congratulate Bronwyn on curating an informative and compelling edition of the Future Leaders Communiqué. As junior doctors, you are at a pivotal point in your careers, exposed to a variety of role models and team cultures, and perhaps choosing or preparing to enter into a tribe of your own. This issue exposes the dangers of assuming that any individual or tribe has all the answers. Always keep the lines of communication open, and question your own assumptions when things don't quite make sense.

It is well worth your time to read this issue and discuss with your peers – whatever tribe they may belong to.

ACKNOWLEDGEMENTS
This initiative has been made possible by collaboration with the Department of Forensic Medicine (DFM), Monash University, Victorian Institute of Forensic Medicine (VIFM) and Victorian Managed Insurance Authority (VMIA), La Trobe University, Dementia Training Centres, Department of Health and Human Services, and the Postgraduate Medical Council of Victoria.

DISCLAIMER
All cases that are discussed in the Future Leaders Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organizations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of, the individual Coroner, the Coroners Court, Department of Health, Department of Forensic Medicine, Victorian Institute of Forensic Medicine or Monash University. If you would like to examine the case in greater detail, please contact us and we will provide the relevant website for the Coroners Court jurisdiction.

FEEDBACK
The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to: flc@vifmcommuniques.org

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CASE THE EYES DON'T SEE WHAT THE MIND DOESN'T KNOW

Case Number:
VIC 1611/2010

Case Précis Author:
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Basic Physician Trainee

CLINICAL SUMMARY

EL was a 31 year old woman who lived with her mother and worked part-time in administration. EL's medical history was significant for the diagnoses at birth of cerebral palsy and hydrocephalus, with a ventriculoperitoneal (VP) shunt inserted at three weeks of age and revised at age 23.

The history of EL's presentation extended over five months prior to her first admission to a major tertiary hospital. EL was a poor historian, however prominent symptoms during this time included a severe daily headache (often incapacitating), as well as changes in memory and behaviour, noted by EL's mother. A General Practitioner (GP) had made a referral to a neurosurgical clinic which EL did not attend. With symptoms persisting, an ambulance was eventually called. EL was admitted to hospital under the neurology unit for investigation of her headaches

Days prior to the neurosurgical clinic follow-up from the first admission, EL's mother noted changes in her daughter's breathing and new urinary incontinence.

On admission, EL was noted to be haemodynamically stable with no overt symptoms or signs of raised intracranial pressure (ICP) which could indicate acute blockage of the VP shunt. Subsequently, a working diagnosis of migraine was made. CT and MRI brain studies were conducted and, on phone advice from a junior consulting neurosurgical registrar, an x-ray series and shunt flow function test were performed to exclude VP shunt dysfunction. By day five of admission EL's symptoms appeared to have improved with migraine treatment and a consultant neurologist had reviewed her on several occasions. She was cleared for discharge.

EL was discharged with referrals for follow-up in outpatient neurology and neurosurgical clinics. Within one week of discharge however, EL presented again with a severe headache. She was discharged home within 48 hours after being treated again for migraine.

Days prior to the neurosurgical clinic follow-up from the first admission, EL's mother noted changes in her daughter's breathing and new urinary incontinence. An ambulance was called. After assessment in the Emergency Department (ED), EL was admitted to the Short Stay Unit to be treated again for migraine. Later that day, EL suffered a cardiac arrest. Fifteen minutes of cardiopulmonary resuscitation (CPR) achieved return of spontaneous circulation, but a CT brain showed significant hypoxic brain injury. EL died later that evening.

The coroner was critical of the decision to admit EL under neurology rather than neurosurgery.

PATHOLOGY

The pathologist who completed the autopsy concluded that the cause of death was raised intracranial pressure (ICP) due to ventriculoperitoneal shunt dysfunction.

INVESTIGATION

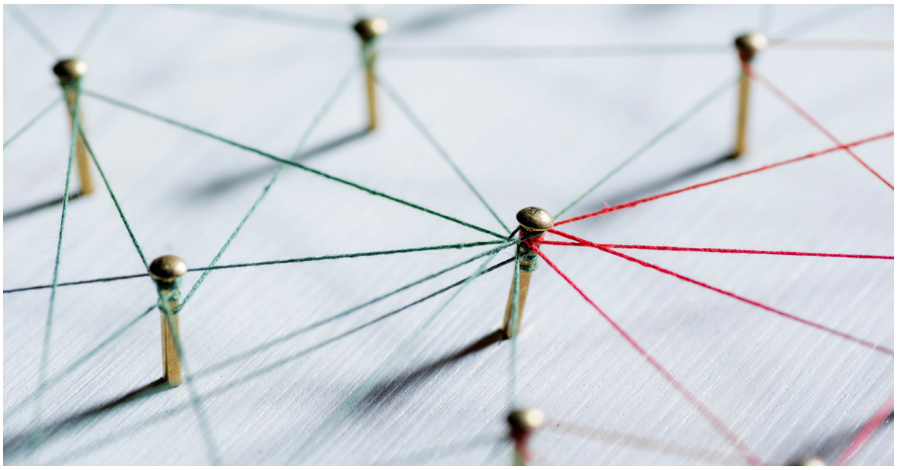
EL's case was reported to the coroner to determine cause of death. An inquest was subsequently held and over the course of five months, statements were received from a number of witnesses and opinions sought from two medical experts.

The witnesses included all six doctors directly involved in EL's hospital admissions. The coroner's focus was on the first admission, primarily the appropriateness of the admitting unit and the interpretation and follow-up of the investigations.

EL was admitted under the neurology unit because migraine was considered the most likely diagnosis based on the history, absence of findings suggestive of raised ICP, and response to migraine specific treatment. However, the inquest heard that the neurology team's primary concern was in fact to rule out possible shunt malfunction, and for this they were reliant on their neurosurgical colleagues. The coroner was therefore critical of the decision to admit EL under neurology rather than neurosurgery.

The consulting neurosurgical registrar assessed EL and agreed that there were no clinical signs of shunt dysfunction. Specific investigations for the VP shunt were recommended including an x-ray series and flow study. The registrar told the coroner at the inquest that this plan was discussed briefly with the neurosurgical consultant on-call, however that communication had not been documented. The investigations ordered by the neurology JMO, were conducted and reported in the following sequence:

1. Shunt x-ray series: *'A burr hole is seen in the cranial vault in the right occipital region. No tubing can be identified in this burr hole site or in the soft tissues posterior to or inferior to the burr hole. In the lower aspect of the image a small calibre tube can be seen passing from the thoracic region to the lower right side of the neck but this cannot be followed in continuity to the level of the burr hole. The tube in the right side of the neck has its proximal extremity at C4-C5 disk level.'*



2. VP shunt study: *'Demonstrated normal flow from the reservoir to the abdominal cavity thereby demonstrating a patent VP shunt. Conclusion: Normally functioning VP shunt.'*

3. MRI Brain: *'Hydrocephalus associated with transependymal oedema and posterior fossa compression with 12mm cerebellar tonsil herniation despite VP shunt, suggestive of shunt obstruction.'*

It was not appreciated by the neurology team that the shunt x-rays and report were indicative of a VP tubing disconnection. At the inquest, the team explained they felt reassured that the shunt was adequately functioning based on the second test - the VP shunt study - reporting 'normal flow'.

Corroboration between post-mortem findings and the x-ray series confirmed a 14cm disconnection in the VP shunt tubing at the level of C4, with fluid instead flowing through a fragile fibrous tract. The inquest heard that this is a rare situation, but both experts agreed that the abnormality found on plain films should have triggered further investigation and escalation to a specialist neurosurgeon. Both registrars (neurology and neurosurgical) involved in EL's case were unaware of the concept of a fibrous tract forming in place of a failed shunt.

The neurology team did not specifically seek a neurosurgical opinion on the abnormal shunt series and the neurosurgical registrar failed to review the images and the report herself. Instead, the registrar was only aware of the shunt study conclusion and, like the neurology team, considered this to be confirmation of an adequately functioning shunt. There was no further neurosurgery involvement during EL's admisson; she was never seen by a consultant neurosurgeon.

The coroner heard that had EL been admitted under the neurosurgical unit it would have been routine for both the neurosurgical registrar and consultant to review all images and accompanying reports.

By the day of her discharge EL had reported significant improvement in her headache with migraine treatment. So, when the MRI report came back suggestive of shunt obstruction, the images were reviewed by the neurology team and thought likely to be chronic changes consistent with long-standing hydrocephalus. Inpatient neurosurgical opinion was not sought regarding the findings on the MRI brain.

CORONER'S FINDINGS

The coroner acknowledged that EL's case was complex. The VP shunt study was misleading, and there was also the possibility of two co-existent diagnoses (idiopathic migraine and shunt malfunction).

However, the coroner found that the clinicians failed in their duty to (1) appreciate the importance of the x-ray findings, (2) consult appropriately with the neurosurgical team, and (3) adequately exclude a shunt malfunction prior to discharge.

The coroner was critical of the lack of documentation of the communication between specialty teams: it was unclear whether the neurology team had sought the opinion of the neurosurgical registrar on the abnormal imaging reports (x-ray series and MRI). Regardless, the conflicting results should have been escalated to a neurosurgical consultant.

Above all, the coroner determined that EL should have been admitted under the neurosurgical unit. The hospital involved has since introduced a policy for any patients with a similar history presenting to the ED. This policy includes a checklist for referrals to be made to both neurosurgical and neurology units and appropriate investigations initiated.

AUTHOR'S COMMENTS

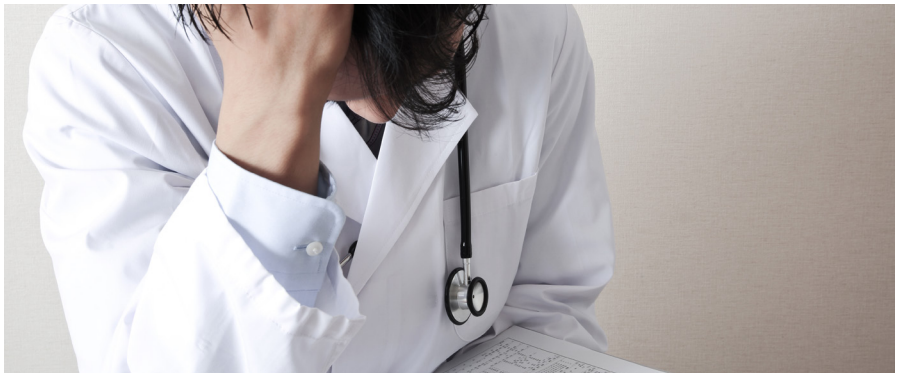
This account of the preventable death of an independent young woman is a sobering reminder of how a series of errors, miscommunications and system failures can have such severe and tragic consequences.

Amongst other issues, this case demonstrates the impact of compartmentalisation in medicine. In tertiary teaching hospitals in particular, compartmentalisation creates barriers to effective collaboration of specialty teams, barriers which are not just physical or logistical but also social and cultural. Sub-specialty 'tribal' cultures can negatively impact the relationships between doctors and create a climate for ineffective communication.

In the setting of increasingly complex medicine and subspecialisation, this case also highlights the potential for bias and missed diagnosis if we do not adopt different perspectives or appropriately seek input from outside our own specialty. For example, none of the clinicians involved in EL's case had sufficient experience with VP shunts to adequately interpret the dedicated investigations. Nonetheless, despite the reported abnormalities and the discrepancies between studies, the neurology team failed to appropriately escalate the findings to the relevant experts in the neurosurgical unit.

Building relationships between departments and specialties to maximise open and effective communication between clinicians is important, especially in complementary areas of medicine such as neurology and neurosurgery. Healthcare organisations have created many opportunities to utilise and maintain these relationships with examples such as multi-disciplinary meetings, combined specialty clinics, grand rounds and journal clubs. A system wide focus on 'closing the loop' has also led to clearer communication practices and notification of abnormal tests. It is very common now that imaging reports with major abnormalities include a final remark along the lines of: *'this is an abnormal result that requires follow-up. The treating team has been notified.'*

EL's case serves as a grave reminder that we need to be ever conscious that the eyes may not see what the mind doesn't know. We need to be aware of our limitations in knowledge and experience and utilise the skills of our expert colleagues.



KEYWORDS

Ventriculoperitoneal shunt, missed diagnosis, neurosurgery, communication, headache.

SUBSPECIALTY MEDICINE: TIME TO ASK THE EXPERTS

Mr Bhadu Kavar

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Whilst some may find it easy in hindsight to be critical of the delay in diagnosis, I believe the case of EL illustrates the importance of the eyes and ears of a consultant who has a particular expertise in a specialty. The combination of EL's symptomatology and multiple presentations should have alerted staff to re-evaluate the case, and it is most unfortunate that the key specialist who may have been able to solve the clinical problem was not appropriately sought to review the patient or her imaging. This missed diagnosis of shunt dysfunction certainly resulted in EL's death.

Hydrocephalus and patients with Ventriculoperitoneal (VP) shunts are a common enough clinical picture in the medical profession and certainly in the neurosurgical community. However, a significant number of patients with VP shunts do have complex problems and this can create bias and diagnostic uncertainty when they present to emergency departments. The most efficient way to break the bias is to ensure regular review by fresh eyes and ears, as well as the involvement of the specialty specific consultant.

Other than clinical signs and symptoms, we are alert to any concern raised by a patient or their family member about any feature of shunt dysfunction - these are aspects of the history that we take very seriously.

EL was admitted under the neurology unit and was reviewed early on by a senior neurologist. However, the referral to the neurosurgical unit was attended by a relatively junior member of the neurosurgical team. This places a huge responsibility on the neurosurgical registrar to be able to appreciate the complexity of a patient with a shunt since early childhood and revised eight years previously.

The registrar is unfortunately not going to have the body of knowledge and experience to adequately assess this type of patient, who may in fact present with symptoms of raised ICP without any signs thereof. The imaging studies were also misleading: the shunt disconnection went unrecognised on plain films and the shunt flow study showed patency of the VP shunt but not adequacy. The MRI findings, without the appropriate clinical suspicion of shunt dysfunction, were interpreted as being chronic changes and so no intervention was initiated.

When EL represented a second and third time the clinical diagnosis should have been challenged. This was a young woman who hadn't had any problems with her shunt for eight years and was now presenting with new significant headaches over a short period.

Any patient in whom there is the possibility of ventriculoperitoneal shunt dysfunction should primarily be managed under the neurosurgical unit.

Even though the neurosurgical registrar did communicate with the consultant, there is no documentation that the consultant ever saw the patient or viewed her imaging.

To give some background, all neurosurgical trainees are obliged to have a 6-month rotation through a paediatric neurosurgical unit.

This certainly results in good exposure to the myriad of patients with VP shunts and an understanding of the different ways that shunt dysfunctions can present. This experience is subsequently built on during the consultant phase: neurosurgeons will regularly see patients who have a variety of clinical presentations when their shunts do block. Other than clinical signs and symptoms, we are alert to any concern raised by a patient or their family member about any feature of shunt dysfunction - these are aspects of the history that we take very seriously.

Thus, if EL had been reviewed by a neurosurgical consultant during any of her presentations to hospital there may well have been a very different end result.

In all of our tertiary hospitals there is a huge demand on EDs as well as the various specialty units. The first line of contact is invariably going to be the more junior members of the team, but it is vital that consultants allow and empower their juniors to have a direct line of communication with them. Over and above it is crucial that patients and their investigations be reviewed at some point by a senior member of the subspecialty team.

Any patient in whom there is the possibility of ventriculoperitoneal shunt dysfunction should primarily be managed under the neurosurgical unit. The priority is to exclude shunt dysfunction prior to care being transferred to any other specialty or admitting unit. This pathway decreases the risk of missed or delayed diagnosis and results in better outcomes for this complex patient population.

We are indeed very fortunate that in the hospital I work there is a good relationship between the neurosurgery and neurology teams. This, however, is not necessarily a universal experience and an adversarial environment can detract from the truly objective assessment and discussion of a patient's clinical problem. As alluded to earlier, the decision processes and algorithms of management of patients under a surgical unit can be slightly different to that of a medical unit, and this can create subtle differences enough to result in delays in diagnosis. We, as clinicians, do need to be cognisant of this.

FURTHER READING

1. Bell, D., & Jones, M. Emergency admissions a time for action and improving patient outcomes. *J Royal Soc Med* 2007; 100 (11): 487–488.

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3. Juma, S., & Goldszmidt, M. What physicians reason about during admission case review. *Adv Health Sci Educ* 2016; 22 (3): 691–711.

CAN A FOCUS ON RELATIONSHIPS HELP PREVENT TRAGEDY?

Dr Eve Purdy

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This tragic case highlights the key issues related to the coordination of care. Thoughtful reflection on the complex reality of modern-day healthcare is relevant not just for this particular hospital or for ventriculoperitoneal shunt presentations, rather it is critical to every institution and every patient who steps through our collective doors. The way we experience work is often in silos but patients experience their journey as one that is delicately supported by a critically interdependent web of providers and carers (figure1).

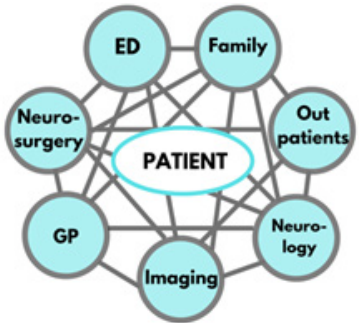

Figure 1

This web is intricately woven by systems, processes, and perhaps most importantly but least acknowledged, relationships. Weakness in the web can result in disaster for the patient who is suspended precariously in the middle. So how, in a "complex socio-technical system… in which individual health care providers, teams and technical services form component subsystems characterized by distinct cultures and belief systems" might we coordinate care, not just to avoid tragedy but also to strive for the best? [1]

So far, hospitals have focused on systems and protocols to improve the explicit coordination of work. Approaches such as the one taken in response to this case - a newly developed policy which now sees a checklist to rule out obstruction used for patients with VP shunts and headache - facilitate overt coordination between and within groups. Optimizing explicit coordination pathways in such ways is certainly important but it is not enough.

Research from the airline industry around the coordination of everyday work (i.e. getting a passenger to their destination, with their bags, on time) reveals that relationships are integral to the implicit coordination of work in high performing, interdependent organizations. [2,3]

This theory of relational coordination, since applied in a variety of healthcare settings, specifies three relational dimensions that support coordination of work: shared goals that transcend specific functional task-related goals, shared knowledge that enables team members to understand how their tasks interrelate with others, and mutual respect that allows members to overcome status barriers and positively regard the work of others. These relational attributes are reinforced by communication that is timely, frequent, accurate, and problem solving-based. Relational coordination has been found to be particularly critical in situations where teams are faced with high levels of task interdependence, uncertainty, and time constraint. [2] Let's think about relational coordination in the context of this specific case with a lens of identifying simple phrases that might allow us to better coordinate work in any situation.

Asking, "what are the main priorities for this patient?" at the time of admission and on ward rounds then clearly communicating these goals is a great start.

1. Shared goals

As Mr. Kavar highlighted, the goal for the patient with a VP shunt and headache is as clear as a priority is ever going to be in medicine – rule out shunt malfunction. In fact, during the inquest, the neurology team reiterated that they clearly recognized the importance of this during EL's initial admission and surely the neurosurgeons agreed. On the surface, the teams involved had shared goals.

So then, why was she discharged before this goal was realized? Yes, there were medical nuances to the case that complicated the matter but there are also any number of unwritten and undiscussed goals that affect our individual and team actions at a given time. Unwritten and often competing goals result from systems pressures and conflicting priorities, not bad people.

In pressured systems, values like "keeping the list short", "getting patients out", "not looking like an idiot to my consultant" and "if we aren't operating on them then we shouldn't be following them" start to emerge. These particular goals may or may not have been at play in this specific case but do often exist in the systems in which we work.

We must acknowledge they exist and understand how they subtly, or not so subtly, affect our engagement with the goals for the patient in front of us. Asking, "what are the main priorities for this patient?" at the time of admission and on ward rounds then clearly communicating these goals is a great start. At the time of discharge asking, "have we addressed the main priorities for this patient?" could help ensure that actual actions taken are in line with stated goals. Simple questions that can be posed by anyone on the team might serve to elucidate and realign goals in a meaningful way.

2. Shared knowledge

Shared knowledge, in the context of relational coordination theory, refers to knowledge about the roles people play and how they interrelate in the pursuit of the shared goal. In this particular case the role of each service is unclear to me. Neurology admitted EL and treated her headache. The neurosurgical team was consulted, presumably because the neurologists wanted assistance with the subtleties of the diagnosis. However, for a variety of reasons the neurosurgical team did not end up ordering or directly interpreting the tests related to the shunt. Further lack of recognition around experience complicated the matter.

Ultimately, a lack of clarity about roles as they related to the shared goal resulted in a mismatch of abilities and tasks, diffusion of responsibility, and contributed to this tragic outcome.

The newly instituted policy addresses the issue of role clarity in this particular situation by dictating the most appropriate treating team for patients with VP shunts, but such a policy fails to acknowledge the fact that all multidisciplinary teams are at risk for similar misunderstandings with every patient they collectively care for. When consulting a new service consider previewing with, "these are the priorities for the patient, and here is how we are hoping you can contribute…" and when receiving a consult consider clarifying, "it sounds like these are the priorities for the patient, and this is how it sounds like I can help…is that correct?"

A final helpful rhetorical question around role clarity, particularly for junior doctors or when you sense a creeping scope is, "am I the right person to be making this decision or caring for this patient?" Often the answer is "yes" but sometimes the answer will be "no". These simple phrases and questions might allow all those involved to understand how their role fits into the bigger picture.

3. Mutual respect

Mutual respect is the easiest to understand, but likely hardest to affect, component of the relational coordination framework. For this specific case it is impossible for me to comment on the degree to which mutual respect was or was not present between individuals and groups. Phrases from the coroner's inquest allude to barriers related to escalating concerns from the junior neurosurgical registrar. Undoubtedly, we do know that issues related to collegiality are considerable in healthcare. [4] I have experienced feelings of hesitancy before picking up the phone to clarify a question with another specialist, recalling our last unproductive interaction. I have avoided calling my boss for fear of being yelled at. I have responded to colleagues in ways that I regret. [5] It happens and it needs to stop.

Mutual respect for colleagues is about far more than "being nice" – though that is probably a good place to start…with simple phrases such as, "hello my name is Eve, how can I help?" or, "thanks for coming to see our patient." True mutual respect is a mind shift to an understanding that others play an integral role and that our collective work is critically dependent on each other. Such humility and gratitude must be practiced on a daily basis and can be deliberately modelled with phrases such as, "didn't [insert service] do a great job" or, "thanks for calling me overnight, I could tell you were worried".

Communication – in person, in the chart, over the phone, or through other means - that is timely, accurate, problem solving-based, and frequent can strengthen foundation of relationships. [2] The opposite will erode them. In relational coordination theory, communication is a critical reinforcer of shared goals, shared knowledge, and mutual respect. There were identified gaps related to the formal documentation and communication in this case of EL.

The formal communication channels discussed in the coroner's finding are important but so too are the everyday words we use, the ways we speak to and about each other, and the conversations that we engage in. Each moment provides the opportunity to build or erode relational foundations. Moving forward, I encourage you to borrow some of the phrases that I have provided throughout this commentary but also encourage you to mindfully develop and implement your own in an effort to prioritize shared goals, align knowledge about roles, and embody mutual respect.

So, can a focus on relationships help us understand and prevent tragedy? Yes. The all too familiar circumstances around EL's death highlight the importance of relationships in the implicit coordination of our everyday work and remind us of its critical importance for the patients we care for. If we are to move towards solidifying the precarious web that patients so delicately rest in, we must commit not just to implementing policies, procedures, and systems but also to maximizing shared goals, shared knowledge, and mutual respect. By recognizing the importance of good relationships with each other we are committing to doing better by our patients; the ones in front of us now, and the ones who will walk through our doors tomorrow.

FURTHER READING

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COMMENTS FROM OUR PEERS

"Antagonism between units about which bedcard patients should be admitted under occur daily in every hospital I have ever worked in. It is an unfortunate reality that patients are often admitted under the less ideal bedcard just because it was easier to do so at the time."

"As a junior registrar being asked to consult on other teams' patients we are acutely aware that the team is requesting a 'specialist' opinion. However, we are not yet specialists, and if our bosses are unavailable or unwilling to supervise or review those patients then we are left in a very difficult position."

"This article from On The Wards quite nicely explores some of the barriers to asking for help and the consequences of this https://onthewards.org/call-need-remember-sign-weakness/.

"This case really highlights the importance of working collaboratively with other specialty teams to ensure investigations are adequately reported and followed up."

"A diagnosis might not be correct, or the only explanation for the patient's symptoms, even if multiple other doctors have concluded the same thing. When patients present recurrently a re-evaluation of the diagnosis should be considered."