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Hierarchy in the Medical Field

Rachel Eaton

Grand Valley State University - Fredrick Meijer Honor College

HNR 499 - Senior Project

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Introduction

Prior to volunteering in a southern United States hospital setting I had only my preconceptions of hierarchy in medicine, but this hospital had a different reality. At the hospital, I noticed a decreased sensitivity to the hierarchical structure of medical professionals in the hospital. I was able to learn that these professionals intermingled very well. As a volunteer on a floor, I could not even differentiate between the different professions, as they all wore similar uniforms and interacted with everyone on the floor. While participating in this volunteer program, I noticed how the health professionals at Arkansas Children's Hospital used tolerance, patience, and empathy to understand the struggles and hardships of co-workers of different professions notably more than they did in hospitals I have volunteered at in Michigan. I was able to develop an appreciation for this style of interactions among medical professionals in a hospital setting and notice how these interactions positively impacted the daily lives of those professionals and their patients. From this experience, I discovered that this regional difference in hierarchical systems in hospitals was significant and by putting myself in the situation of these health professionals both emotionally and physically, I can better understand their feelings and motivations; this will help me to study this area of interest. Due to the large number of GVSU students seeking entry into one of the health-related professions at various levels of profession, and due to the increasingly large medical community in the Grand Rapids area, this study will be of interest to the University and West Michigan communities.

Not many people understand, much less have studied the idea of a hierarchical structure within the medical field. A few areas of interest include regional differences, generational differences, and specialty differences in hierarchical structure. To further investigate, a total of five health professionals of varying practices were interviewed on their thoughts on this

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controversial issue. These professionals spanned a variety of occupations, as well as generational and regional backgrounds. They were interviewed using a non-biased, multiple-choice questionnaire on their opinion and experience with this issue. From this data, we can infer the general opinion of medical professionals, and further analyze their responses based on their gender, occupation, and generational background. The objectives of this study are to examine the different forms of hierarchy among health professionals and discover where and why these hierarchies do or do not exist; and to examine the effects of these relationships on the medical professionals themselves as well as their patients.

Background

Society has been progressing on the path to ensure equality in the workplace. This pattern of equal treatment to all should allow professionals to feel comfortable in their work environment regardless of their position in the field. It is the inappropriate conduct among medical professionals that must be present in order for any sort of hierarchical structure to exist, and this type of interaction between health professionals has raised ethical concerns. Thus many health professions can be highly sensitive to a variety of the social pressures stemming from this phenomenon, and those on the lower end of this hierarchy are especially susceptible. The question becomes where one can draw the line in what is typical behavior and what behaviors stem from a medical hierarchy.

Medical hierarchy discourages the questioning of many decisions made by doctors (Srivastava 2013). Many physicians are cautious to question the opinions of surgeons, especially if they practice internal medicine (Srivastava 2013). Although many of them know there is no basis for this behavior, they usually defer to surgeons, considering them indisputably right,

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incontestable, or merely not worth irritating (Srivastava 2013). In an era when many patients have numerous practical treatment possibilities, many physicians find it more reasonable to yield to the surgeon than to begin an argument for a patient (Srivastava 2013). That approach is absorbed by generations of doctors who basically have to watch in order to learn during residency (Srivastava 2013). Many medical professionals are thus reminded to remain within the limits of their expertise. Even when a patient's life might be endangered, physicians may prefer to accept their uneasiness rather than contest another physician's perspective (Srivastava 2013). It is worrisome though that the main observed point of differentiation is often unequal views of patient well-being. This attitude provides an indication to surgeons that their role is to operate, while everyone else is the supporting cast. Apart from being insincere, this thinking provokes even more stereotypical behaviors.

Additionally, doctors and nurses often experience difficulties when trying to understand one another's professions (S. Knight & J. Knight 1995). Both professions continue to face significant modifications in the way they are meant to practice (S. Knight & J. Knight 1995). These changes are often difficult on the professionals and provide a rich environment for both dissatisfaction and distrust (S. Knight & J. Knight 1995). It is only by trying to comprehend the stresses on each other's professions that they may evade destructive squabbling and conflict, which would weaken the patient's assurance in their professionalism (S. Knight & J. Knight 1995). The solution will attempt to keep the dialogue open in a spirit of mutual respect.

During the last few decades, research has reported gender bias in numerous areas of clinical and academic medicine (Risberg et al. 2006). Ignorance of gender discrimination among medical researchers and health-care professionals can lead to this gender inequality (Risberg et al. 2006). In order to prevent and avoid gender bias, there are aims for a gender equality to be

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included in medicine in the same way that equal opportunities regarding social class, ethnicity, and age are considered (Risberg et al. 2006). Research on obstacles to professional advancement for women in academic medicine has not effectively measured the role of environmental factors and how the structure of organizations affects professional advancement and work experiences (Conrad et al. 2010). The purpose of this study is to investigate the influence of the hierarchy in medical field organization, including both the medical field's hierarchical structure and professionals' perceptions of this structure, on health care professionals' experience and advancement in academic medicine. (Conrad et al. 2010) An interview conducted with medical professionals representing a wide portion of the population will help gauge their overall opinion on this hierarchy. If there is a hierarchical structure in the medical field, then interviews of medical professionals at different levels in the hierarchy will present reports of these individuals feeling its effects.

Methods

An in-depth exploration research project was performed to learn more about hierarchy in the medical field, by reaching out to and conducting interviews with medical professionals. The research also consists largely of scholarly articles and books used to obtain background knowledge and theories on the issue. This study was conducted using interviews with a female Arkansas Children's Hospital representative, a male doctor of a Michigan hospital, a male resident of a Michigan hospital, a female nurse of a Michigan Hospital, and a female certified nurse assistant in Michigan. The names of the individuals interviewed remain anonymous to protect their rights to privacy, and only their profession and gender is revealed by their responses.

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As part of an inductive qualitative study of faculty in five different U.S. medical hospitals, five medical faculty were interviewed at different career stages and in diverse specialties, using in-depth semi-structured interviews, about their perceptions about and experiences in academic medicine (Conrad et al. 2010). Data was analyzed and patterns were recognized in order to construct theories on these practices. The study examined self-reported feelings of unfair and unequal treatment using a questionnaire. Questions were asked and numerical values on a scale 0-2 were given to responses in order measure the individuals overall perception of medical hierarchy with the maximum score of twenty four being the most perceptible. These responses were added to obtain a score for each individual and then averaged to obtain percentage values for the group in question. Scores were also examined for individual questions; these response values were also averaged to obtain percentage values for comparison.

HNR 499 Questionnaire:

1. Gender: Male Female
2. Occupation Title: _____
3. Specialty (if applicable): _____
4. Regional area of workplace: _____
5. Age Range: 20-34 35-49 50-74
6. Have you ever experienced unfair or unequal treatment in while working in the medical field? Yes Somewhat No
7. Have you ever experienced this type of treatment by your superior while working in the medical field? Yes Somewhat No
8. Should this treatment be regulated by your place of employment?
Yes No

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9. How heavily do you think this type of hierarchical structure should be regulated?

Heavily regulated Slightly regulated No regulation

10. Have you heard the term “medical hierarchy”? Yes Maybe No

11. Do you agree that this type of hierarchy of career stages in medicine exists?

Yes Somewhat No I have not heard of the term “medical hierarchy”

12. Do you believe the hierarchy of career stages in medicine is based on the level of education required for each occupation? Yes No

13. Do you believe this “medical hierarchy” has consequences on patient care and the work environment? Yes No

14. Do you believe that “medical hierarchy” affects _____?

a. Incusion? Yes Somewhat No

b. Transparency in decision making? Yes Somewhat No

c. Advancement in the field? Yes Somewhat No

Results

The majority of respondents believed the hierarchy of career stages based on the level of education required, as a central characteristic of the structure of academic medicine. Increasing numbers of indeterminate career stages lessen occupation turnover and may create a bottleneck for advancement (Conrad et al. 2010). Many faculty saw this hierarchy as affecting inclusion, reducing transparency in decision making, and impeding advancement. Both men and women health professionals perceived this hierarchy, but women saw it as more consequential. More female respondents were receptive to the effects of a medical hierarchy than male respondents.

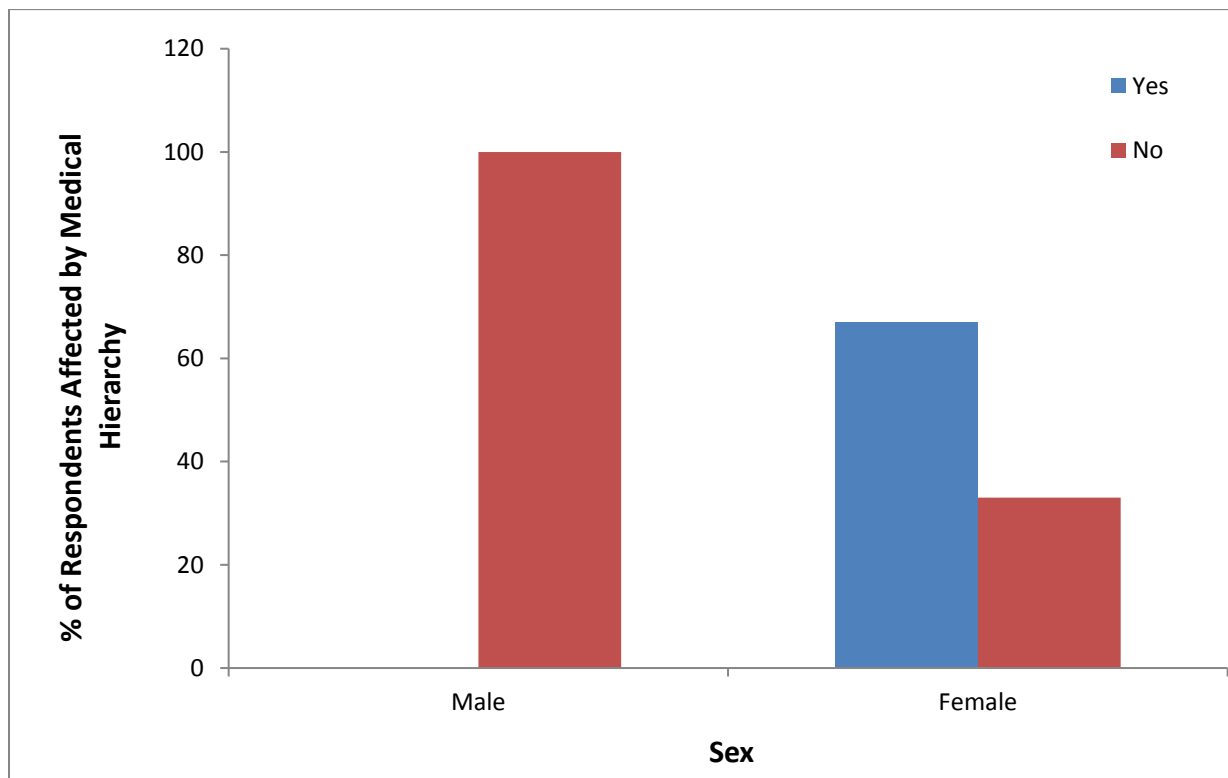


Figure 1. The percentage of male and female respondents who have or have not experienced unfair or unequal treatment while working in the medical field.

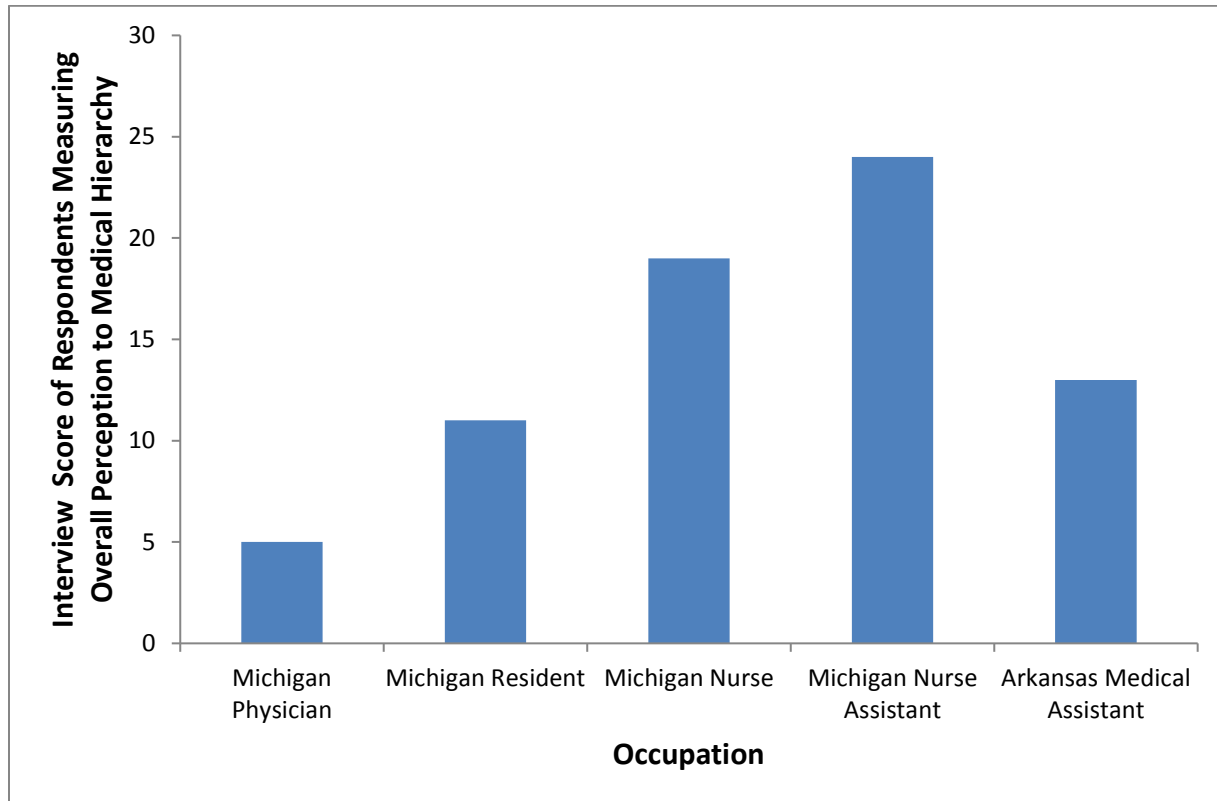


Figure 2. Interview score of five respondents of different occupations, presenting their overall perception to medical hierarchy.

More than 50% of respondents said they believe medical hierarchy affects inclusion. Over 50% of respondents said they believe medical hierarchy reduces transparency in decision making. More than 50% of respondents said they believe medical hierarchy impedes advancement. Over 80% of individuals had possibly heard of the term medical hierarchy, and about 80% of these respondents believed the existence of this type of hierarchy of career stages in medicine is based on the level of education required for each occupation. 40% of respondents said that this behavior should be heavily regulated with only 20% wanting slight regulations, and 40% wanting no regulations whatsoever. 60% of individuals believed unfair and unequal treatment in the medical field should be regulated, and 40% feel it should not be regulated.

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Among those that had previous knowledge of this hierarchy, 60% reported feeling at least somewhat affected by it while 40% hadn't experienced any effects. The majority of respondents (60%) held concerns about the consequences of medical hierarchy on patient care and the work environment. 60% of respondents reported a concern with the unfair or unequal treatment by their superiors emerging from the presence of this medical hierarchy.

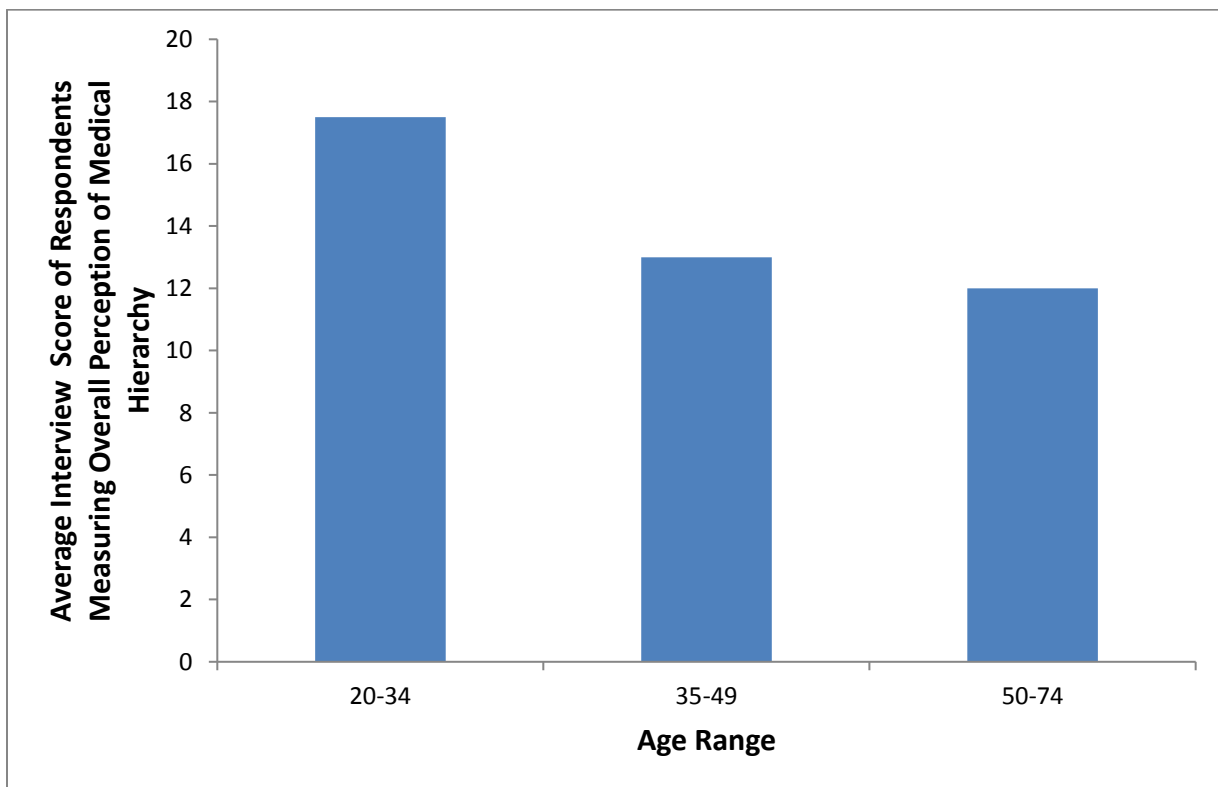


Figure 3. Average interview score of five respondents in three age ranges, presenting their overall perception to medical hierarchy.

Discussion

Nurses seem to not feel confident about communicating details about the patient's condition when information is required by relatives, and are therefore unable to comfort those who are anxious about the patient (S. Knight & J. Knight 1995). Though according to doctors, it is partly due to the fact that nurses are increasingly unwilling to accompany doctors on ward rounds and therefore do not receive up to date information (S. Knight & J. Knight 1995). Regardless, Nurses and Certified Nurse Assistants (CNAs) have never been considered handmaidens to doctors (S. Knight & J. Knight 1995). Many employees in other disciplines follow instructions given by other employees. However, although it may seem so, power frequently does not lie with doctors. Many routines and policies are initiated and preserved by nursing staff (S. Knight & J. Knight 1995). Nurses have substantial power in the medical field as well, which, unfortunately, many readily use in a negative and unassertive way (S. Knight & J. Knight 1995). Recommendations about different practices and approaches are often met with opposition and conflict, and sometimes with spiteful behavior. Often, doctors are accused of not knowing the nurses' responsibilities, but typically the reverse is more accurate (S. Knight & J. Knight 1995). Many experienced nurses do not realize that when they get to go home for the day, the doctors often do not. A doctor's performance may be influenced by the fact that he or she works at least twice the hours in a week that nurses do; all while carrying significantly more accountability for more patients in several parts of the hospital (S. Knight & J. Knight 1995). Still, derogatory and insulting comments about physicians in general or about specific physicians seem to have been a part of nursing culture since the earliest days of training (S. Knight & J. Knight 1995).

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This hierarchy within the medical field contributes to the resistance to a perspective of equality, causing bias and making medical scientific rationality suboptimal (Risberg et al. 2006). It does not matter too much, then, if some medical professionals doing routine procedures are stubborn or strict. Neither does it matter much if some health professionals working with standard conflicts are highly impervious to practical suggestions. Nor does it matter if some medical professionals merely think in terms of career stages; as long as there is a positive interaction between the different kinds of occupations. The tradition of hierarchical structure seems to be a strong excuse for making medical research and clinical medicine immune to the equality discussion taking place in the academic world in other disciplines, and in society at large (Risberg et al. 2006). Research has revealed bias as a result of hierarchical structure in many areas of clinical and academic medicine (Risberg et al. 2006). To avoid such bias a new perspective in medicine is needed (Risberg et al. 2006). The structures and hierarchies of medical science, where the biomedical framework dominates, can unfortunately contribute to negative attitudes to inequality issues and a perspective in the medical society and thereby to bias (Risberg et al. 2006). There is a wider conflict where medical hierarchy often claims the right to define the field and to preserve certain privileges (Risberg et al. 2006).

In a profession filled with experts, no single person's skill should always be seen as superior. Although certain procedural expertise may be specific to a certain specialty, there's a much wider range of skills upon which no crowd has a control (Srivastava 2013). There's no hierarchical structure in using gut instinct, displaying concern for the whole patient, avoiding maltreatment, or inhibiting futile care (Srivastava 2013). We must realize that debate is healthy and that without open discussion, we fill what is unknown with guesses at each other's intentions

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(Srivastava 2013). Identifying the consequences of unquestionable obedience to hierarchy and approaching a colleague with reservations is the best thing that can be done together for patients.

Conclusion

As demonstrated in this study, the investigation of the theoretical model gave us a better understanding of the presence of a medical hierarchy in clinical and academic medicine. This understanding has presented tools to use when handling hierarchical issues in the workplace. We suggest that the model can be applied in a wider medical context when different traditions collide and when misunderstandings between them arise (Risberg 2006). With hierarchies similar to these rapidly approaching the realm of fact, the American public may one day be faced with the implementation of regulations. Greater education of the public on medical hierarchy should be undertaken to ensure an informed, science-literate populace. The hierarchical structure of clinical medicine has a noteworthy impact on faculty work experiences, including advancement, especially for women (Conrad et al. 2010). One might suggest that medical schools consider alternative models of leadership and managerial styles with a greater emphasis on inclusion. This is a structural reform that could increase opportunities for advancement, especially for women, in medicine (Conrad et al. 2010).

Opportunities for Future Research

Future work might involve giving the same or a similar survey to American adults who have been or are attempting to be accepted into pre-professional programs to further explore the relationship between one's proximity to medical field and their views on medical hierarchy. The results of such a survey would be contrasted to those already gathered on average working American professionals who often do not find themselves in these circumstances.

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