Part 4: Irrational Agency – Solving the Problem of Many Hands

Aug 6, 2016 | 0
|
| ontheblogs,patient centred care,Working & training in healthcare

Author: Eamon Merrick

Editor: Chris Elliot

Over the past three weeks I have argued that there is a need to radically rethink how healthcare decision making is organised. This argument has been based on the idea that the organisation of modern healthcare is ad-hoc. That professionals act as nodes within a network to fulfil their virtuous responsibilities. But do so with imperfect information. This week we will look at how the health service responded. I will argue that the response is ill-suited the complexities dealt with by professionals; because institutional rules do not accommodate the freedom of decision making required in professional work. I will conclude by arguing that solving the problem of many hands requires professionals to make a choice.

In this series we have explored the series of events that led to a patient suffering harm. The harm resulted from a systemic error. Following the event the health service undertook a root cause analysis to identify causation. As no single causative factor could be identified the recommendations sought to reinforce existing institutional rules. It was recommended that medical officers be reminded of existing policies requiring a clinical assessment after a patient had fallen. It was also recommended that an audit be undertaken to ensure nurses were undertaking risk assessments for falls. Institutions exist to make rules. Therefore the institutional response is to reinforce existing rules in the hope that compliance will obviate future error. This approach will fail.

Institutional rules will fail because they do not account for the distributed nature of service delivery. In our story each professional interpreted the goals of care. By artfully selecting the mixture of evidence, experience, and resources they determined the best method to achieve these goals. Each professional adapted to an imperfect situation, and acted with imperfect information. The harm that this patient suffered was a function of the spread of information throughout the participants. The institutional response does not account for the many hands involved.

The series of events to leading to the harm should be conceptualised as a problem of many hands. None of the individuals involved with this patients' care can be considered morally responsible for the event; *in the sense that they cannot be blamed*. And if, at any point, you are tempted to blame the patient remember that the patient had little agency. His agency was so diminished he did not get to have his cigarette.

While we cannot consider the professionals involved as morally responsible for the harm. As professionals we do have a virtuous responsibility to ensure that such events do not happen again. We must adopt a forward looking approach. An approach that allows us to think about what actions *may* be undertaken and what outcomes we may hope to achieve or avoid. This approach must take account of the choices of individuals, and the capacity of these individuals to cooperate.

Ibo van de Poel & Zwart[2] hypothesised a number of potential solutions to the problem of many hands. Not all of which are useful in the context of contemporary health care. The solution(s) must account for the trust placed by the patient in the health professional, and the virtuous responsibility of the health professional to honour that trust. The potential solution must also account for the distributed and ad-hoc organisation of complex care. One hypothesised solution suggests that the problem of many hands is less likely in organisations that promote responsibility as virtue.

This may be achieved if professionals actively communicated the expected outcomes of care. If these predictions fail to materialise other professionals might ask why. Including these predictions in regular communications takes courage. But as long as they are clearly identified as predictions the only embarrassment we may suffer will be our own. It may be reasonable to suggest that communicating our predictions would encourage: initiative, the exercise of judgement, moral imagination, and enhance our capacity for reflection and learning.

In our story the patient encountered a sea of concerned faces in diverse clinical settings. During each encounter each professional acted with imperfect information. The harm resulted because of a number of complex interacting factors. In our story the harm would've been less likely to occur if there was redundancy within the system[3]. To achieve this, we must demand that the institution adapts to the realities of service delivery.

Imagine yourself as being involved in our patient's care. Now imagine that there was an external narrator. You could call this narrator at any time. The narrator has access to medical records, imaging, and perhaps even personal experience of working with this patient. Such a care coordinator would be an invaluable source of redundancy in a complex system. And if harm should occur this person would be ideally placed to contribute to the redesign of institutions. Reducing the potential for harm to occur again.

The presence of such a coordinator may seem fanciful. But that does not mean it is impossible. Care coordination has been shown to be effective in primary care. Improving outcomes and reducing adverse events. New models are now being deployed that expand care coordination services to acute care patients with complex comorbidities[4]. These approaches seek to adjust our perspective on patient care. Rather than expecting, and therefore seeing a linear narrative, coordination attempts to bridge the chasm between care delivery and organisational complexity[5].

Who should this narrator be? Whomever it is, the coordinator should not be appointed based on ideas of seniority or discipline. What nurse or junior doctor hasn't faced the daunting prospect of waking a consultant in the middle of the night? And why is it that we assume that a consultant can effectively address emergent clinical problems while in bed?

In their excellent analysis Waring and colleagues[6] revisited the autonomy that expertise grants medicine to judge its own competence. This privilege was first described in the 1970's by Freidson and Illich[1], almost half a century later little has changed. Because of this privilege each professional has a duty to honour the trust of patients and fulfil their virtuous responsibilities. Working together we may not be rational actors. But if each us choses to act with forward looking responsibility, and perhaps if we find a narrator, we can help patients to reclaim their own agency.

Reference

1. Friedson, E. (1970). Professional Dominance. New York, Atherton Press, and Illich, I. (1976). Medical nemesis: the exploration of health. New York, Atherton Press.
2. Poel, I., & Zwart, S.D. (2015). The Problem of Many Hands. Moral responsibility and the problem of many hands. I. Poel, L. Royakkers and S. D. Zwart. New York, NY., Taylor & Fracis: 209-218.
3. Thompson, Dennis F. (In Press). Designing Responsibility: The Problem of Many Hands in Complex Organizations. The Design Turn in Applied Ethics. Hoven, J. Miller, S and Pogge, T. New York and Cambridge UK., Cambridge University Press.
4. Pietrantonio, F., et al. (2016). "Acute complex care model: an organizational approach for the medical care of hospitalized acute complex patients." European Journal of Internal Medicine 26: 759-765.
5. Peerally, M. F., et al. (2016). "The problem with root cause analysis." BMJ Quality & Safety online.
6. Waring, J., et al. (2015). "Healthcare quality and safety: a review of policy, practice and research." Sociology of health and illness 38(2): 198-215.

Related Blogs

- Part 1: Irrational Agency
- Part 2: Irrational Agency – Systemic Harm
- Part 3: Irrational Agency – The problem of many hands

Tags: **#contemporary healthcare,#decision making in healthcare,#healthcare quality and safety,#irrational agency,#Root Cause Analysis,#service delivery,#systemic error**