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IN REPLY

In reply: A view from the middle of the totem pole

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To the Editor,

We thank Dr. Snoek for his comments on our paper.[1]

We understand that some readers may think that the case was ambiguous to the participants. This point has been raised previously[2,3] in response to our previous report on the quantitative data from this study.[4] As we have previously replied,[5] the law in Canada is quite clear on this matter, and a competent adult has the right to refuse unwanted treatment, including blood products, based on autonomy.[6] Residents in both participating institutions are taught that administration of blood to a patient against their will constitutes battery. Therefore, we were confident that the appropriate clinical management of this scenario would be unambiguous to the participants. This was confirmed by the responses in the debriefings and the interviews: every participant stated that they knew that the correct management was not to give blood, with the exception of one participant who had misheard the details of the case.

In response to the second point, we find it interesting that you think that participants who felt "coerced" into being a good "team player" would be less likely to challenge authority. In our minds, this assumption in itself is very telling regarding issues of hierarchy in medical culture. Why would a good team member fail to contribute effectively towards decision-making? Shouldn't our definition of good teamwork include speaking up when necessary?

Finally, as the research question for this qualitative analysis was to examine hierarchy in medical culture, we considered it essential to include questions about hierarchy in the interview protocol. We think the strength of our study was our ability to use an immersive simulation experience as a springboard for participants to talk about a pervasive culture of hierarchy in their clinical experiences. We do accept, however, that negative perceptions may have been heightened in an emotional state after a stressful scenario. In our ongoing qualitative research, our group aims to examine these issues further, without the emotive trigger of a simulation scenario and with participants from different ends of the hierarchy in perioperative care. We point out that the aim of qualitative methods is not to quantify, as you have suggested we may have done with Likert scales and a survey, but rather to understand why and how people behave and think. We respectfully assert that a quantitative survey would not be able to provide this kind of information.

Conflicts of interest None declared.

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