

Appendix

Example #1: Treatment decision at the multidisciplinary cancer conference (mcc)

An oncology resident reports from treatment decision making at the multidisciplinary cancer conference. Consultants, seniors and residents from various disciplines discussed the case of a patient and the course of treatment. Because of the severe and progressed state of the patient they agreed that surgery is not indicated. It was an unequivocal, collective decision. One chief medical officer was late. When he entered the room, he stated "Yes, that's my patient. We operate." and stopped the discussion. A senior consultant was perplexed and asked "Why? What do you want to operate on?" The chief waved him off dismissively and said "I will discuss it with her [the patient]". After that, no one dared to say a word in reply. They then started to discuss the next case. The oncology resident describes her feelings: "It was clear to everybody that surgery poses an unjustified risk to that patient. Benefits would not outweigh the risks. I would have liked to say something and wanted to ask him naively to explain it to me because I could not understand the decision... but I did not dare to. He was so assertive, and as nobody else said something... I thought that my supervisor should have said something. I felt horrible and struggled two days with the decision. I also considered writing an email saying that it was not ok. But I didn't. I simply hoped that the senior would have discussed it with the chief following the mcc and they finally did not operate." The resident did not follow up on the decision and the patient outcome.

Example #2: Prescription error

A senior reports about a prescription error made by his supervisor. When he detected the wrong order he thought about how to bring it carefully forward. He called the supervisor and said "I'm not quite sure. The patient had these tablets now already for three weeks. Is there any specific reason why you prescribed them for four weeks, and not three?" He reports that "then there is a moment of silence and then he [the supervisor] said 'Okay, good that you point me to that'". The senior reports that the supervisor approached him later in a friendly manner and they discussed the incident. The supervisor referred to his work load as explanation for the error. The senior feels that having voiced his concerns has intensified mutual trust between the supervisor and him.

Example #3: Use of gloves and mask

A nurse reports about a senior doctor who persistently does not use mask and gloves for lumbar puncture. The nurse is aware that the senior doctor's behaviour is not in line with guidelines. She reports that, repeatedly, during the procedure other nurses and doctors stand by and recognize the missing precautions but remain silent. At an earlier, similar occasion, another nurse had handed the mask to the senior but he shook his head and simply said "no". The reporting nurse presumes that the senior believes it is not necessary to wear the mask. His behaviour has been subject to discussion among nurses, without consequences. The reporting nurse feels resigned to accepting due to the non-response of the doctor and the shared silence among co-workers. She presumes that the behaviour is silently being accepted because no infection outcome had been observed. "Maybe, because nothing went wrong up to date. If a child would catch an infection afterwards, maybe it would become an issue then. Maybe it's lucky that nothing serious has happened yet."