

dear residents

Teamwork and Hierarchy

October 19, 2025

Dear Residents,

In his 2011 Harvard Medical School [commencement address](#), **Atul Gawande** reflected on how medicine has evolved from a craft defined by individual mastery to one grounded in teamwork. He described an earlier era this way: *We were craftsmen. We could set the fracture, spin the blood, plate the cultures, administer the antiserum. The nature of the knowledge lent itself to prizing autonomy, independence, and self-sufficiency among our highest values and to designing medicine accordingly.* Fast forward to today, he noted how radically that model has changed: *No one person can work up a patient's back pain, run the immunoassay, do the physical therapy, protocol the MRI, and direct the treatment of the unexpected cancer found growing in the spine. I don't even know what it means to 'protocol' the MRI.*

Teamwork, Gawande reminded us, is no longer optional. It is the essential structure of modern medicine. Yet there remain forces deep within our professional psyche that resist it. Medicine was not built for group work. We continue to prize autonomy, self-sufficiency, and independence, and one enduring element reinforces this resistance: hierarchy.

Medicine has always had a hierarchy. We learn within a structure that defines levels of supervision and accountability (intern, resident, fellow, attending). Some of that structure is essential. It ensures safety, provides oversight, and supports the slow, careful granting of autonomy that defines professional formation. We cannot all be equals when lives are at stake.

But some parts of hierarchy persist for no reason other than inertia. The rituals of deference, the silencing of junior voices, the assumption that seniority confers wisdom are remnants of medicine's early architecture. Our profession came of age in the crucibles of the world wars when hospitals were organized like military units and discipline meant survival. That design served its time, but it also left a cultural residue: the attending as officer, the resident as soldier, the intern as recruit. Even after medicine embraced science and evidence, its social structure often remained regimental.

Michel Foucault, in [The Birth of the Clinic](#), described how the modern hospital created a new form of power: the "clinical gaze." To see and name disease was also to claim authority. Knowledge became hierarchical. Those who could interpret the body's signs were not just observers but arbiters of truth. The clinic was, in his view, both a site of healing and a system of control. You can still feel echoes of that logic today: who speaks, who is believed, and who must defer.

In residency training systems, this tension between learning and authority surfaces most vividly at night judged the next morning on post-call rounds or at Morning Report. Residents on call shoulder immense responsibility, often

caring for the sickest patients with limited backup and little rest. We test people's judgment under maximal uncertainty and then evaluate them the next morning as if certainty had been possible. It's an impossible standard, one that conflates learning with performance and transforms vulnerability into shame. Not too long ago, Morning Report was an inquisition of sorts as if certainty had been there all along, simply missed by the "incompetence" of the resident. Morning Report today is a collaborative effort at clinical problem solving.

This is not merely an educational issue; it's a cultural one. Medicine still carries traces of what anthropologists call a "heroic" ethos, the expectation that competence equals self-reliance, that asking for help signals weakness. But **in complex systems, heroism is the enemy of reliability**. When outcomes depend on teams, the lone savior model fails.

Organizational psychologist **Amy Edmondson** has [shown](#) that high-performing teams, from surgical units to NASA crews, share one defining feature: psychological safety, a shared belief that you can speak up with ideas, questions, or concerns without fear of embarrassment or punishment. In medicine, that means creating teams where hierarchy exists to clarify accountability, not to determine who is allowed to think.

What if we reimagined **hierarchy as a network of expertise** rather than a chain of command? The intern who spent the night at the bedside might understand a patient's subtle shifts better than anyone else. The nurse might recognize an early warning sign from years of pattern recognition. The attending's role, then, is not to dictate but to **curate collective intelligence**. To ask, "What did you see? What did you think? What did you fear?" and to treat those answers as data, not confession.

There is a kind of hierarchy worth keeping, the one that ensures accountability and stewardship of care. But there's another kind, the one that demands humiliation, silence, or perfection that we should outgrow. Real professionalism is not omniscience; it's the ability to make decisions amid uncertainty, to own those decisions, and to keep learning from them.

On my last Parkland rotation, the pharmacist on the team was empowered to make important decisions. Relinquishing this to her judgement was powerful and resulted in smarter dosing, safer choices, and lowered costs. It was teamwork unencumbered by hierarchy. I am confident that your generation is poised to build teams that are hierarchical in function but egalitarian in spirit - where responsibility is clear, but voice is shared; where respect flows in all directions; and where safety, learning, and dignity coexist.

There is some rain this weekend and then Fall might finally be here!

Best regards,

Dino Kazi