Emma Hayward and **Richard Mainwaring-Burton** look at the cutthroat world of medical one-up-manship

juniors' forum

Piggy in the middle

The scenario

At times, life as a hospital junior can feel like a never-ending game of piggy in the middle. It's no picnic when you're squashed – like the meat in a sandwich – between two large personalities with opposing priorities and opinions. You know what we're talking about…The consultant who wants a CT scan versus the radiologist who insists it's not indicated…The reg who wants a D-dimer at 3 am versus that technician who won't get out of bed to do it…the scenarios are endless.

Then there's the we-ship-them-out-faster-than-you game. All the other firms are playing it. Fewer patients hanging around post-take means less work for you and shorter ward rounds for your boss. How do you play? Simple: get them investigated fastest - write whatever you have to on the request form to make sure your patient gets that precious scan slot. No, nothing so black and white as lying! It's just a bit of grey truth twisting. What, you don't want to play?..then your patients will lose out.

Dr Diplomat

Emma Hayward
Paediatric SHO on a VTS rotation in Leicester

Along with my MBBS, I often think that having a degree in diplomacy would often come in really useful! After all, juniors often have to act as go-betweens for senior staff and other departments. Certainly, most house officers spend hours relaying messages from their team to different departments and back again; often this carries on until the department in question plays the trump card and requests consultant to consultant referral!

Requests or orders?

A radiographer friend once commented on how I mentioned *ordering* a chest X-ray. When she started work, X-rays were *requested*, not ordered. Perhaps this is a good attitude to take on board. Rather than seeing pathology and radiology departments as service providers, why not view them as we do other specialties from which we wish to have an opinion? We should be requesting their help and expertise, not ordering them around!

Top tip!

To avoid problems arising from unnecessary or inappropriate requests, why not ring up beforehand to make sure that the test you have in mind will actually yield the information required? Get yourself ready first with the patient's details and a concise history. Take previous films down to the radiology department. Write requests legibly and don't miss out relevant details such as your bleep number. This might take a bit longer but may well save you time and arguments later! It's also a way of loving your neighbour in the radiology department!

Nothing but the truth?

As a Christian I try to be truthful at all times, but it is tempting to bend this rule when caught between a rock (your rather fierce registrar) and a hard place (the radiology department). Routine tests are the hardest to justify: how many normal chest X-rays have I seen on post-take ward rounds?! At times I've not been sure why my patients required particular tests, making it difficult to give relevant details on the forms and giving rise to several sticky situations. I found discussing tests with my seniors a useful learning tool: their differential diagnoses were often different to mine. Are we trying to differentiate between diagnoses, confirm a suspected diagnosis or rule another differential out?

On the defensive

The rise and rise of defensive medicine is a related issue. Requesting tests in order to rule out diagnoses is becoming more and more common. There is no easy solution to this. Increasingly, both radiology departments and labs are swamped with requests. We do have a responsibility to use tests wisely, consider costs and think about risk versus benefit for each patient. On the other hand, I have found myself considering the potential costs – financial and emotional – of complaints for missed diagnoses. If I miss a diagnosis through neglecting to request a relevant test, it won't be the radiology consultant having to explain himself!

At the end of the day, as long as the test I've

requested is relevant and has potential benefit to my patient, I have no qualms about stretching already bulging lists or getting the radiology registrar out of bed. Caring for your patient can mean standing your ground and asking your seniors to back you up.

All change?

As a haematology house officer I was ideally placed to audit blood transfusion requests. This helped change our practice, ensuring that the sickest patients received their transfusions on time and that the labs knew which other patients were less urgent. Far from being boring and pointless, a carefully chosen and well-designed audit really can help change clinical practice, improving life for you, your successors and your patients!

Petty bureaucracy

Richard Mainwaring-Burton
Consultant Biochemist at Queen Mary's Hospital, Sidcup

A phone call during one of my weekend consultant biochemist oncalls: 'I'm having some trouble with one of your technicians – she won't let me come down to the lab and label a blood sample!' I hadn't been anticipating trouble as the biomedical scientist working this shift was one of our best team members. 'That is according to our protocols', I replied. 'How can you be sure it's your patient's blood?' 'It's the only one I've taken so it must be…' 'How many other samples do you think our lab's received today?' The discussion continued. The SHO admitted that he'd left the unlabelled bottles with a nurse, expecting that she'd label them before sending them up the chute. Clearly there'd been a misunderstanding between doctor and nurse!

Our practice must be safe at all times. Analysing a blood sample of unproven identity is not only dangerous but adds considerable doubt to the relevance of the results. Hence our apparently draconian policy: it's there to protect the laboratory, the clinician and above all the patient.

Scapegoats

Cynicism born of years of disappointment makes me suspicious that what happened next was, 'Sorry – there's been a laboratory error. We're going to have to take more blood.' It does happen. As a patient myself, I have heard reference to laboratory error. And why not? Possibly the relationship between patient and doctor is more important than my technician's integrity. Indeed, I almost regard this role as one of the responsibilities of the unseen services.

Treating doctors

A significant element of my department's function is treating doctors by reinforcing their confidence in their own clinical judgment, as well as their relationship with their patients. However, whilst recognising this as potentially true, should we allow one group, albeit a front-line team, to be dishonest about a colleague's professionalism in order to defend their own status?

Resources

Analysing unlabelled samples can be seen as uneconomic, as the results may well be ignored or repeated. Unnecessary investigations are wasteful and strain service departments' budgets. They could also be regarded as assaults upon patients! We all have a responsibility regarding proper use of the materials at our disposal and clinicians working at the coal face are not exempt from this.

The recent imposition of targets for A&E discharge times has applied substantial pressure on the service departments to produce more clinical information faster. So we have had to adapt and soften a little regarding the availability of tests.

A matter of protocol

Departments develop protocols, usually in agreement with clinical colleagues, to control inappropriate use of tests. Although these protocols should be respected, deviation from them should be flexible and negotiable, but only through proper channels. It is not appropriate, for instance, to manufacture clinical details on a request relating to a patient in order to justify access to an investigation that would normally fall outside the protocol. This is not just a problem with laboratory requests, but also applies to requests for radiological investigations. I personally regard a request for any investigation as a referral to another clinical discipline, so it would be good to have confidence in the information provided. Doctors providing misinformation on GP or inter-departmental referrals are not long in developing unfavourable reputations!

Setting an example

Unfortunately, there has been a significant escalation in defensive medicine. As in many other spheres of society, there is always a temptation to deflect blame, and we in the service departments are all too well aware of its consequences. Still, we should guard against our moral and ethical positions becoming compromised. Denying our laboratory colleagues the recognition of their professional integrity in upholding their ethical standards is representative of this.

In everything set them an example by doing what is good. (Titus 2:7)

In my experience, the majority of patients would prefer to know the truth, certainly in the longer term. Real trust is better engendered by sympathy and humility than by excuses.

National Juniors' Conference

Caring for your patient can mean standing your ground and asking your seniors to back you up