Inter-departmental cooperation needs education

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The authors (1) deserve applause for bringing up a practical and important deficiency in current medical practice. The incidents narrated by Aggarwal et al appear to follow poor inter-personal relationships between the various clinicians, the need for one or more of them to dominate over others, and sheer cussedness. They may also be the consequence of overwork with little opportunity to relax and shed exhaustion. Whatever the reasons, the patient suffers as a consequence and may worsen or even die, as doctors war over turf or massage their egos.

I'm afraid one of the solutions offered by the authors - the creation of guidelines - may not work. How many guidelines are administrators expected to formulate? Can they ever cover every possible situation that can arise in day-to-day work with patients? Besides, there already exists an over-arching guideline that must serve all doctors: "First of all, do no harm." Enunciated by Charaka and Susruta in our country and Hippocrates in Greece, it embraces all possible situations, is simple and keeps the patient's best interests in mind.

The administration has an important role to play. Every infraction of this guideline should invite action to ensure that there is no repetition. The judicious use of punishment - not by the administration but by a body of peers from among the respected staff members in the clinical fields - will help. Habitual troublemakers need special attention and if recalcitrant, dismissal. Punishment, alone, however, may prove counterproductive. Cussedness views punishment with disfavour and will only prompt more subtle forms of dispute or the use of subterfuge and diversionary tactics.

Far better would be the welding of the entire clinical team into a harmonious unit through the use of education and judicious rewards. Education in the principles of medical ethics and the humanities may prove especially effective in the long run. It is equally important to get to the root causes for the display of anger and frustration and address them. If overwork and exhaustion are noted, the administration should modify work schedules to ensure that no resident doctor is denied the hours of rest and recreation that are his due.

Reference

1. Aggarwal S, Sharma A, Sharma R. Seeking better inter-departmental cooperation in healthcare settings. *Indian J Med Ethics* 2010 Jul-Sep; 7(3): 180.

Conflict resolution in the healthcare environment

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How would you like to be a passenger in an aircraft, where the senior pilot and the co-pilot were having a loud altercation, just a few minutes before landing? This would be rather upsetting. You don't really care about "their" issue, you just expect them to get their act together and be "professional". After all, your life is in their hands, and nothing else is really more important. Sourabh Aggarwal and his co-authors have described a similar situation in the hospital setting (1). A faceoff between the surgeons and anaesthetists over an operation theatre scheduling issue paralyses work and there seems no way to resolve the stalemate. Never mind the patient on the table, he does not matter. The situation described is lamentable with each department stubbornly adhering to its position. On behalf of the fraternity of senior clinicians, I do apologise to all medical students for setting such a bad example. Ego-wars, doctors fighting in the corridors and even throwing surgical instruments in the operation theatres are everyday life occurrences in the hospital setting. Yet most medical students and practitioners seem to have happily internalised these conflicts, over the years, aided by our famous Indian laissez-faire "chalta hain" attitude. We would, however, be less forgiving if this were done by the pilot.

Two key issues of teamwork and patient safety have been highlighted by the authors. The difficulty is in operationalising these concepts in the practice environment. These issues are complex and multifactorial. Also, at the core of these issues is respect for the patient and co-workers.

Understanding the barriers

First, we are human. We deal with other humans and, unlike pilots, we do not deal with machines. So we have a second set of behaviours to deal with, besides our own. Ideally, we need to be happy and content ourselves, to deal with the misery of others. In the real world, physicians often dehumanise themselves as a coping mechanism. Perhaps cynicism is an occupational hazard. To this we can add yet another layer, of inadequate knowledge, unpredictable outcomes, inappropriate technology, stress,

fatigue, a hostile workplace - and we find we are wrecked. Some of the symptoms manifested are blaming others, face-saving explanations, poor patient outcomes and not learning from past mistakes. We often resort to blaming our woes on the "system", the "government" and other third party causative factors.

Second, medicine is incorrigibly hierarchical. It is almost like the army. Physicians, nurses, interns, helpers and administrators are constantly jockeying for position in a one-upmanship game, between and within their groups. Again, the centrality of the patient is lost, as there is no group lobbying for the patient's interest in the hospital.

Third, there is the class issue in Indian medical practice. This is complicated by the patient (especially in public hospitals) being from a lower socio-economic class. The caregivers, by virtue of being from a higher class, seem to feel they have the right to be abusive. The patient who speaks up is quickly silenced. Last, in India, the doctor plays a paternalistic role in the unequal doctor-patient relationship. And of course, we have tremendous work pressure and have no time. We have so many good reasons to behave badly with the patient. We have ventilated all the angst. Just acknowledging the barriers mentioned prompts us to think constructively towards a resolution of this problem.

The solutions

"What" is right is more important than "who"' is right. The patient is the most important person in this whole transaction and the reason why we are all here. It is often forgotten, while we immerse ourselves in petty battles. The first thing about teamwork is having a shared value, about what is important for us. A number of hospitals have resorted to publicly displaying the common goals, with which everyone from the dean to the security guard can identify. It is stating the common purpose, which binds caregivers in a healthcare institution, in terms of a mission statement. While this sounds like superficiality, it is the equivalent of the "red light" at an intersection that says "Stop". There will be people who will ignore it, disobey it, laugh at it; but no one can say that they don't know that it means "stop".

Indians are not known to be team players. Further, a typical physician is a retailer, and can get away with an individualistic pattern of practice. Therefore, teamwork is not inbuilt in our profession and it does not happen naturally. Since it has never been taught in medical schools, it needs to be cultivated in the healthcare environment, and cannot be enforced by administrators. The most important feature of teams is that they consist of different kinds of people -like the proverbial hand needs fingers of different sizes and strengths to form the fist. The operative word which makes teams work is "respect". Good cohesive teams produce extraordinary results with ordinary people. Each member brings his or her set of skills to the table, contributing to the common goal, which, is once again, the patient's health. In this case study, can the surgical team really feel more self-important than the anaesthesia team in caring for the patient? Respect is a two-way process and most senior physicians who are much respected are known to be courteous to their junior-most colleagues. These are usually unassuming, humble people and may go unnoticed. There are fine examples all around us, provided we look out for these pearls in our own workplace.

What can a very junior medical student do about the "system"?

Let's take a traffic example. Each driver with the "me first"' attitude has clogged a traffic circle. No one is willing to give right of way. While all the drivers honk and curse from within the comfort of their vehicles, it takes one unassuming person to come over to the epicentre of the jam and become a proxy policeman. He gives hand signals and starts directing the traffic. Magically, the same disgruntled drivers respond to the hand signals and the jam begins to clear. Leadership. It works! Conflict resolution seems almost impossible with the ego-jostling that we witness every day in the healthcare environment. In the given situation, the residents in the hospital "hopped" between the two departments and displayed leadership in resolving the impasse. While it seems hard to change the world as a medical student, the authors have done just that. They have taught their medical teachers about teamwork, rather than choosing the easier alternative, which was to become a part of the "system". Teachers have a lot more to learn from their students.

Reference

1. Aggarwal S, Sharma A, Sharma R. Seeking better inter-departmental cooperation in healthcare settings. *Indian J Med Ethics* 2010 Jul-Sep; 7(3): 180.