Reflection

Specialist Registrar Trauma and Orthopaedics

Description of Incident

A 21-year old female patient attended the Accident and Emergency Department following a road traffic accident complaining of back pain and a numb left leg. She was attended to appropriately by the Accident and Emergency staff organising medical review and X-rays of her spine whilst keeping her mobilised as one would expect for a spinal injury. The Accident and Emergency registrar phoned me in my capacity as SpR in Trauma and Orthopaedics for my opinion. I recommended urgent CT scan and following this a clinical review by myself. The CT scan was organised. Whilst in the scanner, 4 hours passed and thus the patient breached the “4 hour wait rule”. The nurse in charge insisted that the patient was sent from the scanner and admitted directly to the ward. I requested the patient return to the Accident and Emergency Department for my clinical review as I believed that there was an excellent chance of being able to discharge the patient from the Accident and Emergency Department thus saving the admission. Clearly there was a disagreement here, but the patient was brought back to the Accident and Emergency Department, reviewed promptly by myself (I was waiting in the Accident and Emergency Department for the patient), and as I suspected, discharged with reassurance that no significant injury had occurred albeit at 4.5 hours after presentation. The senior nurse in the Accident and Emergency Department approached me after the event and expressed her displeasure at my insistence that the patient was not admitted and brought back to the Accident and Emergency Department. She explained rather aggressively that the most important issue was the 4 hour rule. I explained that it was not my prime concern and that my number one priority was to give the patient that I believe was the best care that I possibly could.

She told me that she had reported me to the duty manager on call and that I would have to answer to that person later.

The Issues

Why was there a confrontation?

1. Different agenda

The senior nurse’s aim was to get the patient out of the Accident and Emergency Department as fast as possible so that she could meet her departmental targets. I was less concerned with the 4 hour wait but primarily concerned with the best care for the individual patient, which involved a timely and appropriate orthopaedic review. Not only was the patient reassured and pleased with the sequence of her care, but I saved an admission, which save the patient a lot of time before discharge, saved the ward nurses admitting an unnecessary patient, thus giving them time to tend to patients who actually needed their care and also saving the hospital money, as an admission would have been an unnecessary cost to the NHS.

1. The age old Doctor versus Nurse power struggle!

I think that as a senior nurse she felt that she was in charge and made “the decisions” in her department. I however felt that the decision that was most critical was my orthopaedic review, which would determine the extent of injury and subsequent clinical management plan. I believe that the patient would probably have felt the same way as I did and was less concerned with an

arbitrary time limit, but rather more concerned with whether she had a significant injury and what was going to happen about it.

What annoyed me?

I feel that the fact that I was reported was absolutely ridiculous. That annoys me. I find it all rather childish. It seems that the person who puts in the complaint is generally seen as the one “in the right”. I would rather have discussed the issue further with the nurse there and then and then the issue be dealt with. Perhaps the nurse who reported me should have been reported for wasting everybody’s time! Fortunately I have been a trainee for a long time and believe that I have built an excellent reputation as a sound decision maker, which had helped me in this situation, as the people investigating the incident namely the surgical manager and my consultant have backed me up. It would be rather more difficult to deal with complaints like this if I was more junior, was less sure of my decision making and was not confident in having senior support.

The bigger picture

The is rather bigger than an issue between a doctor and a nurse. It is actually about priorities across the health service. Doctors on the whole look after the patient, individually as their number one priority. We have the luxury of being able to make autonomous decisions most of the time, without undue outside influence. This is (or was) the beauty of medicine as a career. The health service is changing. Politicians are more involved, Voters understand targets. Often these target may create a service that looks good on paper through statistics developed from meeting those targets. Most people working in the system realise that adhering to mass targets actually limits the ability to offer each patient the individualised care that they deserve.

What would I have done differently given the chance?

Actually, nothing. I feel on reflection that the patient had excellent care, She was seen in the appropriate place, had assessment, X-rays and urgent CT scan and senior orthopaedic review all within a 4.5 hour period. In this situation the 4 hour rule had less significance. As for the confrontation with the senior nurse, I did not raise my voice, I was not aggressive, I clearly stated the justification for my decision making and therefore would do the same again. I am a good communicator and this has been reflected in every assessment and appraisal I have ever had. I am not there just to do “what I am told”. We are trained to make clinical decisions on serious injuries and implement them taking into account many issues including where the patient is best treated. My decisions may have been unpopular with the senior nurse, but that is not a concern of mine providing I had communicated my plan to her appropriately. The patient is my priority. Or am I just being naïve?