

CASE STUDY

Seeking better inter-departmental cooperation in healthcare settings

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Abstract

Hospital healthcare is essentially teamwork. Frequently, however, one comes across incidents where inter-departmental cooperation is compromised. It can create an awkward situation for residents and other staff members involved in the healthcare system. We can recall many such incidents during our training. Studies have indicated that failure in "tightly coupled" organisational relationships between hospital departments imposes a threat to patient safety. Clear guidelines on how to manage certain situations should be in place, leaving no ambiguity as far as issues concerning patient management are concerned. A lot more needs to be done by administrators to avoid such incidents and to promote inter-departmental co-operation. In addition, more caution and effort by administrators, residents and faculty can help avoid such incidents.

Hospital healthcare is essentially teamwork. Different departments need to work together, each playing a part in the overall management of the patient. Inter-departmental collaboration and harmony is the foundation on which a tertiary care hospital runs and it is of immense importance in ensuring optimum care to patients. Frequently, however, one comes across incidents where inter-departmental cooperation is compromised. The personal ego of physicians occasionally manages to find a way between a doctor and his duty to provide unconditional service to mankind. It can create an awkward situation for residents and other staff members involved in the healthcare system.

We can recall many such unfortunate incidents during our training. To narrate one such incident, during SA's undergraduate anaesthesia posting, a small incident boiled into a proper altercation between the surgeons and the anesthesiologists. The resident prepares a list of surgical procedures to be done, in the order that they are to be done, a day before the surgery date, and pastes it outside the operating theatre early in the morning so that patients are taken into surgery in the appropriate order. Due to a communication gap, the anesthesia residents shifted the patient who was listed second for surgery. The surgeons refused to operate on the patient before the first. An argument ensued in the OT itself. Both surgery and anaesthesia consultants remained adamant on their views for some time. The residents kept hopping from the room of one consultant to the other trying to convince one

of them to shed their ego. Finally after about 30 minutes, the anesthesiologist gave in. The patient was shifted back to the pre-operative room and the other patient shifted to the OT and the surgeons then proceeded with the surgery.

It is not uncommon to see departments fighting over whose case it is. A patient with obstructive uropathy with features of uraemia may find himself in a tizzy as surgical and medical residents slug it out over who should admit the patient. Surgical residents may insist that renal failure must be managed by medicine, and medical residents may argue that surgeons should admit the patient for obstruction. Similar arguments are common over other cases entailing interdepartmental coordination, like non-traumatic pneumothorax, liver abscess and pancreatitis. Such incidents not only hamper patient care but also affect the faith of patients in doctors, which in turn has a psychological impact on their recovery. Studies (1) have indicated that failure in "tightly coupled" organisational relationships between hospital departments, like timely exchange of information, services and resources required for the delivery of care, leads to situations of uncertainty in the work of the operating department, imposing a threat to patient safety. Also, such incidents adversely affect the tender minds of medical students and interns, who are under training and still not exposed to the harsh realities of this field.

We feel a lot more needs to be done by administrators to avoid such incidents and to promote inter-departmental co-operation. Every physician's and resident's work should be well defined and followed properly to maintain a healthy work atmosphere. Clear guidelines on how to manage uncertain situations should be in place, leaving no ambiguity as far as issues concerning patient management are concerned. Once such guidelines are in place, strict action must be taken, without exception, against defaulters whenever patient care is found to be compromised. We feel that a little more caution and effort by administrators, residents and faculty can help avoid such incidents.

Reference

1. Waring J, McDonald R, Harrison S. Safety and complexity: inter-departmental relationships as a threat to patient safety in the operating department. *J Health Organ Manag* 2006; 20(2-3):227-42.