

Chapter 1

1

General principles of management of patients

Communication skills 2

Documentation and note keeping 4

Patient safety in surgical practice 6



Communication skills

Communication is the imparting of knowledge and understanding. Good communication is crucial for the surgeon in his or her daily interaction with patients. The nature of any interaction between surgeon and patient will depend very much on the context of the 'interview', whether you know the patient already, and on the quantity and type of information that needs to be imparted. As a general rule the basis of good communication requires the following:

- **Introduction**

Give your name, explain who you are, greet the patient/relative appropriately (e.g. handshake), check you are talking to the correct person.

- **Establish the purpose of the interview**

Explain the purpose of the interview from the patient's perspective and yours, and the desired outcome of the interview.

- **Establish the patient's baseline knowledge and understanding**

Use open questions, let the patient talk and confirm what they know.

- **Listen actively**

Make it clear to the patient that they have your undivided attention—that you are focusing on them. This involves appropriate body language (keep eye contact—don't look out of the window!).

- **Pick up on and respond to cues**

The patient/relative may offer verbal or non-verbal indications about their thoughts or feelings.

- **Elicit the patient's main concern(s)**

What you think should be the patient's main concerns may not be. Try to find out exactly what the patient is worried about.

- **Chunks and checks**

Give information in small quantities and check that this has been understood. A good way of doing this is to ask the patient to explain what they think you have said.

- **Show empathy**

Let the patient know you understand their feelings.

- **Be non-judgemental**

Don't express your personal views or beliefs.

- **Alternate control of the interview between the patient and yourself**

Allow the patient to take the lead where appropriate.

- **Signpost changes in direction**

State clearly when you move onto a new subject.

- **Avoid the use of jargon**

Use language the patient will understand, rather than medical terminology.

- **Body language**

Use body language that shows the patient that you are interested in their problem and that you understand what they are going through. Respect cultural differences; in some cultures eye contact is regarded as a sign of aggression.

- **Summarize and indicate the next steps**

Summarize what you understand to be the patient's problem, and what the next steps are going to be.



Documentation and note keeping

Royal College of Surgeons' guidelines state that each clinical history sheet should include the patient's name, date of birth, and record number. Each entry should be timed, dated, and signed, and your name and position (e.g. SHO for 'senior house officer' or SPR for 'specialist registrar') should be clearly written in capital letters below each entry. You should also document which other medical staff were present with you on ward rounds or when seeing a patient (e.g. 'ward round—SPR (Mr X)/SHO/HO').

Contemporaneous note keeping is an important part of good clinical practice. Medical notes document the patient's problems, the investigations they have undergone, the diagnosis, and the treatment and its outcome. The notes also provide a channel of communication between doctors and nurses on the ward, and between different medical teams. In order for this communication to be effective and safe, medical notes must be clearly written. They will also be scrutinized in cases of complaint and litigation. Failure to keep accurate, meaningful notes, which are timed, dated, and signed, with your name written in capital letters below, exposes you to the potential for criticism in such cases. The standard of note keeping is seen as an indirect measure of the standard of care you have given your patients. Sloppy notes can be construed as evidence of sloppy care, quite apart from the fact that such notes do not allow you to provide evidence of your actions! Unfortunately, the defence of not having sufficient time to write the notes is not an adequate one, and the courts will regard absence of documentation of your actions as indicating that you did not do what you said you did.

Do not write anything that might later be construed as a personal comment about a patient or colleague (e.g. do not comment on an individual's character or manner). Do not make jokes in the patient's notes. Such comments are unlikely to be helpful and may cause you embarrassment in the future when you are asked to interpret them.

Try to make the notes relevant to the situation. So, for example, in a patient with suspected bleeding, a record of blood pressure and pulse rate is important, but a record of a detailed neurological history and examination is less relevant (unless, for example, a neurological basis for the patient's problem is suspected).

The results of investigations should be clearly documented in the notes, preferably in red ink, with a note of the time and date when the investigation was performed.

Avoid the use of abbreviations. In particular, always write LEFT or RIGHT, in capital letters, rather than Lt/Rt or L/R. A handwritten L can sometimes be mistaken for an R and vice versa.

Operation notes

We include the following information on operation notes:

- Patient name, number, and date of birth
- Date of operation
- Surgeon, assistants
- Patient position (e.g. supine, prone, lithotomy, Lloyd–Davies)
- Type of deep vein thrombosis (DVT) prophylaxis (AK–TEDS, Flowtrons, heparin, etc.)
- Type, time of administration, and doses of antibiotic prophylaxis
- Presence of image intensifier, if appropriate
- Type and size of endoscopes used
- Your signature and your name in capitals
- Post-operative instructions and follow-up, if appropriate.

If a consultant is supervising you, but is not scrubbed, you must clearly state that the 'consultant (named) was in attendance'.

Patient safety in surgical practice

The aviation, nuclear, and petrochemical industries are termed 'high reliability organizations' (HROs) because they have adopted a variety of core safety principles that have enabled them to achieve safety success, despite 'operating' in high-risk environments. Surgeons can learn much from HROs and can adopt some of these safety principles in surgical practice, in order to improve safety in the non-technical aspects of care.

Foremost amongst the safety principles of HROs are:

- **Team working**
- **Use of standard operating procedures (SOPs):** day-to-day tasks are carried out according to a set of rules and in a way that is standardized across the organization
- **Cross-checking:** members of the team check that a procedure, drug, or action has been done or administered by 'verbalizing' that action to another team member. This is most familiar when aircraft cabin crew are asked by the pilot to check that the doors of the plane are locked shut ('doors to cross-check') and crew members cross to the opposite door to confirm this has been done. In surgical practice an example of cross-checking could be 'antibiotic given?', confirmed by a specific reply such as '240mg IV gentamicin given'
- **Regular audit and feedback of audit data:** performance data (both good and bad) is collected regularly and *crucially* team members are notified (e.g. in audit meetings) of where they are performing well or badly
- **Establishment of variable hierarchies:** development of a working environment where junior staff are encouraged to 'speak up' if they believe an error is about to occur, without fear of criticism
- **Cyclical training:** frequent and regular training sessions to reinforce safe practice methods.