Take a note!

A few months ago I began to receive e-mails from Fraser Health concerning discharge summaries. Previously, entering a patient's details about his or her hospital stay by hand on the form provided had been acceptable. These forms were being phased out and, going forward, all discharges would have to be dictated. Now, I don't like being told what to do, so when these e-mails began to infiltrate my inbox, imagine my surprise when Fraser Health thanked me for my over 20 years of service and apologized for any inconvenience the new process might cause, asking for my patience during this transition phase. Except that's not what happened. To paraphrase, the gist of the e-mails was start dictating your summaries or your hospital privileges will be suspended.

It is entirely possible that this got my back up and I began to dream of ways to sabotage the process. I might have uttered these words while pouting, "Take away my privileges and see if I care; they are more like onerous duties anyway."

After receiving even more e-mails, now stating that I had overdue summaries, which if not dictated within a week would result in my suspension, I might have vented in the hospital mailroom about this draconian action. Upon hearing my rant one of my more level-headed colleagues might have mentioned that the practice of dictating discharge summaries was actually good for patient care so I should swallow my pride and just do it. Since I don't want to embarrass this clearly misguided but rational, excellent physician, Dr Philip Cilliers, I won't mention him by name.

One of my more level-headed colleagues might have mentioned that the practice of dictating discharge summaries was actually good for patient care so I should swallow my pride and just do it.

Now shamed, I presented myself to the hospital dictation room on my next available rounds day to complete my dictations. Following the helpful instructions plastered all over the walls, I dialed the dictation number and entered my unique ID (MSP number) as prompted, which is 7787. The system then told me to contact dictation services as there was a problem (how do they know about all my unpaid parking tickets, I wondered). The conversation with the nice woman who answered went something like this: "What is your first and last name?" she asked.

"David Richardson," I answered.

"David R. Richardson from Langley?" she queried, and upon hearing the affirmative she added, "What is your e-mail address?"

Taking a moment to bite my tongue, I replied, "Since you have sent me close to 10 threatening e-mails about this issue, I think you already have it!"

After a pause, "Well, if you don't give it to me I can't send you your unique ID."

"blahblah@gmail.com"

"Thank you, and now could you please give me your office address?"

Biting harder, "How is it possible you don't have it as I have been working in Langley at the same location for over 20 years and you just looked me up in the system?" But remembering Rational Phil, I gave it to her.

Another pause, "What is your phone number?" Thud (sound of my head hitting the table), and so it went until, when she was finally done, I pleaded, "So now can I have my dictation number?"

"No, I have to send your request to a systems analyst."

"But I am ready to dictate now and, seriously, how complicated can it be to give me a number?"

"Well, I will put a rush on it and you will get it later today."

"Listen, I'm not coming back today and in fact I won't be back for 2 weeks, so how about in the meantime you stop sending me threatening e-mails?"

"That isn't our department." Double thud!

I eventually received my ID and it is possible that one of my dictations states, "patient was sick, we did some tests, gave some treatment, and they got better, not sure why."

By the way, the unique dictation ID I received after a few days of intense analysis was 7787.

—DRR

The real stars of the show

It is always busy this time of year, really busy, in the ER. When I came on shift recently the lineup of charts waiting to be picked up was almost falling off the desk. To be expected, I thought.

"We divided the charts into two piles, as one was getting to be too big. Do you want me to put them into single file?" asked the charge nurse. I looked up to see a second long lineup of charts on the shelf above my computer station. Wow, this was a new level of congestion, even for me. As I started moving from bed to bed I noted that every patient had been waiting more than 5 hours to be seen. They all were patient and polite, likely more than I would have been in their shoes.

I am continually amazed at how the nursing staff carry on with patients waiting in every nook and cranny of the department, keeping them safe and cared for before and after the physician attends. All eyes are upon the nurses as they work in the ER, assessing patients, updating the physician, giving medications. It is a fishbowl-like environment and the constant scrutiny is intense.

It's the nurses who often bear the brunt of patient frustration when waits for care are long. How many times have I been gently prepared for a frosty reception in the exam room? But when I finally walk in to see the patient I sense not a bit of impatience. It certainly isn't the result of extraordinary interaction skills on my part. The nurse has done his or her utmost to defuse the situation and be compassionate, usually with excellent results.

As an intern 30 years ago, I got the usual orientation to the wards: writing admission orders, call schedules, who to consult with. But the best advice was the following: "Listen carefully to the nurses—if they are concerned or uncomfortable with how you are going to approach a patient's care, think twice, and then think again. If the nurse doesn't feel the patient should be discharged, you are likely missing something!" I had good sense enough to heed the advice, my patients benefited, and I stayed out of trouble. That advice has stuck with me after all these years and has remained invaluable.

It is so satisfying to watch new grads develop into seasoned ER nurses. Not only do they have to learn new skills, they develop that "sniff-test" ability—being able to sense when something is just not right with one of their patients despite the information at hand. In addition, they have to get used to all our individual physician idiosyncrasies. As one of our veterans explained to a younger colleague, "You will get a feel for which doctor likes what, as there can be a lot of differences sometimes." You have to be very special to accomplish that steep learning curve, and incredibly patient.

Health care has always been a team sport, but not all members get the attention they deserve. We physicians are accustomed to getting a lot of credit for successful outcomes, but we know that our nursing staff contribute a huge amount to patients getting the care they need. Grace under fire might be the best way to put it.

—AIC