

Letters to the Editor

OVERVIEW

Please submit letters for the editor's consideration within 3 weeks of receipt of *Future Healthcare Journal*. Letters should be limited to 350 words, and sent by email to: fhj@rcplondon.ac.uk

Junior doctor exposure to senior management

DOI: 10.7861/fhj.Let.8.1.1

Editor – We read with interest the article by Omar *et al* on the perceived barriers to medical leadership in medical students.¹ They describe well the lack of opportunities medical students face in attaining leadership skills in the curriculum. The doctors' role as clinical leaders is well established now. The General Medical Council (GMC) has clear guidance on the leadership roles for doctors. The Faculty of Medical Leadership management has released a toolkit for junior doctors to help them better engage with managers.²

The doctor–manager relationship has been cited as one of the reasons for discontent among doctors.³ Junior doctors, in particular, can often feel ignored. This may be partly because junior doctors have limited opportunities to interact with senior managers and often have unfavourable perceptions of them. In response to this concern, a number of 10-minute roundtables with managers were organised, bringing together the board with 21 junior doctors. This was exceptionally well received by both managers and junior doctors.⁴ Further, such meetings (including the chief executive and medical, nursing and IT directors, among others) have taken place at Lancashire Teaching Hospitals NHS Foundation Trust, where the meetings have led to a number of improvements which were co-developed with junior doctors and are still in place 3 years later, with excellent feedback.⁵

Undoubtedly, junior doctors are an important part of the NHS and should be involved in decision making and engaged with regularly. Prof Sir Bruce Keogh, former NHS medical director stated that: '[Junior doctors] are the backbone of the medical services and, more importantly, they hold the key to the future of our NHS.'⁶ Hence, in our opinion, teaching and training on the medical leadership skills should start during their undergraduate training to prepare them for what lies ahead and should continue during their postgraduate training. In parallel to their exposure to the clinical practice earlier during the undergraduate years, we believe that medical students should be introduced to the hospital management structure and functioning during the medical school course, too.

Omar *et al* highlighted the need for undergraduate medical leadership training. We believe this should be complemented at postgraduate level and include regular interactions with frontline managers. ■

Omer Ali

Clinical informatics fellow, Lancashire Teaching Hospitals NHS Foundation Trust, Preston, UK and lecturer in public health, Manchester Urban Collaboration on Health (MUCH), Manchester, UK

Tahir Nazir

Consultant physician, Lancashire Teaching Hospitals NHS Foundation Trust, Preston, UK and postgraduate doctoral research fellow in cardiovascular sciences, The University of Manchester, Manchester, UK

References

- 1 Omar A, Shrestha A, Fernandes R, Shah A. Perceived barriers to medical leadership training and methods to mitigate them in the undergraduate medical curriculum: A mixed-methods study of final-year medical students at two medical schools. *FHJ* 2020;7:e11–6.
- 2 Faculty of Medical Leadership and Management. *Leading as a junior doctor*. FMLM. www.fmlm.ac.uk/members/resources/leading-as-a-junior-doctor [Accessed 21 December 2020].
- 3 Davies HTO, Harrison S. Trends in doctor-manager relationships. *BMJ* 2003;326:646–9.
- 4 Kadir S, Nazir T, Ahmed-Little Y. Meet the management: a local initiative. *Br J Healthc Manag* 2010;16:533–5.
- 5 Ali O, Howells J, Partington K. 94 Bridging the divide: senior managers and junior doctors working together. *BMJ Lead* 2018;2:A39.
- 6 McCay L, Jonas S. *A junior doctor's guide to the NHS*. Department of Health, 2009.

Plans for restart following COVID-19 should consider the whole system including the impact on diagnostic services, not just the demands of frontline clinics

DOI: 10.7861/fhj.Let.8.1.2

Editor – The Royal College of Physicians' teach-in 'Resetting of services post COVID-19' on 29 June 2020 had some helpful advice and observations.¹ Concerning was the recommendation by one of the speakers that physicians should consider arranging diagnostic tests prior to seeing patients as a way of mitigating the impact of social distancing and return to work.

As a neurophysiologist running a diagnostic service, I would like to outline the adverse consequences of pursuing this route.

- > Most diagnostic departments struggled to deliver a timely service prior to COVID-19. Any increase in referrals just shifts the problem onto another area of the hospital.
- > There are shortages of diagnostic unit staff.
- > Most diagnostic units have reduced throughput due to social distancing. They are unable to increase numbers to compensate for other specialties.
- > Many investigations require a breach of social distancing. Whether phlebotomy, a nerve conduction study or electrocardiography, the investigator will be less than 1 metre from the patient.
- > Investigations take time. Each neurophysiology referral needs triaging, administering, recording and reporting. The referral typically requires 20 minutes of consultant time, 20 minutes of secretarial time and over 2 hours of physiologist time.

- > Investigations are not without harm: phlebotomy has the risk of haematoma, electromyography can result in compartment syndrome and computed tomography delivers radiation. The risk of injury is considered appropriate if there is advantage for the patient. When the measure of utility is reduced, the burden of unnecessary risk is increased.
- > The sensitivity and specificity of every investigation is highest when there is a high pre-test probability of an outcome prior to an investigation. When diagnostic tests are ordered in a scatter-gun approach, the sensitivity and specificity of the investigation is lowered. Two per cent of the healthy population have changes on their electroencephalography (EEG) which would be in keeping with epilepsy. Having identified this on EEG, the patient would receive an unnecessary driving ban.² This approach therefore violates the principle of 'first, do no harm'.
- > Every investigation can produce ambiguous results. Investigations rarely give a yes/no answer and a reporting diagnostician needs to have as much clinical information as possible prior to the investigation to help focus the investigation and guide interpretation.
- > Unnecessary investigations generate unnecessary anxiety for patients.

- > If all referrals are made without a history, I am unable to prioritise my limited resource and those who are genuinely unwell will need to wait longer.

I wish all physicians the best of luck in dealing with the aftermath of COVID-19 and the resetting of services. Rather than adopt an approach which risks shifting workload from one part of the hospital to another, there is another way: working together we can create 'one-stop-shop clinics' and true multidisciplinary team working. This has been pioneered in breast cancer diagnostics and orthopaedic clinics. This approach leads to better relationships between clinicians, fewer hospital visits for patients and better outcomes all round. ■

Gareth Payne

Consultant clinical neurophysiologist, Ysbyty Gwynedd, Bangor UK

References

- 1 Royal College of Physicians. *Reset of services*. RCP, 2020. <https://player.rcplondon.ac.uk/covid-response/reset-of-services/164821701>
- 2 Smith SJM. EEG in the diagnosis, classification, and management of patients with epilepsy. *J Neurol Neurosurg Psychiatry* 2005; 76(suppl 2):ii2–7.