

On My Ideas of the Qualities of an Ideal Resident Staff

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Editor's Comments.

This article was first published in 1981 in "the Occasional Publication" of the Department of Medicine, University College Hospital, Ibadan, Nigeria. It is herein reproduced with the kind permission of the incumbent Head of Department, Professor A. Ogunniyi. This reproduction consists of the article sandwiched between the editorial and editorial comments. The author, Dr. T.A. Akintewe, was then a Senior Registrar in the Department while the editorial and editorial comments were written by the Late Professor A.A. Adetuyibi, the then Head of Department of Medicine. It is felt that the principles and ideas expounded in the article and the accompanying editorial comments have great lessons for current and future generations of resident doctors, hence this reproduction.

EDITORIAL

The term "resident staff" is one that is peculiar to the hierarchical set-up of a university affiliated hospital where *service to patients* is combined with the *training* of doctors, dentists, nurses, laboratory technologists, electro-cardiographers and radiologists to mention only a few, as well as, *research* aimed at advancing the frontiers of medical knowledge.

This term covers all grades of doctors from the newly qualified ones to those adjudged competent enough to be regarded as the ultimate authorities especially on patients care matters in their various specialities, who under the British hospital hierarchical set-up are referred to as 'consultants'. Such consultant may hold concurrent university posts for the purposes of teaching or the training of medical graduates and for research into the problems pertaining to their specialities.

The reason for 'resident staff' set-up in a place like a teaching hospital is the fact that expertise is

borne out of graduate experience and the recognition of the fact that the qualifying examinations for medical degrees merely test how much of the art and science of medical practice has been learnt and does not imply that such a graduate is necessarily competent to function optimally without supervision. Medicine in this respect is like all forms of 'trade', where a pupil engineer or an articled accountant graduates into a full-fledged engineer or a chartered accountant and becomes so accredited or where a baker or a chess player, after several years of baking experience or of participating in chess tournament becomes a master baker or a grand master in chess. Hippocrates of Cos, moved from place to place with his pupils while the medieval association of barbers, who removed scalp cysts obtained a royal charter to become an association of surgeons as they are presently known.

An ideal residency programme must realise its essentially hierarchical nature and the level of expertise expected at every stage in the programme must be clearly and unambiguously defined. Although different terminologies may be used for the different grades of a 'residency' scheme, such as the housemanship or internship for the period of training preceding full registration and junior residency, senior registrarship, thereafter, the hierarchical concept is essentially the same. In this hierarchical set-up, the medical profession is not peculiar. It is a feature of very many professions such as the nursing and the military.

An ideal residency programme is one that ensures that the final products, in terms of full-fledged physicians, surgeons, gynaecologists and obstetricians, paediatricians, pathologists, and radiologists, among others, are most proficient in the practice of their specialties.

Although, it may be a most desirable goal for the final products of residency programme to be excellent teachers or researchers, most people would

agree that *professional competence and expertise* is the most desirable, from the utilitarian point of view especially as factors such as natural inclination and 'gift' may influence one's ability to function optimally as a teacher or a researcher. There are instances of gifted researchers who are poor at importing knowledge by formal teaching and of gifted teachers who loathe the 'creative' mental endeavour required for meaningful investigative work.

If the primary aim of a residency training scheme is to produce a *professionally competent product*, then the crucial factor would be the quality of training, with set objectives for the various stages of the residency training, it has to be decided as well, what type of personality, one desires in one's end product. 'Personality' is too sophisticated a psychological term to be defined by the uninitiated, but by and large, a good end-product physician is one who is not only professionally competent but realizes the limitations of his competence and approximate to the "Hippocratic" model of a physician as regards ethics, relationship with colleagues and most especially with patients. Bed rest and kind words of re-assurance may, sometimes, do more for a patient with psychosomatic symptoms than the most potent of mood-altering drugs.

At the inception of the present administration of the department of medicine, one of the set objectives was a radical improvement in the *quality of the residency training programme*. Circulars were issued to initiate a dialogue between the departmental authorities and the resident staff; guidelines were issued as to how to improve the quality of case presentation and discussion, by the resident staff; those of them who had the opportunity to spend 'a year abroad' as part of their training were to be made to share their experiences with those who had no such yardstick for comparison; regular assessment of proficiency of resident staff was to be introduced, but it soon became apparent that all forms of continuous assessment were an abhorrent event to postgraduate trainees, in spite of a firm assurance of their benefits and their practice in other countries such as the USA and Germany while programmes of short courses on 'recent advances in medicine; research methodology for the clinicians' etc were proposed. A guide-

line on the levels of responsibility expected of the various cadres of the various cadres of the resident staff was issued as part of this effort.

The idea recently occurred to me, as general editor of these occasional publications, that somebody who had been a junior resident staff here in the past and later went abroad to train in more or less the same professional grade levels might be in an advantageous position to advise his colleagues as to what he considers the qualities of an ideal resident staff. The present issue of the occasional publications contains his view with the permission to express them as freely as he wished.

I thank Dr. Thomas Akintewe for accepting to do this for me on behalf of the department. I hope that being a resident staff himself, his colleagues would be more inclined to believe him and to decide for themselves how far short of Dr. Akintewe's ideal they have been, if at all.

The standard of a hospital is usually depicted by the quality of its resident staff. This in turn is determined by several factors, among which are the standard of medical training of the individual resident, job satisfaction, good working environment, good motivation and existence of a tradition of excellence. My aim is to set out what I consider are the best pre-requisites of an ideal resident staff.

The Immediate Care Of The Patient

Patient's survival comes first. This transcends all policies, commitments or staff dispositions. His day's work is not finished if somebody's life hangs in the balance. Medical care should be available to the patient immediately it is required. This means that when a patient arrives in the hospital, he should be seen immediately and assessed. It is indefensible for a patient to die before he is seen by a medical personnel. The treatment available should be correct and appropriate. The patient should be informed of the nature of his clinical problem and reassured. It is not to be forgotten that the hospital is a very strange environment. The ideal doctor reassures his patient and makes him feel that at least one face is familiar.

The investigations required and the treatment prescribed should be acceptable to the patient. The longer an acutely ill patient goes without appropriate therapy, the worse the prognosis.

Availability Of Medical Care

By definition the house doctor should be available to his patients round the clock except when he is off duty. He should be able to answer calls within second. This means that an ideal house officer should have an effective means of receiving communication, for example easy access to reliable telephone. A bleep system is very important for the functioning of an ideal house doctors and he must as a necessity live in close proximity to his ward. The rest of the resident staff must also be available when they are required. All members of the team must know each others' movements at all times while on duty. It makes good working relationship when patient relatives, nurses or colleagues know that in the event of emergencies appropriate personnels are always available.

The Quality Of Medical Care

The organisation of the resident staff is designed to ensure that medical decisions are correct and treatments are appropriate and prompt. It is the job of the house doctor to attempt to diagnose his patient as soon as he is admitted and to initiate effective therapy. His actions should be supervised by his senior house officer or registrar. At this level, diagnosis and management should be correct, most of the time. If the margin of diagnostic the error is high there is something seriously wrong.

The patient should understand his doctors language. It is mandatory that a patient should know what medication he is prescribed and why he is taking the drug. On more than one occasion, I have seen a patient who believes his multivitamin is for his pulmonary tuberculosis. Hence they have not bothered to obtain the specific anti-tuberculous tablets that were prescribed with the vitamins. It is also important to tell the patient for how long he will be on therapy. A diabetic or hypertensive patient will need to know that he may have to be on tablets for the rest of his life in order to prevent the complications of the disease. By painstaking explanation and reassurance, the patient would be more than willing to comply with his treatment.

Bedside Manners

The quality of care a doctor is going to de-

liver often shows best by his bedside manners. An ideal resident must be courteous at all times to his patient. Patient's privacy must be guarded. Physical examination of the patient should only be performed behind drawn curtain. The patient's permission should be obtained before performing any physical examination. For instance, do you mind if I listen to your heart is the sort of request that should precede cardiac auscultation. Permission of the patient must be sought and obtained before procedures like rectal or vaginal examination or even simple venepuncture is carried out. It is not only polite to do this but also mandatory. One might be accused of assault if one proceeds to carry out these investigations without the patient's consent. Although the presence of a chaperon is ever so important, this is not always feasible.

One should never leave a patient uncovered after a clinical examination. One must also leave the patient as tidily as possible after examination. It pleases the patient and pleases the nurses as well.

Confidentiality

This is not the place for discussing ethics. But an ideal doctor will never divulge any information about his patient unprofessionally. How far one should adhere to this depends on the circumstance. Patient's interest comes first and the doctor must never betray patient's trust.

Patient's Comfort

As far as possible the doctor must not embark on any procedure or treatment that could compromise the patient comfort. Every effort must be made to minimize pain. At times, the resident may have to prick the patient more than once. But ideally he should have made every effort to be successful at the first attempt.

One must not prescribe a drug that causes more harm than good. A good doctor will not prescribe a drug he is not familiar with without looking it up. Even when instructed to write it up or it is repeat prescription he must look up its active component (s) and side effects. One must be able to justify every drug entered in the kardex. A young man with diastolic blood pressure of 100mmHg made impotent because of drug has possibly more to lose

from his treatment than his blood pressure. An ideal resident staff must always prescribe the standard drug of choice with the best side effect. Sometimes non-availability of particular drugs(s) may leave doctor with little choice. Equally important, a doctor must never embark on any procedure that he is not confident to perform.

The Ward Round

There are various traditions surrounding ward rounds. Very often the impression a doctor leaves with his senior colleagues is created from how well he performs during ward rounds. It is considered in bad taste if the chief arrives on the ward before the resident. An ideal resident must be tidy for his ward round.

It is the time to change the white coat if he wears one. All the facts relevant to the patient such as the x-ray report and results of other investigation must be available. The drug kardex must be regular examined. Prescriptions must be cancelled when appropriate or they may be modified or amended. How well a resident knows his patient, his presentation of the cases, his comments during a ward round and his general demeanour usually ensure a good reference later. Hence the resident must take his ward round seriously.

The Case Notes

The ideal resident looks after his patient's case notes as he would, a very important document. The language used must be precise and accurate. It is often overlooked that what is written in the case notes may be used as evidence in legal actions. The patient's condition, management and progress must be well documented. The resident, preferably the house officer, would write a definite diagnosis as soon as possible and certainly before discharged. If he cannot make a diagnosis, he must get his consultant to suggest a diagnosis.

A concise discharge summary is vital and case the note is meaningless without one. The in-patient's case note must be readily available at any time of the day. It is the resident's job to ensure this. The case note must always reflect the patient's condition on admission, while in the ward and on discharge; the treatment and investigations the patient and had their results. The case-note must not only be legible but tidy.

The Dying Patient

The dying patient spends his last few days with the resident as well as the nurses. It is the resident's function to inform relations of any deterioration in patient condition. Then they can prepare their minds for the worst. While the resident must not allow emotional involvement to affect his work, a dying patient must always be shown compassion and must be kept comfortable. A good resident must say something to each of his patients everyday. It is amazing how often a patients' day is made miserable because his doctors walk past his bed without a word. When a patient dies, it is important that a member of the resident staff extends some words condolence to the patient's relations. I remember a mother who lost a son with leukaemia saying the most painful experience was that the doctors just handed her the death certificate without a word of sympathy. In the medical profession, sympathy and understanding go a long way.

Learning and Teaching.

By definition or implication the resident doctor is undergoing a training programme. It is imperative for any doctor to continue to widen his horizon of knowledge. A day must not be allowed to pass without acquiring new knowledge. The ideal resident to my mind, is always willing to learn from his colleagues and superiors. His interest must go far beyond the patient immediately under his care. He must, as a rule, read the British Medical Journal, the Lancet and New England Journal of Medicine. Other important journals would depend on the various specialities of the resident staff. The various clinical meetings are ever so important as sources of knowledge and experience.

It is a pity that a doctor's progress in the setting of a hospital depends on passing various examination. This being so, a doctor will make it his priority to get through his examination while at the same time fulfilling his employment obligations. It is no use if a doctor is brilliant but is negligent. Its time goes on the number of paper a doctor publishes figures prominently in his curriculum vitae. It is not very easy to get your name in the journals. It is best to start writing with case note reports and then graduate to drug trials and lastly consider original investigations.

There is a tight bottle neck now in the hospital doctors career. One has to excel to get through. Part of this requirement is the ability to publish papers Unfortunately this is the least talked about and certainly few consultants actively any on-going research work in his unit.

Clinical teaching of undergraduate is one aspect of the resident's life which some love and other hate. It is most important that the resident should look after the interest of the medical students attached to his unit. He has to set a good example for future generation of doctors. He must not impart misleading information or perpetuate wrong habits. The house doctor should involve the students attached to his ward in the day to day activities of the ward. The ideal resident could be a good teacher of medicine, not only by the formal teaching and tutorial but by setting a good example of excellence in his duties. In this profession one depends a lot on the service of other personnel. In order to get things done one must be in good terms with everybody. The sunny pleasant doc will always have the nurses on his side and the technicians would do anything for him. My attitudes is that every workers in the hospital setting should be treated as a colleague. The doctor who is quick to jump at other peoples throat at the slightest opportunity is the one who finds a low level of cooperation. In the same breath I must emphasize that one must be thoroughly professional in one interactions with others at work.

The ideal resident should be a good public relations officer. He should know all his patients and also their home background. As an example, if he is going to discharge a paraplegic he should know whether or not he lives in a ground floor accommodation or ground level and what sort of help will be available at home. He should make sure that the patient has no difficulty in obtaining his drugs. The doctor should ensure that his patient is kept comfortable.

Often relatives are in the dark as to what is wrong with their sick relative and some of them complain they could never find a doctors to speak to. The doctor should make a point of talking to the relative of his patient. Very often some vital information come to light or one may allay some apprehension on the part of the relatives. The patient is welfare aside, the resident must also be interested

in the smooth running of the ward.

He should regularly ask the nursing staff if there are difficulties. Sometimes a patient may be difficult or there may be difficulty in obtaining essential utensils. The resident should look round the ward in the evening before retiring. It does save and certainly would reduce the number of times one is got out bed to attend to minor ailments.

Question of Conduct

The medical profession as a whole relies on each individual doctor to project an image of trust. The patient who is prepared to allow a doctors judgment to determine whether he lives or dies should be able to trust him. Doctors should not quarrel or argue in front of the patient. Otherwise this might raise doubt's about the doctors integrity in the presence of the patients. The doctor's relationship with the patient must be thoroughly professional and unquestionable above suspicion. ably above suspicion.

The doctor should be a good ambassador for his profession at all times. The image of the doctor has suffered in some countries and more so in some parts then others. Doctors are being sued and their judgments increasingly challenged by the public. An ideal resident would bear in mind at all times his moral and professional obligations and must be satisfied at all times that he has done his best and the possible best for his patient.

The doctor must protect himself by being a member of a medical defense or protection society. Even when one has done the right thing, he may still have to prove that he done the right in a court of law. To do this successfully may involve considerable expenses in legal fees. An insurance scheme would cover this kind of eventuality. Also being human, one must be protected against the possibility of an unintentional mishap.

In conclusion, it appears that a doctor's responsibility must be first and foremost to his patient. But equally his own interest must be given good consideration.

He must put his own progress and success in his career on the same scale of importance as that of patient's welfare. It is possible to be conscientious at ones clinical work and to suffer ultimately careerwise. Proficiency aside, the ideal doctor must

be a sympathetic and considerate human being.

EDITORIAL COMMENTS

1. One must assume that "the ideal resident staff" whose qualities are enumerated by Dr. Akintewe is one who among other things (i) has had a sound training in the art and science of medical practical as an undergraduate and only needs that 'bit' which comes practical experience of real life situation that is provided by supervised practice to transform him or her from a successful trainee to an expert practitioner (ii) has as his or her superior, those who are truly more experienced and competent than himself or herself and are willing to give freely of their expertise towards the training of these less experienced colleagues and (iii) has the where wit held to practise the medical professional as best as it should be done. It follows from these, that where undergraduate training and qualifying assessment are defective; where senior resident staff are not much more competent or knowledgeable than the junior ones or where reagents, instruments and equipment e.g. for urine, stool, CSF or blood testing are obsolete or not at all available, the resident staff would be anything but "Ideal".

2. Where the above provisions, for having "an ideal resident staff" are partially or totally absent, a "near ideal" resident staff can still be produced and Dr. Akintewe's article shall be commented upon from this point of view.

3. In relating the standard of a hospital to the quality of its resident staff, Dr. Akintewe was fair enough to qualify this provision with such factors as the quality of training of the residents and the existence of not only job satisfaction, good working environment and good motivation but by that of a tradition of excellence. As it is difficult to say categorically that all the resident staff are well motivated, very satisfied with their working conditions including environment, it would be difficulty to make a categorical statement on the standard of say the University College Hospital, Ibadan. One tradition that it seems to have maintained it that its medical faculty (now college) attracts the cream of the prospective entrants into the various universities in the country, by way of their performance rating either at the "O" or the "A" level examinations.

4. The importance of immediate care of patients on arrival in hospital reflects not only on the organizational set-up of a hospital, but on the sense of commitment, compassion and discipline of its staff. The idea of not leaving a patient who is desperately ill until someone else arrives to take over, calls for the 'noblest ideal' in a doctors; an ideal' that had been negatively influenced by several factors that include poor motivation, a sense of frustration and a definite shift towards materialism in society. The best guarantee against delays in seeing patients is one of organisation which ensures an efficient teamwork. If technological gadgets such as the telephone do not function reliably, then physical presence of the doctor over a period of time would appear to be the most appropriate answer. It is indefensible for a patient to be denied much needed help during say a comatose state and during status asthmaticus or epilepticus, because electronic gadgets such as the telephone or a 'bleep' system does not function. My idea of an ideal resident staff is that of a doctor who can do his best for a patient in spite of all odds of technological backwardness and who can in addition improvise if need be. I do not regard as "ideal", a resident doctor in a third world country who experts the "Mayo Clinic" standard of facilities to do his best for a patients.

5. Dr Akintewe quite rightly emphasized the inter-personal relationship aspect of the duties of a doctor in re assuring bewildered patients, curious relations and dying patients; maintaining good working relationships with other colleagues in other specialities, the nurses, the laboratory technologist, the electro-physiological recordists and the radiographers among others. If a resident staff takes the trouble of taking an X-ray film down to the professor of Radiology, the chances are that he would be advised on interpretation within a few minutes, although it might take several days for such information to be obtained in formal way. The same goes for a liver biopsy specimen; a friendly chat with the histopathology technologist shall ensure a rapid section and staining of the slide which may be taken to a consultant in pathology for an 'on the spot' opinion which is more likely than not to be given.

6. *on the quality of medical care* which depends crucially on the ability to make a correct

diagnosis as a pre-requisite for appropriate therapy, the standard or quality of training is important. It is not unusual to find clinical clerking of patients to be poorer than that expected of some one being examined for the qualifying examination. Both the history and physical examination are more often than not shoddy and in some cases may comprise a repetition of the symptoms and signs of the referring doctor. A gamut or battery of routine investigation is listed without regard to relevance to a probable diagnosis which is to be confirmed or excluded. With the concept of 'medical audit' even in richer, developed countries, careful watch is being made of the request for expensive and sophisticated investigations. Minimal investigations required to confirm a diagnosis such as a chest X-ray and sputum examination for AFB may be all that is required for the diagnosis of pulmonary tuberculosis or an E.C.G. and a chest X-ray for detecting the end-organ effect of chronic systemic hypertension on the heart. Urinalysis and blood urea and electrolytes may serve to exclude a renal cause. P.C.V. determination and a full blood count may be superfluous where no conjunctival pallor is present.

Research-oriented investigations must be clearly distinguished from those necessary to make a diagnosis as a pre-requisite to therapy.

A residency-training programme must be considered defective where interns or house physicians see their jobs as one of routine bleeding session and form filling without attempt at looking up textbooks or even monographs on cases being managed by them. It is despicable where an intermediate or senior resident staff cannot develop or cultivate a critical attitude to the diagnostic value of certain clinical features, results of laboratory investigation or the traditional way of management of cases. These groups of residents staff must be up to date with the literature on the commoner diseases and their discussion of these with their consultants must show that they are able to weigh clinical evidences carefully and dispassionately. It is however, assumed that a consultant would be open-minded most of the time and avail the resident staff of his experience where theory conflict with what obtains in practice. With regard to bedside manner while it is possible by a deliberate 'behaviour therapy' to

modify behavioural attitudes of some people by a toward friendliness and respect for the person and privacy of others by constant reinforcement of these attitudes in trainees and resident staff, there is usually a hard core of people who, by temperament, are not cut to be 'ideal' doctors with respect to the way they relate to patients. They may be brilliant diagnosticians with an encyclopedic knowledge of both past and present forms of treatment of a host of disease states but their approach to patients usually falls short of the ideal. Their patients may get better but they are not the types that eventually become life-long friends of their patients. The anxiety that there is no royal road to learning is particularly true of practical procedures such as venesection, lumbar puncture, liver biopsy etc. Practice makes perfect and a good residency programme ought to insist on a minimum of experience in these procedures.

Medico-legal problems arising from professional negligence or incompetence or both are still not much of a problem because of our socio-cultural milieu which regards, in many cases, a contemplated legal action against somebody engaged in a humanitarian service such as medical care, as abhorrent. Things may however, change in the future and a residency training programme should inculcate into trainees the value of accurate record keeping and an appreciation of the need for caution in the use of drugs with which one is not familiar.

Prompt attendance at ward rounds one's personal appearance, proper use of case notes and treatment sheets as well as the writing of discharge summaries are matters for discipline within a consultants unit, although a broad policy may be adopted throughout the hospital.

On the problem of learning and teaching, one observes that resident staff of all grades prefer to be spoon-fed by way of formal teaching rather than going out to learn by themselves. A cursory supervision of teaching by some resident staff to the medical students shows in some instances, an appallingly low understanding of the subject matter being taught by the teacher, who in this case is the resident staff. One major drawback of the current system of residency training programme, is the lack

of formal introduction to research methodology.

With the establishment of the postgraduate institute for medical research and training within the college of medicine of the University of Ibadan, such courses lasting some three months at a time with the incorporation of a small project such as literature review, may help clinicians acquired the necessary skill much earlier during their training period. Spe-

cialists in various fields of clinical research may be invited to give lecture and demonstration for this purpose.

Medical ethics is a wide subject which I, as general editor, regard as being outside the scope of this type of editorial comments.