How to read clinical journals: X. How to react when your colleagues haven't read a thing

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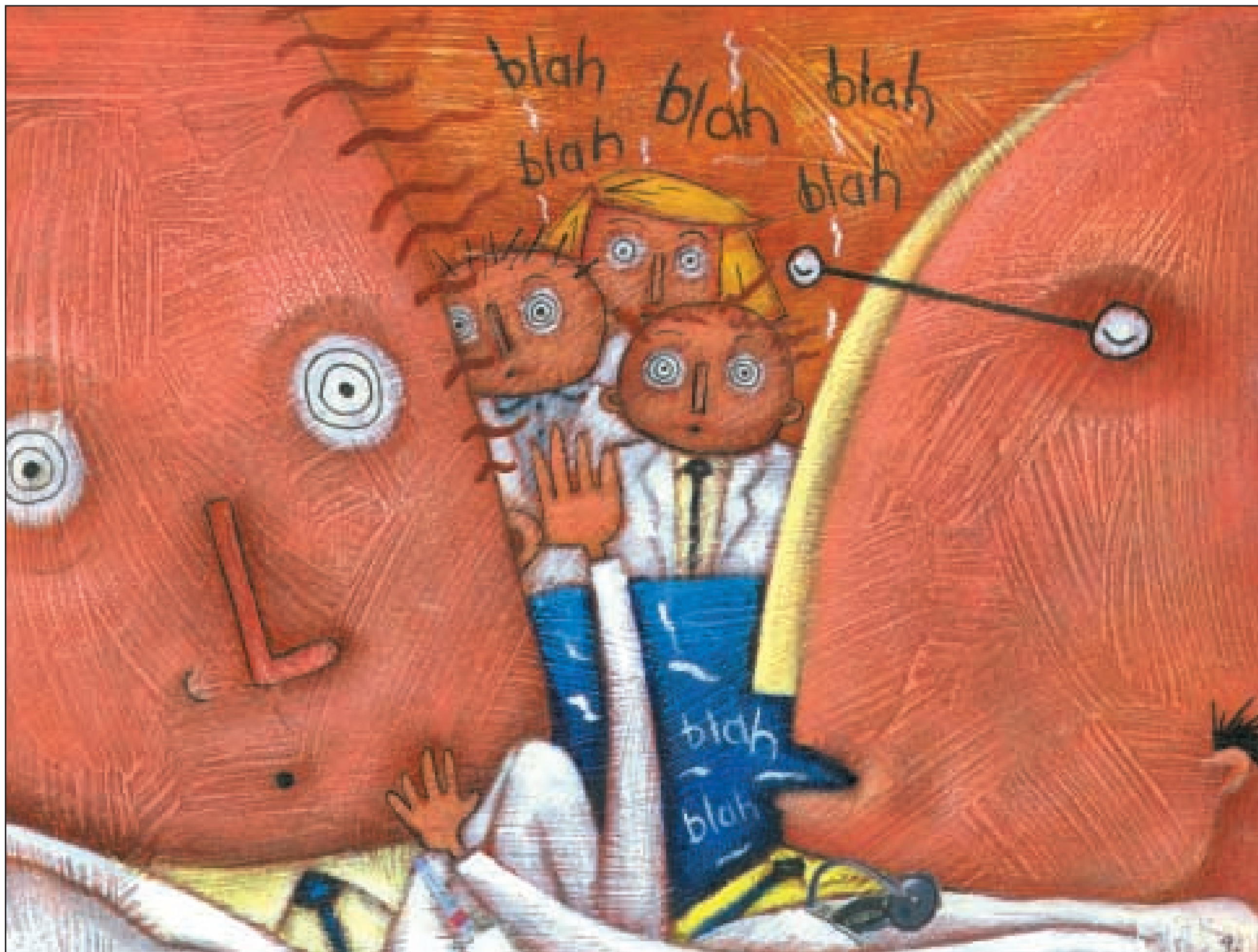

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Abstract

Physicians receive little instruction on how to interact with colleagues, and even less guidance on what to do when their colleagues are poorly informed. Eight techniques are presented here that may be of use in dealing with colleagues who have clearly not read the literature and are unable to maintain the facade that they have. If employed properly and used judiciously, these techniques may help avoid embarrassment for all and may also improve the exchange of valuable information between professionals.

Earlier in this series we reviewed the important topic of how to read medical journals, including the specific task of "sounding like you've read the literature when you haven't read a thing."[1] Two years have passed, and it now seems necessary to follow up with a companion article on a related subject: namely, how to respond to your colleagues when it's clear that they haven't read a thing. Alas, this task would not be so necessary if more readers had actually read our original article on bluffing (and had not just bluffed).

Consider the following scenario. During rounds with your colleague, you see a hypertensive patient suffering

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from a transient ischemic attack due to atrial fibrillation. Your colleague comments that anticoagulation is not indicated in this patient given its minimal efficacy for preventing cardioembolic events. Do you respond by saying, "OK," and then finish rounds by yourself that night after supper? Or do you reply with, "Yes. And by the way, how's that new position looking?" knowing full well that this position is at a premier teaching hospital where the house staff make the real decisions. Or perhaps, "No. Stay away from my patient. Don't make me call security."

In this article, we suggest some diplomatic methods for handling this type of situation. Some physicians are terrific at dealing with patients but pathetic at dealing with other physicians. Our goal is to present effective strategies for busy practitioners to use when they need to talk with colleagues who are out of date or out of line. As with previous articles in this series, these guidelines constitute "applied common sense," are relevant to diverse clinical settings, and are especially valuable when interacting with trainees. Our methods emphasize the prevention of embarrassment, the preservation of collegiality and the teaching of a thing or two. As realists, though, we'll settle for 2 of 3.

1. Assume responsibility for their mistake

Turning the tables is an easy and kind way of dealing with this problem. Suppose your colleague says, "Screening mammography in women over the age of 50 is a waste of time and resources." You might respond with, "It's my fault for not giving rounds about this. Screening in this situation is certainly important. I guess I should have worked harder to review things with everybody." Alternatively, if you have given rounds on just that point and now need to repeat that lesson, you should try, "I told you that, didn't I? But you know, I was wrong. Turns out that there's now strong evidence showing.…"

Turning the tables in this way requires a certain degree of confidence and may not be suitable for the more diffident among us. Also, when using this technique, there is a danger that your reputation could get somewhat tarnished. It's yet another example of where you must sacrifice yourself in the hope of achieving better patient outcomes.

2. Pretend you misheard

This is a safe technique that maintains your intellectual stature. Anyone can use it, although it helps to have cultivated a reputation for having worked through medical school as a jackhammer operator. Consider the following hypothetical exchange. Your colleague says, "Well, one thing's for sure. There's hardly any role for cholesterol reduction after a myocardial infarction." You say, "Absolutely. Well put. A very *hearty* role indeed. What with all the studies showing the benefit of cholesterol reduction, it's surprising that statins aren't being put in the drinking water. Which one would you recommend I use?"

Note the skill displayed here. First, you've turned the ignorance around and have actually complimented your colleague for bringing up such an important issue. Second, you've informed him about the current evidence and even alluded to the best treatment with statins. Third, you've slipped in a clever pun to help maintain good spirits for all. Well done!

Of course, this approach can lead to problems if overused. Consider this exchange. Your colleague says, "Those vitamin fanatics! Now they say that all pregnant women should take folate." You reply, "You're right. Vitamins are *fantastic*. I'm finding more and more uses for them." Your colleague says, "As a friend, I have to say that I'm worried about your hearing." You (continuing the facade) respond, "Well, it's the year 2000 and I don't think anyone will mind if I wear an earring!"

3. Blame someone or something else

With the proliferation of panels, guidelines and the like, it is now easy to find a scapegoat for the mistakes of a colleague. So, when your colleague asserts that "there's nothing to be gained by striving for improved glucose control in diabetic patients," you could respond with, "You know, I can see why you're confused. One panel says this, another says that. And another says this *and* that. What we need is an expert panel to guide the experts!" This approach may be especially valuable if you can trace the fault back to medical school, as with the response, "Actually, you're wrong. But it's not your fault. It's that damn new curriculum!"

This technique can be extended to essentially any area. And even if your colleague's medical school curriculum did cover the problem, who cares? He or she is not going to point that out. We should also note explicitly that a shared rant (and it will be shared — your colleagues will definitely nod in agreement and possibly slam their fists down on a convenient surface) has its own benefits in collegial bonding. Given the endless vogue of curriculum renewal, this technique will have widespread utility and enduring relevance.

4. Pretend you think they're joking

This approach is quite simple and really needs no explanation. And, since everyone in the medical profession believes that they have a better than average sense of humour, there's nobody you can't use it on. Once more, a simple example suffices. Your colleague says, "Well, I really don't think that there's much to be gained by employing the 'Ottawa' ankle rules." You (beginning to chuckle) respond, "Yeah. What a laugh. Very funny. I know what you mean. We can't trust too much of anything that comes out of the nation's capital."

It is important to understand, however, that the use of humour requires talent. Its use should be reserved for those professionals who can still tell a joke, yet remain politically correct. Of course, if you are truly gifted at being funny,

you should leave medical practice immediately and make a much greater contribution to human welfare through the entertainment industry. And more money too.

5. Give permission for error

This technique is especially useful when you are dumbstruck by a colleague's approach, or lack thereof. So, when your usually sharp colleague says, "I'm not aware of any evidence to suggest that bedridden patients should receive deep vein thrombosis prophylaxis," you respond with, "Actually, there is. But, what with so many things to learn, memorize, relearn and then rememorize as new developments come forth, it's impossible to keep on top of everything." Unlike some approaches reviewed in this article, this technique has the merit of being honest and is, therefore, especially useful if you have a conscience.

6. Find the one in a million case where they're right and segue back to reality

This approach is best illustrated by an example. Suppose your colleague is considering that Mr. Jones, a 75-year-old man who's never been outside Sudbury, has hematuria due to schistosomiasis. You might respond with "I see what you're getting at. Always thinking, aren't you? You must have seen that case report in the Journal of 'X' " (with "X" being something you're sure he doesn't know exists and, in fact, may *not* exist). "Well, let's keep that in mind, but you know his prostate was huge on digital rectal.…"

This technique may be most suitable, and almost obligatory, for trainees. Consider the following encounter regarding an otherwise well 50-year-old woman, Ms. Smith, who has classic carpal tunnel syndrome. A student says, "I think that we really must rule out acromegaly. Ms. Smith, do you have headaches, visual changes, oily skin?" You say, "I told you, Ms. Smith, these students are getting more and more clever. And it's great to see that they keep an open mind. I guess if you're like me and have seen hundreds of cases, you tend to close your mind a bit and focus on the common."

7. Make the mistake part of a raging academic debate

Despite its designation, use of this tactic is not restricted to academic centres. Consider the following example. Your colleague asks, "Do you know any good neurosurgeons? I just saw a fellow with a right carotid bruit and a 30% right internal carotid stenosis." You (using technique 5) respond with, "That's a 'toughie.' There's been so much written about therapy for cerebrovascular disease that it's hard to know what's best. Still, I'm pretty confident that nothing specific is needed, certainly not an operation." Colleague (resisting) says, "You're telling me he doesn't need surgery?" You (initiating technique 7) reply, "You've stumbled into the vortex of controversy. You can't pick up a journal without coming across this debate. People can get pretty heated talking about it, so be careful. I wouldn't operate unless it's symptomatic, and then only if the stenosis is greater than 70%."

8. Rejoice in finding an ally against Nature's absurdity

Who has not been chagrined at the counterintuitive aspects of medicine? Who has not been disappointed when some hard-learned physiologic understanding becomes a liability? The canny clinician exploits these paradoxes. Your colleague says, "I took over the care of a nice old chap today. He's got congestive heart failure. But some fool put him on beta-blockers. Just what he doesn't need — depressed myocardial contractility." You reply, "I know exactly what you mean. I used to go around warning patients with CHF to avoid beta-blockers like the plague. Turns out they would have done better to avoid me. Beta-blockers actually reduce mortality in CHF! I think it may be time for us old folks to unlearn a thing or two."

Conclusion

In this paper we presented 8 techniques that may be of help in dealing with a colleague who is, well, um, wrong. If employed properly and used judiciously, these techniques may help avoid embarrassment for all and might even allow you to convey some valuable information. Perhaps one day hospital disciplinary committees might also adopt some of these points of diplomacy. Furthermore, by using these approaches, you may be able to create for yourself a reservoir of good will among your colleagues. This may prove to be of immense help when *you* make a mistake.

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Reference

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