Why rivers run: on the headwaters of family medicine

David Loxterkamp reflects on the river as metaphor for the doctor-patient relationship

Most general practitioners I know are reasonably accomplished diagnosticians, skilled technicians, composed professionals, and hard workers. We do a job; it pays the bills. Our surgeries are a formidable façade for life’s free-for-all: making friends, building businesses, raising families, and growing old together. We have never thought to enforce a degree of separation between the patient and us. In the process, we have learned about human relationships and the larder of trust and gratitude our patients stock on our behalf.

Their real value cannot be proved in a laboratory—how can friendship be double blinded or controlled? Yet in this setting, over the space of days or years, patients can discover why they come to see us. We learn how to help. We might even begin to recognise the source of our patients’ unhappiness, which lies behind their symptoms and beyond the reach of our diagnostic categories. We offer them recognition, as John Berger taught us in A Fortunate Man. We offer something more.

**Hope**

If therapeutic relationships possess a certain unquantifiable magic, it is the magic of hope. When a patient visits the doctor, he or she hopes to be reassured that the lump is not cancer; that the pain will soon end; that a ladder leads from this despair. Hope hinges on the presence of another and the reassurance that yes, we are knowable, even in the darkest place, yet unknowable to ourselves. Patients and their families need treatment plans to assure them that “everything is being done” and that the struggle has meaning and purpose in their own terms.

If all this could be accomplished with computerised interviews, health maintenance checklists, and evidence based guidelines, we would not need doctors. Vulnerable patients come to us in desperation. Their fears and insecurities must be met with authority, knowledge, and action. But their humanity requires something more: a handshake, a funny story, our undivided attention—and all that this implies: a doctor who will champion and remain faithful to their cause. This is what distinguishes primary care physicians from consultants. We are not merely underachieving specialists; let’s not be judged on specialists’ terms, but on ours.

Serious efforts are now being made to test and prove the clinical efficacy of the therapeutic alliance, and I applaud them. But the true value of human relationship eludes description. Like fish in water, doctors and patients are largely oblivious to what gives us breath. The descriptors of relationship centred care are embedded in long, twisting narratives that often bend back to include the narrators themselves. Here, rivers have something to teach about relationships.

The river

My first extended canoe trip was on the Allagash Wilderness Waterway, near Maine’s Canadian border, in the summer of 2007. Before that, I had little connection to rivers except to cross or skirt them, or admire their proud pedigree: the Kennebec, the Cobossecontee, the Penobscot, the St Croix.

With my son and two of his friends, their fathers, and the guide and his family, we took a week to paddle 100 miles from Eagle Lake to St Francis at Maine’s northern tip. We quickly came to grasp the purpose for which we rose and rested each day: to paddle, only this; to move with the river towards our destiny.

A river is not simply a conduit or a sewer system, or something to be bridged, harnessed for hydroelectric power, diverted for the unquenchable thirst of agribusiness, or—in a word—engineered. It can also wash us and feed word—engineered. It can also wash us and feed industry and condensed geography.

There are seasons to a river. It flows fast and wide and wild in its vernal youth, then settles to a steady stride by mid-July, and finally bares its rocky bars as summer nights take on an autumn chill. Largely unshackled, the Allagash moves with the river towards our destiny. And rested each day: to paddle, only this; to move with the river towards our destiny.

Rivers also have a destructive force, a fury that can wash away our constructions and drown the weak and heedless. Though we had an uneventful journey, we minded the submerged rocks, the sweepers...
(low outstretched branches), and the headwinds on Chamberlain Lake that would have blown us backwards. And there was Chase Rapids, which in the spring has class 2+ whitewater—we were thankful to portage our cargo and hire a guide. Chip Cochran, who grew up on the river and guided solo at the age of 17, was a surgeon in command of his operating field. His skill lay in reading each undulation of the rapids while making spot calculations of current speed, wind direction, and the maturing ability of his fledgling crew so as to guide us through safely.

As we ended our week 100 miles downstream and hauled out the canoes, it was bittersweet to watch the Allagash wend on without us. Our river run was a metaphor for human relationships. Rivers move us, often regardless of or contrary to our will. They hold a mythical place in our imagination and unsettle us when we see trash and oil slicks where merganser ducks and canvas canoes should be. This is why a burning river, like the Cuyahoga in 1969, could stir the US Congress to pass the Clean Water Act of 1972 and create the Environmental Protection Agency. Rivers are threatened by the pace and pressure of civilisation and need conservationists and naturalists to protect them.

Some rivers have purpose. They carry barges or spawn salmon or create kilowatts or supply municipal reservoirs. They pull their weight. But to make demands on a river is to miss its intrinsic value. Rivers carry us, past and future. They soak watersheds and fertilise deltas. They grow the pines that harbour eagles and moose. They are ever moving, changing, cleansing, bearing, and through their tributaries they become deeper and wider as they approach their self-immolation in the sea. Those who navigate them are not the same as those who approach the river; it is larger and more lasting than they. But once they have experienced the river, they are forever absorbed.

Relationships

Less than a year into practice, I was called to the office. And I saw him for the next two decades—through his spiritual crisis, marital affair, intentional overdose, hospitalisation for obsessive-compulsive disorder, second and third valve replacements, divorce, remarriage, treatment for alcoholism, and separation once again. He “fired” me not long ago, but when I refused to rebuke or forget him, he soon returned.

I cannot prove that my intimate knowledge of and liking for the man yielded any clinical benefit. I never cracked his chest, managed a ventilator, or sorted out the complex imbalances of his brain. But are these the things that constitute real medicine? My patient received earlier treatment, more consistent care, personal advocacy, and the steady voice of an ally who believed in him when he himself had lost hope. His life goes on—this is a fact—and we built a friendship on the reasons that some choose to stay alive.

It might be said that I buoyed him at his low point, helped him through rocky times—saw around a bend in the river that he, for one dark moment, could not. Together we let the river carry us, knowing it was stronger and swifter than our solitary effort to swim ashore.

Life goes on

I am reminded that the life of Robert Frost, the great American poet, was racked with grief and self-doubt. He buried three of his children: two in infancy and one from suicide. His wife preceded him in death. Through all of this, he wrote some of the most beautiful, serene, and widely read poetry of the 20th century. He once said: “In three words I can sum up everything I’ve learned about life: it goes on.”

We can learn the value of human relationships as readily in general practice as we can on the Allagash. It requires only time and attention.

The curriculum emphasises the common good, nature’s severe beauty and vengeance, and the irreversible stream of human events. With maturing intuition, we learn to read the river’s course and react to it. We gradually shed our presumptions and preoccupations in order to fully experience the flow around us. On the river, too, it is still possible to imagine those who came before us—the Penobscot brave, Bangor lumberjack, Maine guide; the naturalists and outdoor sports enthusiasts; and anyone who has ever appreciated or found hope in a river. Life goes on.

Mindfulness

A patient sits nervously before the doctor, hiding an old embarrassment, a new growth, or some deep unsettled sadness. His secret is not something easily elicited by a checklist of questions or revealed in a digital image or metabolic panel. It is doubtful that this patient, with only vague yet insistent complaints, could ever be cured by a procedure or meet study criteria. Circumstances alone make it unlikely that his real needs will match my expertise or that the bill I send him will find a permanent address.

The doctor, arriving late and already anticipating her next three moves, could deflect the ambiguity of his averted eyes and nervous hands by writing a prescription and moving to the next room, where a strep test has already turned positive. Or she could gamble her balancing act on five unscripted minutes that could open a can of worms.

At that moment of indecision, why would a patient risk self-disclosure or the doctor relinquish the safety of higher ground? Their choice often reflects a mutual leaning towards relationship: trust that here one’s true self can safely emerge; reassurance that their galloping fears will be calmed through the clinician’s touch, words, and familiar surroundings; companionship that ends the exile of illness and offers a promise of deliverance to some recognisable shore; some sign that there is shelter here, and restorative good will. And mindfulness of what matters most. Why do we live? What is our sacrifice for? When is there more to cherish than the time stretched between us?

The investment of these moments, whose consequence ripples in ever widening arcs, matters as much as any lifesaving heroics. These are the moments that make life worth saving. They unveil the worth of a living thing, an intrinsic value that can never be priced or marketed or proved beyond the affirmation of a handshake or nod of thanks. We cannot justify the comfort a river offers us. But it runs for all. Like the doctor-patient relationship, its presence matters. It matters for all the reasons we ignore, take for granted, exploit, and desperately clutch when our chins slip below the waterline of sanity. There is good will and fidelity between humans and their encountered world. We trust that these feelings will nourish us, and by their endurance carry our hopes for life unending.

David Loxterkamp is a physician, Seaport Family Practice, 41 Wight Street, Belfast, ME 04915, USA. mclobster@verizon.net

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Bumf: increasing exponentially

Since 1998, we have collected all the bumf (unsolicited mail and leaflets) pushed through our letterbox each week, after discarding any envelope or plastic covering. At the end of each month we weigh the bumf, and then put it in recycling. From time to time we add the weights to our bumf spreadsheet. Here we report 11 years’ follow-up.

The distribution of the weight of bumf received follows a consistent monthly pattern (Fig 1). Twice as much bumf is received per month in September, October, and November than in each of the summer months. The weight of bumf received has been increasing (Fig 2). In 1998 we received about 10 kg of bumf. By 2004, this had doubled and seemed to have reached a peak. However, 2008 is heading towards a record weight of more than 29 kg. The best fit curve is an exponential ($W_t = 8055 \times e^{0.01014 \times t}$, $R = 0.933$, $P<0.001$).

So, on past performance, don’t expect bumf to disappear any time soon and expect more of it in the autumn.

John R Kirwan Rosmarie Kirwan, Bristol
john.kirwan@bristol.ac.uk

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Back to the future

Warfare in ancient Greece and modern emergency departments have much in common, says Bernard A Foëx

Ancient Greek warfare, as depicted in the Iliad, focuses on the exploits of individual heroes such as Achilles and Ajax. The ordinary soldiers take second place in the narrative.

In the 6th and 5th centuries BC the armies fielded by the Greek city states against each other and against the invading Persians were characterised by the phalanx of hoplites: citizen soldiers, who paid for their own equipment. They were briefly drilled before a campaign but were in no way a professional army: the exception being Sparta. These armies were commanded by a “king” or a general. A small number of light infantry and cavalry also existed, usually stationed on the wings. The battle itself was generally decided by the discipline and the bravery of the hoplites and their general.

The end of the hoplites

The 4th century BC saw the emergence of other battle formations. Iphicrates defeated a Spartan hoplite phalanx using peltasts, light infantry armed with javelins, at the battle of Lechaem in 390 BC. Their ability to out manoeuvre the heavily armed hoplites proved decisive. At the same time the northern Greeks developed a much more effective cavalry force than their southern rivals. At the battle of Leuctra (371 BC) the Theban commander Epaminondas used his Thessalian cavalry to great effect, routing the Spartan cavalry, which then hindered the formation of the Spartan phalanx. As Macedonia came to dominate the classical world under Philip and then Alexander, so cavalry increasingly proved decisive. The Macedonian phalanx still had to hold the line but it alone could no longer win the battle.

The successors and the Hellenistic period

After the death of Alexander in 323 BC the armies of the successors showed a much greater diversity of troops, with units drawn from all quarters of the ancient world. Their armies still contained troops fighting in the phalanx formation, but there were also units of light infantry, companion cavalry (heavy cavalry), Thracian cavalry, lancers, and horse archers from Parthia, as well as units of Indian elephants, all with their own distinctive battle formations and ways of fighting.

Evolution of the emergency department

Emergency medicine developed in mythical times around a few heroes whose feats have entered the legend of emergency medicine rather like Homer’s heroes. More recently, the historical record describes casualty departments under the command of one general, often an orthopaedic surgeon, staffed by citizen doctors (senior house officers) from various specialty rotations, briefly drilled at the start of a six month campaign. They were the phalanx and the battle was won or lost by their ability to hold the line—or cope. Occasionally cavalry appeared in the form of registrars from hospital specialties to engage particular enemies: a case of epiglottitis, for example.

As casualty departments became accident and emergency departments the army started to change. The generals, now specialists in their own right, not only commanded the army but also fought in the phalanx, as their predecessors the Spartan kings had done. In addition to the phalanx of citizen soldiers there emerged the specialist registrars: an elite, whose continual training was paid for by the deanery. Now the battle was largely won by their ability to cope.

The end of the hoplites

(senior house officers)

With growing pressures on emergency departments, including the four hour target, the model of the hoplite phalanx was no longer adequate. As in Iphicrates’s time a new type of troop was needed, lighter armed
The successor departments (the emergency care village)

Emergency departments now resemble the armies of the successors in the Hellenistic period. There is still the phalanx of trainees in foundation year 2, holding the line, and the elite units, the old style specialist registrars, veterans of many campaigns, trusted to make the decisive push or to stabilise a faltering phalanx. But there are also specialist troops, such as the specialty trainees in their third year doing paediatric modules, and the paediatric trained nurses, operating on one flank in the audiovisually separated paediatric area; the emergency nurse practitioners, who continue to operate largely independently, skirmishing in the minor injury unit. There are acute care common stem trainees and specialty trainees, deployed in “majors,” and behind the front line there is the clinical decision unit. Increasingly, the “army” includes an advance guard: the primary care centre.

The generals (consultants)

What of the generals? In Homeric times they fought individual combats with selected enemies. Later they commanded armies, selecting the place and the time of battle and occasionally joining in the fighting at the front of the phalanx. With ever larger emergency departments there may now be several generals, each with a specific role: one might lead the paediatric area, another the resuscitation room. These generals will tend to be clinical decision makers. The overall strategic vision will still be needed. As with Alexander’s successors these generals must be strategists and warriors excelling in hand to hand combat, all at the same time.

King Pyrrhus of Epirus epitomised this dual role. According to Plutarch, “above all, although he exposed himself in personal combat and drove back all who encountered him, he kept throughout a complete grasp of the progress of the battle and never lost his presence of mind. He directed the action as though he were watching it from a distance, yet he was everywhere himself, and always managed to be at hand to support his troops wherever the pressure was greatest.”

Back to the future

So emergency medicine and emergency departments have developed in much the same way as the armies of ancient Greece. Does this parallel give us clues to the future? The apotheosis of these armies was Alexander’s. With his armies he conquered the known world. His successors never matched his achievements and while they squabbled over his legacy another super power would emerge, insignificant in Alexander’s time: Rome.

Rome with its army of fanatical citizen soldiers would eventually dominate the ancient world. Its army was also based on infantry. In contrast to the hoplites, with their spears, the legionaries fought with an effective short sword (gladius) after first throwing javelins. Their great advantages over the Macedonians were their ability to fight over broken terrain and their confidence in their own ability, their ferocity or virtus. This they demonstrated at the Battle of Cynoscephalae (197 BC) when part of the Macedonian phalanx was outflanked and slaughtered. A generation later at the Battle of Pydna (168 BC) the result was the same once the phalanx’s deadly array of pikes had been disrupted by the uneven terrain.

What then is the threat to the “Hellenistic” emergency departments of today? Arguably it is the army of fanatical citizen providers of emergency care, who, according to the Department of Health’s NHS next stage review, may be able to provide urgent care out in the community around the clock. With vast resources this primary care army may well sweep aside the smaller forces of highly skilled professionals, just as their predecessors did 2000 years ago.

Bernard A Foëx is a consultant in emergency medicine and critical care at Manchester Royal Infirmary, Manchester M13 9WL
Bernard.Foex@cmmc.nhs.uk

Further reading:


The ideas for this article were prompted by reading Christian Cameron’s novel, Tyrant: a wonderful example of scholarship and imagination. I thank Hans van Wees for his helpful comments and the concept of armies of fanatical amateurs.

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The small things in life are important, and as a seasoned conference attendee my first rush of excitement is at the registration desk. After I have felt that frisson of panic (did I remember to register?) the registrar acknowledges my efficient planning and reaches under the desk for the conference bag.

Many of us have spent hours planning the scientific content of congresses, but the choice of bag is often seen as of marginal importance. This could not be further from the truth; carefully chosen, the bag may become a cherished possession—an everlasting monument to the congress, living witness to the International Congress of Palmistry (Zagreb, 2001). However, immortality of this nature is illusive—course members are discriminating, and “cult bag” status must be earned.

The rules

1. Course organisers must be discreet in terms of logo, and letters may be better than words for some of the perineal specialties. Font size should be small, although an exception might be made for the congress (if that is the collective) of sex therapists.
2. A memorable bag does not mean a memorable colour. Luminous colours usually mean that the bag will be left in the hotel on the final day or at best given to the children for their swimming kit to reduce the risk of them being run over by a car at night.
3. Bag access is the subject of strong and diverse opinion. Only dorsal zips are correct from my point of view—I particularly dislike a huge dorsal flap secured at the base by two plastic clips. Such a travesty of a conference bag is disheartening, and I am sure that many do not even survive their first day of use.
4. Ideally, a bag has one large compartment that copes easily with A4 size documents and is 10-15 cm wide, with a firm plastic board at the base, which can be flipped horizontally. Preferably, this compartment would have a single partition, dividing the cavity into 3 and 12 cm. A narrower, full length pocket on the side is useful, with a general area capable of taking standard paperbacks, perhaps three pockets for pens, and broader pockets for phone and similar sized objects. Zips that can be padlocked are rare but have benefit.
5. The strap should be reasonably broad and adjustable, swivelling at the base of the clips, facilitating correct alignment, with
a broader sleeve to share weight over the shoulder. An additional haversack option that leaves both arms free is increasingly popular; the double shoulder straps are tucked away in an additional side pocket when not in use.

A bag’s material is a crucial feature—nylon is the preferred material, creating a bag that is light, waterproof, and durable. Lightness is particularly important if the bag is to be used as a flight bag in the future.

Cult status
Connoisseurs often take a cherished old conference bag to a congress. If the new bag does not meet expectations it can be rejected and the conference material transferred to old faithful. You then have a distinctive bag, which is not likely to be picked up by a colleague in error.

Hopefully, at your congress, most people will have learnt something, and you will have facilitated social networking. Will you also have created a cult bag for your specialty? Imagine, seeing your congress bag on the shoulder of a traveller in some far flung corner of the world—then you will know your congress has achieved the ultimate objective.

Frank D Burke is professor, Pulvertaft Hand Unit, Derbyshire Royal Infirmary, Derby DE1 2QY
frank.burke@virgin.net
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Do you have a favourite conference bag?
Can you describe it in less than 250 words?
We’ll publish the best description we receive by 15 January, along with a specially commissioned photograph of the winning bag.
Post a rapid response to this article on bmj.com.

Just say no
One of the privileges of being a doctor is receiving a regular salary—a salary sufficiently generous that I can afford the cost of useful items such as pens and bags. So it concerns me that every time I attend a conference I am furnished with another bag and a plethora of pens.

For a few days the bag becomes a symbol of membership of the “in” sect. I readily strike up conversations with fellow bag carriers, confident that they share my interests. After that, however, its use vanishes and it is added to the pile of conference clutter on my return home.

My husband is also a doctor, and we each average two conferences a year. Four bags a year for the next 20 years means our pile of clutter might require us to build a house extension.

At a recent conference we were issued with “eco-friendly” bags made out of recyclable materials. Was it a misspelling for “ego-friendly,” designed to make doctors feel better despite our knowledge that recyclable does not equate to recycled?

The solution? The most environmentally friendly bag is the one I already own that accompanied me to the conference. So next conference I shall say “goodbye to the bag.”
Do you think I’ll get a discount on my registration?

Susan M Wearne medical educator, Remote Vocational Training Scheme, Alice Springs, Australia
susan.wearne@rvts.org.au
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European Federation of Hand Surgeons Conference (Goteborg, 2005). Black, 630 g, discreet logo. Large padded compartment suitable for laptop and smaller compartment for power cables and mouse. Small enough to fit in the large compartment of bag 2 when travelling.

Cyprus Orthopaedic Congress (Paphos, 1993). Silver grey, 900 g, very robust. One large compartment and a 15 cm compartment with two dividers. Excellent overnight bag (now superseded by bag 2), but remains my favourite for medicolegal conferences or attendance at court, where large files need to be transported.

AO Mini Fragment Fixation Bag (Derby, 1995). Black, 600 g, slim, main compartment 5-8 cm wide, with inner side pockets for pens, phones, and so on. Smaller pocket for book on the outside. Used as a daily briefcase.
Finger rings harbour surface bacteria so should be removed before scrubbing for theatre and left off while operating.¹ There are many anecdotes of surgeons losing their wedding rings and rooting through clinical waste or surgical scrub bins to find the lost items. We present a method of safeguarding a wedding ring while in theatre.

**Technique**

Surgical scrubs are put on in the usual fashion. A single throw is placed in the trouser cord—this is the first half of a reef knot. The cord on the right is passed over the cord on the left (fig 1). The wedding ring is then threaded onto one of the cords (fig 2). The reef knot is completed by passing a throw in the opposite direction, so the cord on the left passes over the cord on the right (fig 3). Figure 3 shows the cords before the knot is tightened to show the reef knot. The wedding ring will be held tightly within the reef knot. The reef knot is secured by passing a third throw in the same manner as the first (fig 4). The surgeon has the option to add extra throws if they are deemed necessary.

**Discussion**

The method presented was tested on 10 colleagues and proved to be reliable, safe, and quick. The ring will not become tarnished, as it could if it were left on during scrubbing, and has no chance of being swept into the waste bin with other items that have been left on the counter in theatre. It is less likely to be lost than if it were placed in the pocket of a bag, and the knot ensures that it will not fall out, as it might if the scrubs pocket were damaged.

**A Ardolino and colleagues** give a way to avoid losing rings during scrubbing

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They don’t train them like they used to

How polite are young doctors compared with other healthcare staff, ask James S Taylor and Simon Nicholson

Table 1 | Use of “please” on radiology request forms

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Surgery</th>
<th>Orthopaedics</th>
<th>Ear, nose, and throat</th>
<th>Urology</th>
<th>Accident and emergency</th>
<th>Intensive therapy unit</th>
<th>Medicine</th>
<th>Other</th>
<th>No/total (%) using “yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>4/9</td>
<td>0/14</td>
<td>0/3</td>
<td>1/4</td>
<td>0/4</td>
<td>0/1</td>
<td>11/24</td>
<td>2/7</td>
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<td>Associate specialists</td>
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<td>-</td>
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<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>5/14 (36)</td>
</tr>
<tr>
<td>Core trainee 3 upwards (registrar)</td>
<td>1/13</td>
<td>3/23</td>
<td>6/15</td>
<td>2/5</td>
<td>0/16</td>
<td>0/2</td>
<td>3/15</td>
<td>0/2</td>
<td>15/91 (16)</td>
</tr>
<tr>
<td>Core trainee 1 and 2 (senior house officer)</td>
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<td>2/12</td>
<td>1/7</td>
<td>0/1</td>
<td>1/16</td>
<td>1/9</td>
<td>4/20</td>
<td>0/0</td>
<td>9/69 (13)</td>
</tr>
<tr>
<td>Foundation doctors</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10/53 (19)</td>
</tr>
<tr>
<td>Nurses</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4/33 (12)</td>
</tr>
<tr>
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<td>5/49</td>
<td>7/25</td>
<td>3/10</td>
<td>1/36</td>
<td>1/12</td>
<td>8/59</td>
<td>2/9</td>
<td>63/339 (19)</td>
</tr>
</tbody>
</table>

Other=Paediatrics; Radiology; and Obstetrics and Gynaecology.
The dashes indicate that these categories are not divided into subspecialties.

To check perceptions that the younger generation are lacking the etiquette of their seniors, we reviewed over 300 radiology request forms written on a single weekday in a hospital on the south coast of England. We used the presence of the word “please” on the request form as a proxy measure of courtesy (table 1).

Consultants and associate specialists came out on top. Junior hospital doctors (all grades) did less well, although better than nurses. Overall, the staff in the intensive therapy unit and the accident and emergency department scored modestly.

Among consultants, those in general surgery and general medicine were the most courteous, and orthopaedic surgeons conformed to their alleged stereotype of never requesting politely. However, the results for orthopaedic juniors give faint grounds for hope.

Graduates of Birmingham, Bristol, and Nottingham medical schools seemed the most polite, although the numbers are small (table 2). Foundation year doctors’ results were variable, with notable politeness from St George’s Medical School. Senior trainees from Guy’s, King’s and St Thomas’ and from Cambridge also scored very well.

Our investigation shows that seniors still set the gold standard for chivalry, with the rest of us only hoping to emulate them.

James S Taylor is a specialist trainee year 1 (general practice) at Steyning Health Centre, Steyning BN44 3RJ
drjstaylor@hotmail.com

Simon Nicholson is a foundation year 2 doctor (trauma and orthopaedic surgery) at Maidstone General Hospital, Maidstone ME16 9QQ

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A-Z OF RADIOLOGY

By Matthew Tam. For further information on the techniques, and the findings they reveal, see bmj.com

Matthew Tam is a specialist registrar Radiology Academy, Norfolk and Norwich University Hospital, Norwich NR4 7UB matthewtam2005@gmail.com