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ACUTE PERSPECTIVE

David Oliver: Interrupting doctors' work

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Constant interruptions bedevil the work of doctors in hospital wards and emergency departments. We practise much of our medicine standing up or sitting at desks, often in very public areas without the protection of closed consulting room doors. Interruptions and distractions can become relentless.

Perhaps they're an inevitable and necessary part of acute care, and we're in the wrong job if we can't learn to live with them. But I do worry about their impact on clinical staff and direct patient care. We should at least try to reduce them.

When asked about the causes of their moral distress or burnout, staff frequently cite multiple competing demands, unhelpful work environments, and a lack of support.[1 2] Research has also linked interruptions to clinical error and impaired patient safety, especially when we're engaged in safety critical tasks such as prescribing complex drug regimens.[3] Interruptions can impair focused, sensitive communication with patients.

Such interruptions arise from patients' needs, from their visitors and families, from phones or pagers, and from other healthcare staff. Some are essential for care and communication about patients in real time, where action or reassessment is needed quickly in an evolving clinical situation, or where a patient is distressed and needs us to stop what we're doing and help immediately.

However, other interruptions could wait. Different ways of organising or supporting our work might reduce them so that we could focus on our patients and tasks. Guidance on *Modern Ward Rounds*, led by the Royal College of Physicians and written in conjunction with nursing and allied professional colleges, set out some of these ways—although many still rely on adequate staffing, which we often lack in the NHS.[4 5]

One obvious area for mitigation is the role and expectations of visitors. Generally, these are family members and are often crucial to the patient's care and communication. But with many visitors present at once it can be hard to do any clinical work without being overheard, listened in on, overlooked, and often interrupted mid-task when with another patient.

This is different from speaking to a patient's family at their bedside in the course of a round or consultation. But especially on evening and weekend shifts, doctors who attend a ward to see one specific patient can find themselves facing excessive demand from families of other patients, or from patients they don't know and weren't asked to see. Often, families and friends have struggled to get any information or convey their concerns over the phone, so "doorstepping" medical staff is a reaction to this. And sometimes they're not happy with the information they've received.

Much clearer public information and expectations about when and how to speak to clinical staff would help, and the ability to book timed conversations in quiet rooms off the ward or by phone could be a "win-win" for us, for patients, and for their relatives.

Ward landline phones are also a big issue. In busy, short staffed ward areas, multiple phones may be ringing on a loop, unanswered. We can ignore them, but this feels uncaring. We can hope that someone else answers or may feel compelled to pick up the phone ourselves, only to find that it's a problem we can't personally help with. We then have to find someone—but our focus on the patient or task in hand is now broken.

Conversations with clinicians from other teams who have come to see our patients are crucial and welcome. But some other interruptions come from "progress chasers" repeatedly exhorting us to discharge patients (which we're already trying to do) or to rush out a DNACPR form for patient transport—which would ideally be organised well in advance.

There's also an issue that with such a high percentage of modern hospital inpatients having dementia, delirium, or psychological distress, they will quite understandably call doctors over repeatedly for reassurance and support. Ideally, we'd have more specially trained care assistants to be with patients and provide this contact, vigilance, and reassurance.

Even more ideally, however, we'd have enough nurses and healthcare assistants, and enough doctors and ward administration staff, to make everyone's shift more manageable and less likely to be pulled in different directions. We also need more closed spaces away from main wards, to allow staff to get on with key clinical administration and calls out of the public eye.

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