Team working: a guide for the foundation year doctor

Introduction

Team working sounds like a simple term, but it is more complex than a spider's web. The human, being the most civilised and developed social animal, is involved in goals that are more complex than just making a web and require more than one spider to work in it to reach the goal. The idea of team working is not like every spider making its own web, but all spiders working towards making one large web.

The NHS itself is a large web with multiple complexities. Each and every individual working in it needs to work in harmony to reach one goal that is quality and equality within the NHS. The question is: how could we make the team work in this complex setting within the NHS?

Working towards the overall goal

A well-known anecdote about the North American Space Agency (NASA) illustrates this very well. Two cleaners were asked what they were doing. One said: 'I'm cleaning the floor', and the other said: 'I'm helping to put men on the moon'. The first person talked about working for his own goal, but the second talked of working towards the overall goal, more like being a part of the team working towards the common goal of putting people on the moon.

A team comprises subunits of each individual. Every individual within the team has a well-defined role to play. The combined effort of each helps in achieving the goal. It is crucial that every individual within the team appreciates how important his/her role is and also respect other team members, no matter how lowly their tasks and/or roles may be perceived as being.

Every unit has a leader and the subordinate team members who work alongside him or her. It is vital that every individual understands the role of each team member. In a team when various grades of individual are involved, such as managers, doctors, nurses, health-care assistants, secretaries and domestics, every individual should be aware of how important each other individual's role is. All team members should work to achieve their fullest potential and ability within the role they are given without thinking about whether a task is perceived to be at their level or below it. For instance, occasionally, doctors may end up doing tasks that are below their competence, but they get on and do them with dignity, to help the team.

Within the NHS, managers are meant to look after the economic and financial aspects and clinicians are responsible for the clinical side of patient care. Although they deal with different aspects of the NHS, they are still working towards the common goal of improving patient care. Rather than questioning whether one is more important than the other, if they realized how equally important both aspects are and worked in harmony as a team to reach the common goal, this would help the NHS run more efficiently, with improved patient care and high quality.

Motivation and potential

It is also important for the team leader to make a continuous effort to enhance every individual's potential and at times criticize the work constructively to get the best outcome. In order for team members to take criticism constructively, the team leader should encourage and appreciate good work as and when required. People may not find it so hard to take criticism when they recall the instances when their good work was acknowledged and admired. For example, a secretary feels her boss never appreciates her when she finishes her work on time very efficiently. He keeps criticizing a piece of work he needed urgently and which he asked her to do an hour ago and is still not finished, in spite of her working hard to complete it. It might feel demoralising for the secretary to work in such an environment and it might not be helpful in enhancing her potential. She probably would have understood the urgency of the matter and would not have minded her boss criticizing her when he was in a hurry to get her to complete the work if, at other times, he admired her good work.

Consider also how not to motivate team members. One team leader would set tasks without defining exactly what she wanted. Her staff would go off, feeling empowered to set the scope and deliver the outcome. However, when they reported back to her out of courtesy, she told them they had done it wrong. From then on, staff would ask her more precisely what she had in mind, but nothing they did seemed to be right for her. When they kept asking, they were told off and informed that as senior managers, they should not need so much guidance. Needless to say, the team did not flourish, which led the manager to exert even more control, and so on into a downward spiral.

A leader should, by his/her good deeds, constantly set a good example and work towards earning rather than asking for respect from his/her subordinates. This encourages good faith within the team and avoids disputes for power, which come into play only when the subordinate member does not have respect for his/her leader and feels that he/she is better. This can make the team dysfunctional or may actually make it fail to function at all.

Managing team work is a complex phenomenon as it involves different psychological aspects of humans which need to be moulded and guided constructively to help reach the goal, otherwise once again there is a chance the team may fail to function.

Miss Deepali Trivedi *is Ophthalmologist, Birmingham and Midland Eye Centre, Sandwell and West Birmingham Hospitals NHS Trust, Birmingham,* **Dr Aveek Mitra** *is a Foundation House Officer 2 at Northampton General Hospital NHS Trust, Cliftonville, Northampton and* **Dr Rachel Hooke** *is Working Time Directive (WTD) Implementation Manager, Airedale NHS Trust, Skipton Road, Steeton, Keighley, West Yorkshire BD20 6TD*

Correspondence to: Dr R Hooke

Team working is seen as a relatively new phenomenon for doctors, although there has always been a medical 'firm' structure consisting of a consultant, various juniors and other grades. Now that teams are becoming more complex and multidisciplinary, issues of accountability are increasing in prominence.

KEY POINTS

- Teams are complex and require individuals to work towards a collective rather than an individual goal.
- It is important for the team leader to set a good example and motivate members.
- Individual potential can be enhanced by constructive, not destructive, criticism.
- Everyone can play a part, from the cleaner to the chief executive.
- Team members should understand the importance of each other's roles.

Conclusions

The NHS is a complex organization which requires all staff to work together as teams to achieve the ultimate goal. Each individual can contribute to the common good of enhancing patient care. A good team leader will set a positive example, be a good role model and motivate staff to achieve. BJHM

Conflict of interest: Dr Hooke has worked in both management and medicine.

Effects of labour and mode of delivery on peripartum thromboembolic risk by thromboelastography

The* British Journal of Hospital Medicine *is pleased to be publishing some abstracts from the Royal Society of Medicine's Student Members' Group Research Presentation. This is the third place oral presentation. For information about entering this year's prize, please contact young.fellows@rsm.ac.uk

Abstract

Background and purpose

Thromboelastography (TEG) assesses whole blood coagulation, including both cellular and humoral aspects of the coagulation process. It offers advantages over coagulation tests and may improve thromboembolic risk prediction. Thromboembolic disease remains the leading direct cause of maternal death and there is a real need to identify and quantify factors which increase maternal thromboembolic risk.

Method

After obtaining approval from the local ethics committee, 151 patients were recruited in early labour (less than 5 cm dilation). Blood samples were taken from each patient at recruitment, and at 1 hour and 24 hours post-delivery. R, K, α angle and MA values from the TEG analysis were compared for each mode of delivery. Data were analysed using paired and independent Student *t*-tests. The effect of various demographics and variables of labour on TEG parameters was investigated.

Results

The mean age of patients recruited was 28 years and mean body mass index was 25.4 kg/m^2. Eighty-four patients were primiparous. Before delivery 96 patients had a low thromboembolic risk and 55 had a moderate thromboembolic risk assessed using the Royal College of Obstetricians and Gynaecologists (1995) guidelines on risk stratification. Labour ranged from 99–2192 minutes, mean 517 minutes. 95 women delivered normally, 29 had instrumental deliveries and 27 were delivered by emergency caesarean section. There was a significant decrease in R values 1 hour after normal delivery (P=0.001), which is consistent with hypercoagulability post-delivery. After instrumental delivery the reduction in R time was more marked, and K values also showed significant reduction (P=0.017), consistent with hypercoagulability. The trend towards hypercoagulability was further increased in those who had a caesarean section, with three parameters (R, K and α angle) showing significant hypercoagulability changes post-delivery (all P<0.002). When the samples taken 1 hour after delivery were compared according to mode of delivery the most marked difference was between normal and instrumental deliveries, with R, K and α angle significant. There was less difference between instrumental and caesarean deliveries 1 hour after delivery. The significant difference between instrumental and normal deliveries persisted 24 hours after delivery.

Increasing age was associated with increasing coagulability. Duration of labour, volume of fluids in labour and, use of epidural had no significant effect on maternal coagulability.

Conclusions

These results demonstrate a significant increase in the coagulability of maternal blood following delivery, particularly in the rate of clot formation. This is in keeping physiological prevention of postpartum haemorrhage, but may also help explain why the risk of venous thromboembolism is greatly increased post-partum. The differences in coagulability are exaggerated with instrumental deliveries and further after caesarean section delivery; increasing intervention at delivery, including instrumental delivery, may therefore be associated with increased thromboembolic risk. BJHM

Ms E Cordle *is a medical student at University of Leicester/Warwick Medical School, and* **Dr J Waugh** *is Consultant in Maternal Medicine, Royal Victoria Infirmary, Newcastle-upon-Tyne*

Correspondence to: Ms E Cordle, c/o BJHM

Royal College of Obstetricians and Gynaecologists (1995) *Report of the RCOG working party on prophylaxis against thromboembolism in gynaecology and obstetrics.* RCOG Press, London