Interpreting shoulder radiographs – a systematic ABC approach

Sir,

Patients with shoulder pain frequently present to accident and emergency departments (Fraenkel et al, 1998). Evaluation and diagnosis of these patients is often undertaken by nurse practitioners and junior medical staff. For these staff, shoulder radiographs can be difficult to order and interpret because of unfamiliarity with the differing views offered by radiographers and the complex bony anatomy of the shoulder. It follows that many acute conditions, including dislocation, can be misinterpreted leading to mismanagement and increased patient morbidity (Hatzis et al, 2001).

Shoulder pain accounts for 2% of all general practice consultations and shoulder dislocation accounts for 60% of all dislocations presenting to accident and emergency (Fraenkel et al, 1998). Although posterior dislocations make up 1–4% of all shoulder dislocations (Perron and Jones, 2000), Hatzis et al (2001) found that up to 60% of these are missed by the attending orthopaedic surgeon.

Following the above, we read with interest the article by O'Regan et al (vol 67(2), 2006, p M27) regarding the interpretation of shoulder radiographs. They set out an excellent systematic method in approaching the shoulder radiograph.

In our institution, we currently use a simplified ABC approach to shoulder radiograph evaluation which compliments O'Regan's method. This method adopts a systematic approach examining alignment, bones, and cartilage and congruity of the joint.

We examined the effectiveness of the ABC system by asking junior staff with no previous experience in orthopaedics or accident and emergency to interpret a series of different radiographs before and after education with the ABC system (NJ Little et al, unpublished data, 2007). They were assessed again 3 months after education, and showed a 50% improvement in correct interpretation. Furthermore, 86% of all dislocations were identified post education compared with 38% before education. However, 15% of posterior dislocations were still missed.

We therefore suggest that all junior staff are taught a systematic approach in interpreting shoulder radiographs. We commend O'Regan et al on their approach but highlight that, despite junior staff education, there is a small group of patients that will have their injury missed.

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Hatzis N, Kaar TK, Wirth MA, Rockwood CA Jr (2001) The often overlooked posterior dislocation of the shoulder. *Tex Med* **97:** 62–7
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The new breed of junior doctors: glorified secretaries

Sir,

As I approach the end of my third month as a foundation year one doctor I still remain unclear, to some extent, as to my exact role within the NHS system. On the one hand I am privileged to be the first port of call for patient care after the conclusion of the daily round. Of course it is a team effort but as juniors spend the majority of time manning the wards it is our responsibility to monitor and manage patient progress during the day and inform seniors of anything that concerns us. However, a seemingly arduous component to my position is the dreaded aspect of administration which has helped pave the way for the notorious branding of house officers as 'glorified secretaries'.

Of course there are certain administration roles which are part and parcel of our duty. Such examples include ordering and chasing any necessary radiological investigations, patient list updating, making referrals and compiling discharge summaries. These have notable clinical relevance and therefore it is only right for these tasks to be our responsibility.

However, there are times when I feel this is not necessary. The NHS has invested huge sums of money in the employment of a variety of managerial and administrative staff, but has this been truly effective in relieving our administrative burden?

As a surgical FY1 I am involved in assessing patients before their proposed surgery. This is a clinical role and my priority. However, on several occasions I have been left to arrange their admissions into hospital, constantly chase bed managers with regard to bed status and even telephone patients at home to inform them of their proposed admission date. This barely scratches the surface. While recently on call I clerked three patients with abscesses which needed incision and drainage. My senior house officer informed both the bed manager and theatre coordinator of this who verbally stated that they would be amenable for surgery the following day and that they would arrange their admission. The following day the coordinator informed me that these cases would not be treated that day because of the lack of beds and I was told to inform the patients. Being at the bottom of the hierarchy I could not argue and had the task of breaking such news in succession while having to ease their frustration and anger. Why was it my responsibility to do this? Surely this should have been left to those who did not arrange their admission.

I'm sure my fellow juniors have had similar experiences and I feel it is unjust to hand down such responsibility. Not only are we expected to look after our patients we are now being forced into administrative roles which add unnecessarily to our work load. Surely the above example also adversely affects the satisfaction, trust and confidence patients place in the service we provide.

Joseph Heller summed this up well in *Catch 22*: 'Without realizing how it had come about, the combat men in the squadron discovered themselves dominated by the administrators appointed to serve them. They were bullied, insulted, harassed and shoved about all day long by one after the other…'. Quite fitting I'm sure you'll agree.

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