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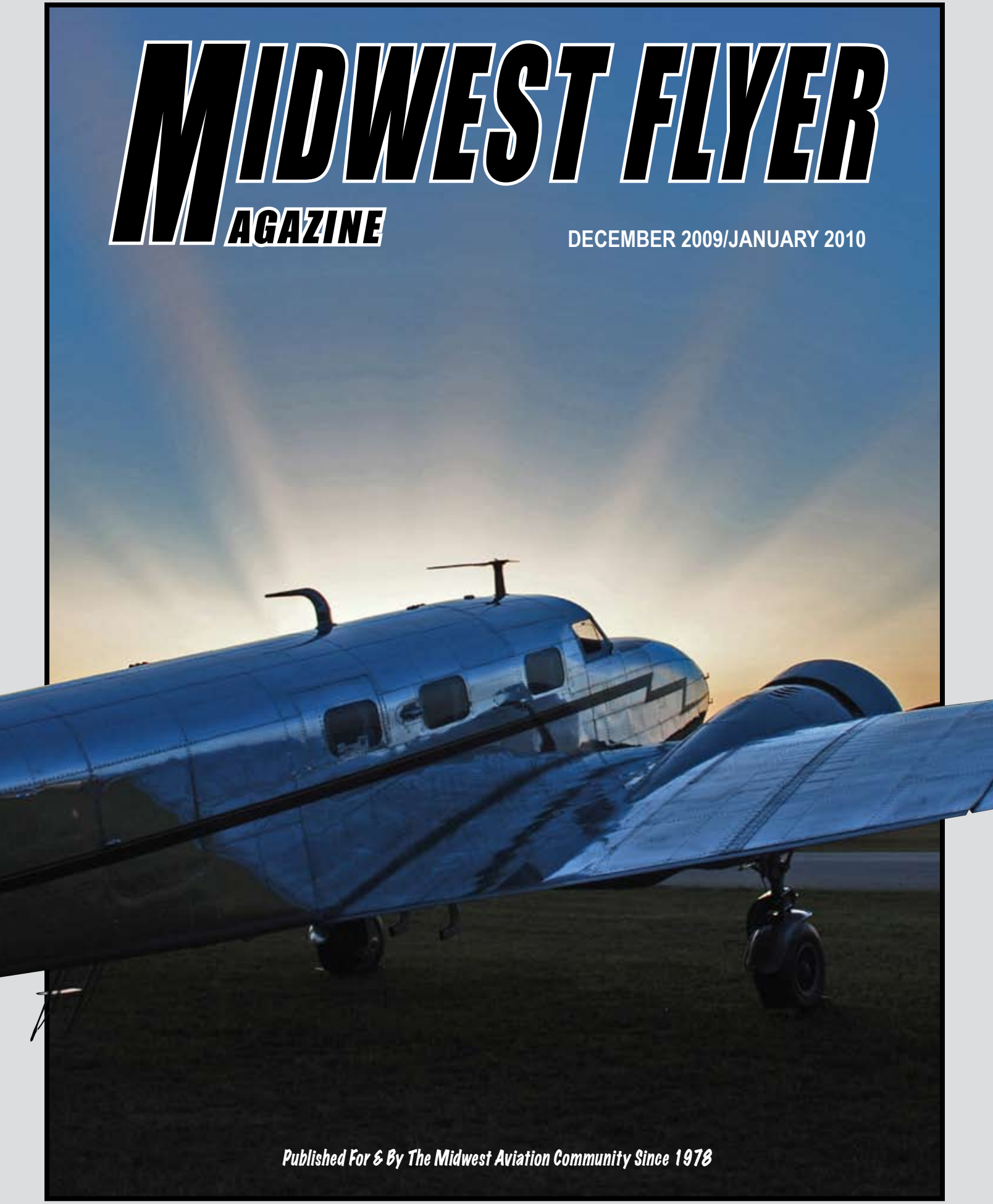

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Help your doc get it right!

by John W. Beasley, MD

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Dr. John W. Beasley

A couple of days ago I was trying to get a medication order done just right in the computer – Click here… Click there… Click…. and the patient kept talking to me. "By the way, my elbow is…" I looked at his elbow and back at the computer. Click here… Click there… Oops… I almost started my 78-year-old man on birth control pills. It's a bit like being on final approach and having a passenger who wants to chat.

Sometimes there is just too much to cope with at one time. In the cockpit, I have what the instruments tell me, what's on the Jepp chart, the notes I made, sound of the airplane, and more. Dang, ATC just amended my clearance!

There are many times when we are in a state of information overload – just too much stuff coming at us. And, some of the things that make it harder to handle this overload are interruptions. Interruptions cause what is known as a "break in task" and, as you can imagine, performance suffers. I reply to ATC and now my heading is off 20 degrees.

It's not too different in my office. Unless the issue is a really simple one (the equivalent of a nice VFR flight at cruising altitude), I'm trying to integrate information about the patient's problems from the chart (paper or computer), what the patient is telling me, what the non-verbals are (how he or she looks), what the nurse just told me, what I remember and more as I work to figure out what's going on and what to do about it all.

In aviation, the FAA has mandated a rule that there is no extraneous conversation (the "sterile cockpit") under 10,000 feet (where the workload is higher) for the airlines. This is recognizing that there is only so much we can handle at one time.

From my perspective, we need some version of that rule in medical care as well.

So how can you help your "doc" avoid errors? First, be aware that being a doc with a patient, unless the problem is trivial, is a bit like being on the ILS final approach. He or she is trying to figure out what's going on (location, speed, heading, altitude) and working to achieve what we call, in both professions, "situational awareness." Where are we and where are we going? While the doc needs to give you time to explain what's bothering you, at the same time you need to give him or her time to think, compose questions, examine you, read consultant notes, make decisions or write prescriptions. I cannot both listen to your heart and have you talk at the same time. And I cannot make decisions about your heart when you're trying to talk about your elbow. And I may screw up your prescription if you keep talking while I'm entering it.

It really helps to come in with a list of the things – all of them – that you want to discuss so that, if there is not enough time to address all of them, you and your doc can pick out the most important ones. The average appointment time is between 10 and 20 minutes and if you have four problems, that's about 2 to 5 minutes per problem. Not a lot of time to reach diagnoses and suggest treatments, let alone do all the computer work that's required. Time is limiting and while I'm willing to spend more time with patients than is on the schedule, I'm very sensitive to the fact that patients have appointments too, and it is both of our jobs to try to keep on time. Most docs do their best to stay on schedule, but often we fail. Believe me, I'm tired of starting off every visit saying, "Gosh, I'm sorry I'm running late!" It's one of the most stressful parts of my work.

If you are taking medicines, please bring them with you; the actual stuff in the bottle. Yeah, I know it is supposed to be in the computer, but you don't want me to rely on that. I know how things can get entered wrong, changes may not be recorded and errors can be perpetuated by computer systems. Trust me, I've been there.

Please – pretty please! – avoid what we docs call the "hand on the doorknob" problem. A while back I had finished up a 15-minute visit with a very complex – and wonderful – elderly patient and as I had my hand on the doorknob (literally!), her husband says: "You know, she's hallucinating in the mornings." Talk about a show stopper! Now I'm running 45 minutes behind schedule. It's a little

FAA Publishes Final Rule Updating FAR Parts 61, 91 And 141

by Greg Reigel
Attorney At Law


Greg Reigel

On August 21, 2009, the FAA published a Final Rule in the Federal Register that revises the training, qualification, certification, and operating requirements for pilots, flight instructors, ground instructors, and pilot schools. According to the Final Rule, "[t]hese changes are needed to clarify, update, and correct our existing regulations...to ensure a better understanding of these rules that relate to aircraft operations in the National Airspace System."

The Final Rule contains a significant number of changes to FARs 61, 91 and 141 in a variety of areas. Fortunately, the Final Rule does not include changes to instrument currency requirements that the FAA proposed in its original notice of proposed rulemaking ("NPRM"). (The NPRM proposed requiring pilots to perform precision and nonprecision approaches; fly a missed approach; hold at a "radio station," intersection, or waypoint; and conduct a one-hour cross-country flight, all in addition to the current instrument currency requirements.)

Pertinent changes include changing the duration of student pilot certificates to match the duration of a third-class medical certificate, changing the definition of "cross country" from "at least 50 nautical miles" to "more than 50 nautical miles," adding training and currency requirements for the use of night vision goggles and allowing for issuance of flight instructor certificates and ratings to military instructor pilots and examiners who can show having been designated as a U.S. military instructor pilot or examiner, to name a few.

The Final Rule went into effect October 20, 2009. If you would like further information regarding the Final Rule, you may contact John D. Lynch, Certification and General Aviation Operations Branch, AFS-810, General Aviation and Commercial Division, Flight Standards Service, Federal Aviation Administration, 800 Independence Avenue, SW, Washington, DC 20591; telephone (202) 267-3844; e-mail to john.d.lynch@faa.gov. For legal interpretative questions about this final rule, contact: Michael Chase, AGC-240, Office of Chief Counsel, Regulations Division, Federal Aviation Administration, 800 Independence Avenue, SW, Washington, DC 20591; telephone (202) 267-3110; e-mail to michael.chase@faa.gov.

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HIGH ON HEALTH CONTINUED

like getting a whole new approach thrown at you just as you are coming up on the marker. This is a great way to make errors in either aviation or medicine. So please be sure we know about the important or puzzling stuff at the beginning of the visit.

In the research part of my life, I'm doing some work with the UW Department of Industrial Engineering working on patient safety issues. We are exploring these problems of information overload and what helps or hinders us as we deal with it. There's a lot that the practice of medicine and aviation have in common. We need to work together to keep both safe!

In aviation, we say: "Don't worry… You will eventually see the ground."

In medicine, we say: "Don't worry… All bleeding stops eventually." ❑