It has happened in every team I have ever been attached to. For most of the day we will work within the territory of our own tribal environment, locked away in our own silo of familiarity—surrounded by people following the same logic. Everything is familiar…until suddenly it is not. A boundary of scope is reached, referral for assistance from another specialty is required. Interaction must occur between the different specialty silos; two cultures of two different tribes are set to collide. A large proportion of the time these interactions will be fine—best practice is clear and everybody is on the same page:

- GP refers → hospital team reviews
- Investigation is requested → Investigation is booked and completed.
- Inpatient or outpatient referral is made → specialty reviews patient.

“Day 18: the locals have begun to accept me as one of their own… I have found that, as with the previous communities with which I have tried to assimilate, joining in the animated conversations about the ridiculousness of culture within neighbouring villages has done much too facilitate my acceptance as ‘one of their own’…”
However, when communication is muddied and it becomes unclear whether a request or transfer is appropriate or is in the patient’s best interest, it can be harder for cooperation to occur. Sometimes the subject matter is so foreign to the referring practitioner they may have no idea what assistance is needed, or how urgently, but they know which service should take care of this:

“Blood coming from this area? Sounds like something specialty X should take care of.”

Another scenario where confusion occurs is where a patient tells one story to the referrer and a completely different story to the consulting team (sometimes they even have different clinical signs)—a classic problem for patients referred from ED or from GP too. Possibly even more commonly though is that in the time-pressured Chinese whispers of the referral process, information is lost in the communication between teams.

These are the classic trigger moments when an intra-specialty rant can commence. Those sending the referral cannot believe how arrogant and obstructive the team they are asking for help are being. The team requested for help cannot believe how vague and evasive the requesting team are being. Both teams rant about the culture of the other tribe of doctors and how their tribe is reasonable and how the other tribe seems to attract inferior specimens. Everyone feels better and closer to their immediate colleagues after getting the grievance off their chest and having their views reinforced by the rest of their tribe-mates.

Except, when we change tribes the picture changes—this is perhaps especially clear for students and interns, as during the earlier stages in training, changing from one specialty to a completely different one some weeks later is just part of the routine. The temptation is to get sucked into the new rants about other specialties as a quick way to be accepted by the new group.
But if we manage to remember that it is often the peculiar pressures of the work environment that create the tensions between different specialties, and that if we were in the place of the individual that appears to be causing the problem—who is only trying to care for the patient too—then we might likely behave the same way as they do.

Some papers suggest that the stereotypes of different medical tribes are more about the pressures of the work environment and less about the type of people those specialties attract. If you walk a mile in your adversaries’ shoes, when you are finished you will be a whole mile away from them and you will have their shoes! But hopefully you may also have learned a bit more about their perspective too. Avoiding joining in the ‘oh so easy’ blame game whenever the chance arises could help us work together, and might just help us help our patients a bit more too.

References
1. Extract from the imaginary journal within Dr Cheesman’s mind.