Personal view

Crowd pleasers

M C Bateson

Patient centred care

Some 60 years ago my mother was a surgical inpatient on a public ward in a West Yorkshire city. She subsequently riveted her children with a description of the experience. Catering was rudimentary and rations were generally supplemented by relatives, for the luckier patients at least. Clinical care was basically paternalistic and the patient was expected to become compliant and grateful.

The consultant ward round was especially interesting. All the patients on the whole ward were to be in bed, with the top sheet turned down to exactly the same length. Hands were to be clearly visible resting on the exposed sheet. Nobody spoke unless spoken to by the consultant or sister in charge. Nothing else happened but clinical review of the patients: junior doctors or students presented the cases and were quizzed by the boss. Nursing comments were supplied by the sister, who was always accompanied by at least one other nurse as a runner for messages or to perform any task which could not be done at the bedside. No outsiders were allowed in the ward during the round.

The patient might or might not be encouraged to comment on their care but would be in no doubt that this was their 15 minutes of fame, when all attention focused on their medical problem and its resolution. This system obviously pre-dated the NHS and the concept of patient rights. It depended on the labour of single women for whom the nursing profession provided not only their job but their home. Junior doctors were resident and only allowed out on sufferance. Marriage for them was rare and usually concealed. Opportunities for treatment were strictly limited, and the opinion of the senior man was recorded as unchallenged fact. Problems, mishaps, and mistakes were either unacknowledged, or blamed on the most junior member of the team or the patient. However, there was an ordered and informed environment where continuity of care was unquestioned. There was a high level of commitment to medicine which occupied most of these health workers' waking hours.

As a senior registrar in a teaching hospital 25 years ago I found some elements of the past still recognisable. A lot of ancillary staff now accompanied the professorial ward round, with their own opinions about management, but at least we all went round together in a calm atmosphere where patient care could be carefully considered.

I thought of this again a couple of years ago when conducting a consultant ward round on a Nightingale ward of 20 beds. Mum had been intensely proud of my achievement in becoming a doctor, but probably wouldn't have recognised my experience from her own recollection!

The ward sister was holding a harassed conversation at the nursing station, while simultaneously on the telephone. As ever she was cheerful and very keen to attend the round but was having difficulty juggling too many balls at the same time. Patients were wandering about, some were on the telephone, and some beds were pushed out for cleaning purposes. Domestic staff, social workers, ECG technicians, phlebotomists, pharmacists, visitors, porters, hospital estate staff, and other unidentified workers were going about their business. I counted 14 people additional to the patients and unconnected with my ward round, which was definitely scheduled to be the major business. Television sets were operational showing the usual mind diluting daytime TV. One or two seriously incapacitated elderly women were having loud radios played at them in side rooms, in a PC attempt to stimulate, which may have more enraged them. It was, in short, bedlam.

Why is it like this? We have allegedly user friendly services with approachable staff. There is great freedom of access to wards by pretty well everyone (even when they are locked!). Everyone has rights, but the paradoxical net effect seems to be disenfranchisement of all. There are, of course, many more doctors and nurses, but shorter working hours and shift systems means that it is often possible to be the only doctor on a ward round who has met the patient before. The named nurse system means relays of supporting staff appear and vanish during a round.

The persistence of mixed sex wards, farming out of patients to beds in other specialties, and the use of individual wards for the patients of many different consultants generates an air of crisis management rather than orderly care. But this is in a small friendly general hospital with stable dedicated staff, an adequate number of beds, no tradition of trolley waits in casualty, and with a supportive local community of patients' friends and relatives. What can it be like in larger and less favoured establishments?

People locally appreciate the secondary medical care but the stressful environment in which it is delivered could be improved with benefit to all.

What one learns from working in an institution is that managerial efforts are always focused on demonstrating change and improvements, even when the outcome of fresh ideas is not always positive. One is always recognising the recycled concepts of the past.

So what I propose is this New Model of Patient Centred Care. Ward rounds are to be conducted at fixed times on wards where other activity is suspended as far as possible to aid concentration. At least one other person apart from the consultant should know exactly what is going on with each patient. Patients under the care of particular consultants should be grouped together as far as possible. Only one consultant would be allowed on a ward at any one time, and junior doctors from other firms would be encouraged to avoid these periods.

There would, of course, be resistance from traditionally conservative senior medical staff, but with the right incentives, training, and off-site residential educational seminars they should be persuaded that this is indeed the Right Way Forward. They would then be forced to look after the patients better and it would be good for everyone's nerves. Patient satisfaction is bound to increase.

What do you think, mother?

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