

doctors to hinder and encourage learning and teaching opportunities on post-take ward rounds. Ward rounds have always been an essential part of postgraduate medical education since first described in 1660.¹ In the mid-1980s a survey reported that 58% of senior house officers' learning occurred on ward rounds.² However, medical education has been turned on its head in recent years with the adoption of the European Working Time Directive and the implementation of Modernising Medical Careers and the foundation year (FY) programme. In a recent study I found that only 18% of FY doctor learning occurs on ward rounds and I suspect that the issues outlined by Dewhurst play a major role in this decrease, noticeably, reduced time, reduced team cohesion and lack of awareness of learning and teaching skills.

I disagree with two commonly held views on how to improve ward-based teaching, the first is that all doctors should be teachers and therefore should learn teaching skills. There is no doubt that all experiences can provide an opportunity to learn, even the bad ones but, suggesting that all activities should have a focus on education, or an element that is taught, is an inefficient way of using a sparse resource. In the case of post-take ward rounds I believe there should sometimes be a focus on 'getting the work done', and at other times emphasis on teaching, as the most inefficient ward rounds are those in which the focus is placed on teaching but there is simply too much 'service provision' to allow learners to focus and absorb their experiences.

Teaching, like all specialties, is a skill that few are excellent at, most are reasonable at and some are terrible at. The challenge is identifying those who are good at teaching, and then promote their education activities by providing the time, recognition and financial reward that will encourage them to pursue this rapidly evolving area.

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References

- 1 Baron JH. The first teaching ward round: Leyden 1660. *BMJ* 2006;333:483.

- 2 Grant J, Marsden P, King RC. Senior house officers and their training. 2. Perceptions of service and training. *BMJ* 1989;299:1265–8.

Intermediate care for older people in the UK

Editor – I welcome Woodford and George's recent journal article (*Clin Med* April 2010 pp 119–23). Older people represent the fastest growing sector of the population in the UK. Health and social care design is of paramount importance not simply because of the burgeoning cost, but because how we treat the frailest and most vulnerable in society is the barometer of developed countries whose human cost can be measured in disability, morbidity and death.

Woodford and George's article highlights that 'failing to plan is planning to fail' as the wholesale national investment in healthcare policy without an adequate evidence base is resource put at risk. The clear message is that healthcare systems that are centrally managed and funded must show greater governance and invest in research and evidence development before implementing healthcare policy.

Nevertheless the message may not be as gloomy in relation to cost savings as indicated by the authors. Firstly because the evidence for community rehabilitation as reviewed in a meta-analysis of 96 trials of 97,984 people by Beswick and colleagues is strong in terms of reduced nursing home admissions (odds ratio (OR) 0.87, 0.83–0.90), hospital admissions (OR 0.94, 0.91–0.97) and falls (OR 0.90, 0.86–0.95).¹ In addition, there was clear benefit from improved physical function. Secondly because even modest benefits in the reduction of admission to nursing homes (as cited in the paper) is both an outcome desirable to patients and because the cost saving to society is significant. In the current economic climate the NHS cannot operate in isolation to other publicly funded local authority partners where closer cooperation may benefit both in cost avoidance and must be considered unavoidable.

Robust evaluation, transparent accountability and good metrics have got to go hand in hand with any development however, so that we do not risk further follies.

And please, someone, invest in further research.

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Reference

- 1 Beswick AD, Rees K, Dieppe P *et al*. Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 2008;371:725–35.

Endorsement of peer review

Editor – We read with interest the paper by Roberts *et al* (*Clin Med* June 2010 pp 223–7) describing their positive qualitative experience of peer review in respiratory medicine. We would like to further endorse the peer-review process based on our experiences in rheumatology.

In rheumatology, peer-review programmes are encouraged on a regional basis, using a nationally agreed proforma developed by the British Society for Rheumatology and the British Health Professionals in Rheumatology based on evidence-based clinical guidelines. Within the West Midlands region the cycle of multi-disciplinary peer review visits occur over a five-year period. Analysis of this programme demonstrated many qualitative benefits, including perceptions that peer review helped obtain more consultant posts, secure day case facilities, set strategies for the next five years, focus managerial requirements and foster a positive learning environment where strengths could be transferred between units. Quantitative analysis revealed many of the recommendations of the peer-review reports had been implemented. It was agreed that peer review was a worthwhile and constructive component of continuing professional development.¹ For some units there was a five-year interval between their peer review and our study which may explain why we were able to detect improvements in staffing and facilities; we agree with Roberts *et al* that their 12-month follow-up period may have been too short to capture changes in their respiratory services.