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From the Editor

Quality of care

A new Birmingham University teaching hospital will open in 2010: a new phase in history of patient care stretching back more than 200 years. To provide a link from the old to the new for both patients and staff, a brief history has been established on the trust's website. The most striking and arresting features are the old drawings and photographs of the wards. There is an air of calm caring and a gentle pace of clinical life pervades the scene which is all but unknown today. There were few occupants in each ward with acres of space between the beds. The patients looked as if they had taken up residence for life. The wards were spotless with gleaming wooden furniture and floors. Vases of flowers were everywhere. The nurses were impeccably dressed and seemed to have all the time in the world to deliver compassionate care. This atmosphere even persisted in those photographs of the present hospital around the time that it opened in 1939.

There could be no more striking contrast with the acute medical unit of today with its frenetic pace, rapid turnover and intensive investigation. Men and women are often to be found side by side with young and old, drunk and sober, the sane and demented all sharing the same ward. Advantages are difficult to identify except perhaps for my elderly retired consultant neighbour who decided recently to give in gracefully and take a room in the local nursing home. He was unhappy with his new home until an overnight stay in the acute admission unit of the local hospital. Placed between a happy and loquacious drunk and a noisy confused elderly lady, he returned to the nursing home the next day which he regarded ever after as a haven of delight, peace and tranquillity.

There are still pockets of peace and tranquillity in medical care, discovered recently during regular visits to a hospice which in view of its excellence should not remain anonymous but named as the J Arthur Rank Hospice in Cambridge. The same calm atmosphere exists reminiscent of those photographs from an earlier era. The care of the patients and their families was outstanding. Excellent drug treatment relieved the stress and anxiety of illness without the sedation so commonly associated with such treatment. Time was freely put aside by all the staff to discuss options, anxieties and concerns. A kitchen was provided for relatives to prepare drinks and meals. The garden was tended by volunteers creating a further area of peace. The coffee shop was also run by volunteers keen to help and listen. The clinical care was funded by the NHS (unusual for many hospices which are largely run on a voluntary basis) but all the additional support was provided through voluntary fundraising.

The gulf between the calm supportive environment of the hospice and the front line services of acute medicine is huge. Can it be bridged or is it simply too late? We have lived through an era when services had to be provided regardless of the difficulties and challenges and perhaps it never really occurred to physicians to 'draw a line in the sand' and determine that certain practices were unacceptable. These features might include mixed gender wards, movement of patients from one ward to another unrelated to medical need, and lack of time for personal care and discussion with relatives. As the recent expansion of funding in the NHS draws to a close, implementation may prove even harder but at least we should be aware of those features which need attention and that what we are used to in practice is not the same as those features being acceptable.

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