

Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within 6 weeks of receipt of *Future Healthcare Journal*. Letters should ideally be limited to 350 words, and sent by email to: FHJ@rcplondon.ac.uk

Exploring the psoriasis self-management landscape

Editor – We read the article by Silver¹ with great interest, and agree that as healthcare providers, we need to be involved in developing robust self-management strategies for our patients. In dermatology, we see patients with several chronic skin conditions, which often require years of secondary care follow-up. One such example is psoriasis, a common inflammatory skin condition, in which inadequate patient support and information can result in poor compliance and treatment failure. We have reviewed the literature of interventions designed to promote self-management in adults with psoriasis in order to better conceptualise self-management and to identify barriers. A total of 29 primary research articles were identified concerning self-management in psoriasis.

The literature reveals a broad view of self-management which focuses on patients tailoring treatment around their everyday lives. This applies across treatment modalities, from conventional topical therapies to home-based phototherapy.² Whilst beneficial in theory, this autonomy may also pose significant challenges to patients in situations where their knowledge is limited, treatment is ineffective or psychosocial support is inadequate. This can lead to non-adherence, inappropriate self-medication and disengagement from healthcare appointments.

The evidence reinforces that the benefits of patient autonomy are optimised when care is individualised. To achieve this, physicians should provide guidance that enables patients to have an active role in decision making, whilst offering continuity of care. The perceived lack of knowledge among patients with psoriasis calls for targeted education. Given limited consultation times, the published evidence suggests that web-based technology³ and education delivered by allied healthcare professionals⁴ will be essential if patients are to develop self-management skills.

Six of the studies we reviewed included analysis of cost effectiveness, with three demonstrating a clear cost saving benefit for self-management for psoriasis, and three being equivocal. Going forward, randomised controlled trials with economic evaluation are required to rigorously test such educational interventions, as well as other self-management modalities. As we work towards better defined self-management interventions, we can anticipate improved treatment-adherence, better patient outcomes, less need for outpatient follow-up, and possible savings in our cash-strapped health service. ■

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Who delivers care is just as important

Editor – I read with interest the study carried out by Zaman *et al* looking into the perspective of patients on the acute medical unit of physician associates (PAs);¹ a member of the medical team whose number and role has expanded through my time in medicine so far. I have had mostly positive experiences working with PAs and it is encouraging that patients found their experience of care under them equally largely satisfactory.

One crucial thing that this study fails to capture however is the patient's perspective of what a PA is. Previous studies have highlighted that the patient population can be confused about what the difference between a PA and a doctor is, and that this can impact on their willingness to be treated by them.^{2,3} It would be interesting to see what the patient population surveyed in Zaman *et al*'s study understood the qualifications and skills of the PAs to be and see how this related to their satisfaction.

PAs are a relatively new role in hospitals in the UK and the patient population has limited knowledge and experience with them. Education of our patient population is of the upmost importance, but it does not just relate to their diagnoses and treatment but also to our role in their care along with our abilities and limitations. While satisfaction with the service obtained is of course important it shouldn't be attained at the expense of

patients knowing who is delivering their care. While skilled and highly trained, PAs are not the same as medical doctors and in an open and honest health service we need to be careful that patients do not equate the two as always equivalent. ■

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Engineering better ward rounds

Editor – The October issue's attention to systems approaches in healthcare is timely. Belatedly, the NHS might now realise that it will benefit more from engineering approaches than from accountancy-based management consultants.

In the same month's *Commentary*, Dr Sinha describes the demise of well-organised ward rounds and explains why this degrades safe, high-quality care and staff morale.¹ The *Future Healthcare Journal* article by Clarkson *et al*² indicates how a systems approach might help resurrect effective ward rounds. In 2009, the Royal College of Physicians (RCP) asked me to report on an innovative ward round project in a district hospital. This project and its architect became key components of the 2012 guidance³ and I am disappointed that this did little to reverse the decline but not surprised given that such documents alone are never sufficient to bring about widespread, lasting change. Having worked on this problem for some years before retirement, and having spoken recently to colleagues still in practice, I suspect that progress is blocked less by obstructive managers than by a sense of hopelessness about correcting underlying causes.

Ward rounds are logistics challenges to assemble the right staff and information at the right time in the right place. Patients are already in place unless undergoing treatment or investigation off the ward and the most common problems involve attendance and contributions of nurses and junior medical staff. That nurses don't feel they have time to attend is understandable given the shameful lack of nursing numbers but, arguably, the time spent jointly sharing and recording the same accurate information once is less than that needed to gather this information separately later, inefficiently, in other ways. Inability of junior medical staff to

participate fully in ward rounds seems largely due to the change from firms and rotas to shifts that don't seem to have benefited anyone. Both problems show what happens when we don't consider systems and what could go wrong.

Other factors cited are lack of time in consultant job plans and inability to get results of investigation to the ward round. The former needs very firm backing from the RCP but to anyone who still pleads the latter I suggest they speak to their hospital engineers who understand and solve the infinitely more difficult problems of supplying electricity, oxygen and suction to every bedside 24-hours a day!

I don't agree that we need surveys or studies of cost effectiveness before we can begin to restore good ward rounds. The benefits listed by the RCP and the Royal College of Nursing and others are unarguable and are precisely what patients, clinicians and managers say they want. To anyone worried about costs I would say, simply, that the costs of not doing this are much higher even considering just errors, complaints and litigation.

Might I suggest that the RCP identify, and give practical support to, physicians who volunteer to attempt restoration of good rounds in their trusts. No one model is right in every context but just making a start, involving managers and other disciplines, is an urgent requirement. Progress can be fed back to the RCP to inform further development. Managers need not be seen as the enemy and might welcome being asked how they could bring their skills to help solve this problem. Isn't the core function of a manager still to make it easier for clinicians to do their best work? In trusts where the medical director is an RCP fellow, it seems inconceivable that the board cannot be educated to support what needs to be done.

Two conditions apply: first that the patients' needs and wishes remain central; second, that ward rounds do not become platforms for consultants to grandstand. The latter can deter nurses and other professionals when their contributions are most needed.

Ward rounds can evolve using engineering approaches and technology but should remain as exemplars of team interactions with patients and peers. Without urgent determination and good will, the future of ward rounds and thereby of healthcare in hospitals looks bleak. ■

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