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. ■

JAMES WILSON
Core medical trainee, Royal Brompton Hospital, London, UK

References

1 Zaman Q, Yogamoorthy S, Zaman M, Fouda RMFR. Patients' perspective of physician associates in an acute medical unit within an English district general teaching hospital – a pilot survey study. *Future Healthcare Journal* 2018;5:213–7.
2 Halter M, Drennan VM, Joly LM *et al.* Patients' experiences of consultations with physician associates in primary care in England: A qualitative study. *Health Expect* 2017;20;1011–9.
3 Phillips MJ, Harris M. What's in a name? An evaluation of public perception around job role titles with the modern anaesthesia team. *J Perioper Pract* 2015;25:68–71.

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 guidance[3] 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. ■

DAVID LEVINE
Retired consultant physician, Sennen, Cornwall, UK

References

1 Sinha R. We need to go beyond the basics: how to fix the medical ward round. *Commentary* 2018;5:7.
2 Clarkson J, Dean J, Ward J, Komashie A, Bashford T. A systems approach to healthcare from thinking to practice. *Future Healthcare Journal* 2018;5:151–5.
3 Royal College of Physicians, Royal College of Nursing. *Ward rounds in medicine: principles for best practice*. London: RCP, 2012.