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PROCESS AND SYSTEMS

Afternoon ward rounds: bad for patients, bad for doctors?

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ABSTRACT

Hospital medicine in the UK is under unprecedented pressure, with increasing demand on physicians as well as challenges in recruiting new doctors into the physicianly specialties.

We sought to assess the prevalence of the afternoon ward round and its effect on those undertaking them. We sampled each hospital within our postgraduate region, surveying junior doctors working on inpatient medical wards.

We surveyed roughly two-thirds of eligible doctors, finding that 30% of juniors had some commitment, of varying frequency, to ward rounds beginning after 1.00pm. Of the doctors involved in afternoon ward rounds, the majority felt they contributed to late finishes, delayed discharge of patients, reduced team efficiency and reduced job satisfaction. Just under 80% felt they were less likely to consider a career in hospital medicine as a result

The afternoon ward round lives on, and we should not underestimate its effect. Low junior doctor morale coupled with high work intensity can lead to burnout as well as impairing the effectiveness of the clinical service. Clinical leaders should consider leaving this practice in the past so we can cope with the challenges of the future.

KEYWORDS: Ward rounds, general internal medicine, junior doctors, time management, morale

Introduction

Training and service provision in general internal medicine (GIM) within the UK is currently under immense pressure. Unprecedented difficulty in recruiting new doctors into the physicianly specialties is coupled with the challenge of delivering safe and effective general medical care to an ageing population in an era of shrinking resources and acute hospitals already at breaking point.

Our acute medical services are seeing an overall progressive deterioration in performance in accepted metrics such as the proportion of medically fit patients experiencing 'delayed transfers of care'[1] and the so-called 4-hour wait figure for patients attending emergency departments.[2] This may be multifactorial,[3] but increased demand on services coupled with real-terms reductions in health and social care funding, are likely to be major contributors. Within medical recruitment, we face an existential crisis. In 2017, only 42.6% of doctors completing the foundation programme stated they planned to pursue specialty training within the UK, a figure which has been steadily declining from 71.3% in 2011.[4] The same report showed that in 2016, core medical training (CMT) had the second-lowest fill rate of any training specialty and that only 22% of first-year doctors were considering subsequently applying for CMT. Indeed, early CMT recruitment figures for 2017, while still incomplete, show the post fill-rate has continued to deteriorate.[5]

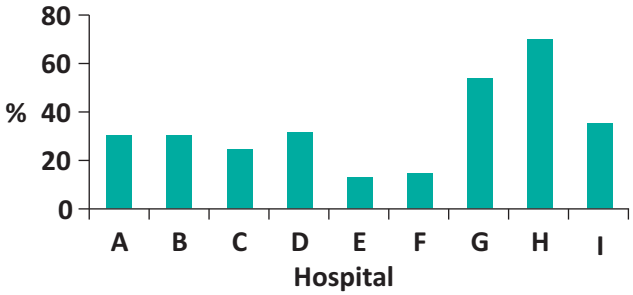

Fig 1. Anonymised comparison between hospitals of proportion of doctors reporting involvement in ward rounds commencing after 1.00pm.

Increased pressure of day-to-day work, worsening rota gaps and the recent protracted junior doctor contract dispute all have the potential to sap morale, but a career in GIM still has much to offer. The Royal College of Physicians (RCP) has been vocal in drawing attention to some of the root causes of these issues in recent reports (*Underfunded. Underdoctored. Overstretched. The NHS in 2016*),[6] as well as championing some of what is still fulfilling and rewarding in the physicianly specialties (in their *Keeping medicine brilliant* campaign).[7] In their report, *Being a junior doctor*,[8] the RCP reported that four in five junior doctors 'regularly experienced excessive stress' due to the job. Similarly, excessive administrative workload was seen as a serious threat to patient safety. Over 90% reported regularly working longer than their rostered hours with almost half (46%) reporting stays of over 2 hours post finishing time within the last month.

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Inpatient care forms the core of most physicianly specialties, and ward rounds the backbone of this work. Indeed as the key meeting time for a medical team, this is a vital time for patient review, flagging up of important issues and allocation of tasks to progress the patient journey. The afternoon ward round was once a common occurrence, with consultant ward time slotted around clinics and procedure lists, often with other senior registrars providing ward round input for the remainder of the week. With the increasing pressures of a sicker population, stretched bed-base and the expectation that unwell, new or potentially discharge-able patients are reviewed by a consultant, is the concept of an afternoon ward round still fit for purpose in 21st century healthcare? Anecdotally, the authors felt that consultant ward rounds which began late in the day were detrimental, reducing the ability of junior doctors to structure their day, ensure patients were seen in a timely manner with an appropriate management plan and then leave enough time to subsequently undertake any tasks generated by the ward round. More seriously, there is a hypothetical risk that such an approach impedes the efficiency of the medical team, potentially creating safety issues and slowing discharges. The effect on the junior doctors themselves can also be significant, with informal reports of significant effects of late finishes on undermining doctor morale. The inability of doctors working on certain wards to structure their working day in a logical manner, coupled with frequent late finishes seems to produce issues detrimental to both patient and doctor.

Methods

To further clarify the scale of the issue and the effects it may or may not be having on the workforce, we undertook to survey junior doctors within the 'Severn' region. At each hospital in the region, a trainee doctor physically visited every medical inpatient ward and surveyed the juniors present. This was done on a single day at each hospital site, to minimise overlap of respondents or movement of juniors between ward rotations. Responses from representatives at each acute hospital site in the region were received within a 6-month period, thus removing the potentially confounding effect of junior movement between hospital trusts.

Juniors were defined as foundation doctors, senior house officers or other doctors at that level but below registrar level. Medical admissions units were excluded as these often operate in a different manner with staggered shift patterns and the continual arrival of patients as well as ongoing post-take ward rounds. Doctors were surveyed using a structured pro forma (see supplementary material S1), with a focus only on consultant-led ward rounds, those considered to be the 'main' rounds, rather than quick 'troubleshooting' or select patient reviews. Afternoon ward rounds were defined as those which started after 1.00pm.

The total number of juniors on the ward surveyed, as well as the total number on the rota for that ward, were collected. This allowed us to estimate the proportion of applicable doctors that our survey had reached. Our pro forma quantifies the frequency of afternoon ward rounds and late finishes. Subsequently, those who undertook or had previous experience of afternoon ward rounds were asked qualitative questions regarding the possible effects of these rounds, with the doctor able to rate their agreement with the statement.

Results

Every hospital in the Severn Deanery (now part of Health Education South West) was successfully surveyed, with 172 of 274 (63%) eligible doctors surveyed. See Tables 1 and 2 for tabulated results.

Of 172 surveyed, 51 (30%) stated that during their current placement, they were expected to attend ward rounds which began after 1.00pm. Of those 51 juniors, 11 (22%) did this less than once per month, five (10%) one–two times per month, five (10%) three–four times per month, 20 (40%) once or twice per week and 10 (20%) experiencing afternoon ward rounds three–five times per week. There was considerable variation between hospitals (see Table 3 for the anonymised comparison) with one smaller district general hospital reporting late ward rounds in 7 of 10 respondents.

On the question of afternoon ward rounds contributing to a late finish, of those 51 doctors who undertook them, 46 (90%) felt they contributed to late finishes. Of these, eight (17%) felt this occurred less than once per month, six (13%) one–two times per month, nine (20%) three–four times per month, 20 (44%) one–two times per week and three (7%) reported that their afternoon ward rounds contributed to late finishes three–five times per week.

Responses to the qualitative questions were received from 58 respondents (51 who undertook afternoon ward rounds plus 7 further respondents with recent experience of them) and are displayed in Table 2. Notably, 72% agreed or strongly agreed that afternoon ward rounds contributed to delayed discharge of patients. Exactly half felt that they contributed to reduced communication with relatives, with some responses indicating that rounding in the afternoon allowed overlap with visiting hours, thus improving the potential for communication with relatives. 91% agreed or strongly agreed that the juniors on the ward could work more efficiently if all ward rounds began promptly at the start of the day. Sixty per cent agreed or strongly agreed that afternoon ward rounds detrimentally affected their sense of satisfaction/fulfilment with the job. Most disappointingly, 78% of respondents agreed or strongly agreed that the prospect of a lifetime of afternoon ward rounds made hospital medicine seem less appealing as a career choice. Other comments recorded by respondents frequently reflected a sense of frustration around the inefficiencies of this practice, with some juniors feeling they have little choice but to stay late to ensure patients have management plans in place and appropriate discharges are undertaken.

Discussion

Modern healthcare delivery in the UK deals with an increasingly frail and complex cohort of patients across a system under financial and workforce pressures. There is some evidence that consultant ward rounds do reduce average patient length of stay on medical and surgical wards,[9,10] with a suggestion that afternoon ward rounds may be particularly effective in an acute admission environment to identify patients appropriate for possible early discharge.

The acute medical assessment unit is a unique environment with continuous patient admission and discharge, with a need for almost-continuous senior review and decision making. Data linking increased consultant-patient contact to reduced mortality within an acute medical setting remains controversial and requires further study.[11] Our group wished to assess the common practices on medical inpatient wards, where the routine flow of patients would reasonably be assumed to be significantly reduced by comparison to an acute unit. Indeed, the RCP's own 2012 guidance on ward rounds in its comprehensive document *Ward*

Table 1. Anonymised table of results demonstrating the number of junior doctors involved in afternoon ward rounds (after 1.00pm) across nine hospitals

Hospital	Ward total	Number surveyed	Never late WR	Late WR	<1/mo	1–2/mo	3–4/mo	1–2/wk	3–5/wk
A	36	20	14	6	2	0	0	1	3
B	40	20	20	0	0	0	0	0	0
C	33	25	19	6	1	0	1	4	0
D	18	13	9	4	0	2	0	2	0
E	41	17	15	2	0	0	0	2	0
F	18	14	12	2	2	0	0	0	0
G	39	30	14	16	3	2	4	4	3
H	23	10	3	7	2	0	0	3	2
I	26	23	15	8	1	1	0	4	2
Totals, n	274	172	121	51	11	5	5	20	10
Per cent of total surveyed, %	n/a	100.0	70.3	29.7	6.4	2.9	2.9	11.6	5.8
Per cent of late finishes, %	n/a	n/a	n/a	n/a	21.6	9.8	9.8	39.2	19.6
Of these, %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Hospital	Ward total	Number surveyed	Of late WR, number that contribute to a late finish	<1/mo	1–2/mo	3–4/mo	1–2/wk	3–5/wk
A	36	20	6	2	0	1	3	0
B	40	20	0	0	0	0	0	0
C	33	25	5	0	0	1	4	0
D	18	13	3	1	2	0	0	0
E	41	17	2	0	1	1	0	0
F	18	14	1	0	0	1	0	0
G	39	30	15	3	1	5	6	0
H	23	10	6	1	2	0	3	0
I	26	23	8	1	0	0	4	3
Totals, n	274	172	46	8	6	9	20	3
Per cent of total surveyed, %	n/a	100.0	26.7	4.7	3.5	5.2	11.6	1.7
Per cent of late finishes, %	n/a	n/a	90.2	15.7	11.8	17.6	39.2	5.9
Of these, %	n/a	n/a	n/a	17.4	13.0	19.6	43.5	6.5

Of those undertaking late ward rounds, the frequency of these is shown as well as the proportion contributing to a late finish. Percentage totals, including those adjusted for number undertaking late ward rounds, are displayed. mo = month; n/a = not applicable; WR = ward round; wk = week

rounds in medicine: Principles for best practice suggests that 'Consultant-led ward rounds should be conducted in the morning to facilitate timely completion of tasks during the working day.'[12]

Our survey captured what we feel to be a representative real-world sample of junior doctors working on medical wards across nine hospitals in the south west of England. It revealed that just under a third were expected to contribute to afternoon ward rounds with a majority of these occurring at least weekly. A majority of those undertaking afternoon ward rounds reported that these contributed to late finishes for junior doctors at least weekly, with a small number reporting almost daily late finishes as a result. Although there was no clear consensus on the effect on communication with relatives, the responses on the effect on delayed discharges, doctor efficiency and morale were compelling and alarming in equal measure.

These data show significant variation in practice between the nine acute hospitals surveyed in the region, with some avoiding afternoon ward rounds altogether. This suggests that the practice is not intrinsic and may reflect local organisational or departmental norms. Importantly, this suggests that there is scope to critically appraise such practices and modify them if necessary. This change could arise from members of a team engaging with their consultant staff in a collaborative and constructive manner. Ideally, the consultants and clinical leaders of the present and future would drive this change from within, and this survey may be a useful tool to inform that discussion.

Table 2. Anonymised table showing the number of junior doctor respondents for each response to the qualitative statements regarding afternoon ward rounds

Hospital	Number of respondents														
	Afternoon ward rounds contribute to delayed discharge of patients.					Afternoon ward rounds contribute to reduced communication with relatives.					The junior doctors on this ward could work more efficiently if ward rounds all began promptly at the start of the day.				
	SA	A	DK	D	SD	SA	A	DK	D	SD	SA	A	DK	D	SD
A	3	1	1	1	0	2	0	1	3	0	2	4	0	0	0
B	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
C	0	4	1	1	0	0	4	0	2	0	0	4	0	1	0
D	0	4	0	0	0	0	2	0	2	0	3	1	0	0	0
E	0	2	0	0	0	0	2	0	0	0	0	2	0	0	0
F	1	1	0	0	0	1	1	0	0	0	2	0	0	0	0
G	1	7	4	3	0	2	7	4	3	0	9	6	1	0	0
H	0	3	1	3	0	0	3	1	3	0	4	3	0	0	0
I	4	11	1	0	0	2	3	2	6	2	8	5	0	0	0
Totals	9	33	8	8	0	7	22	8	19	2	28	25	1	1	0
% of total	15.5	56.9	13.8	13.8	0.0	12.1	37.9	13.8	32.8	3.4	48.3	43.1	1.7	1.7	0.0

Hospital	Afternoon ward rounds detrimentally affect our sense of satisfaction/fulfillment with the job.					The prospect of a lifetime of afternoon ward rounds makes hospital medicine seem less appealing as a career choice.				
	SA	A	DK	D	SD	SA	A	DK	D	SD
A	1	2	1	2	0	1	2	1	2	0
B	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
C	0	3	1	2	0	1	2	1	1	1
D	0	3	1	0	0	2	1	0	1	0
E	0	1	1	0	0	1	1	0	0	0
F	1	0	1	0	0	1	1	0	0	0
G	2	8	2	4	0	4	6	4	1	0
H	0	1	2	4	0	3	2	1	0	0
I	5	8	1	1	0	9	8	1	0	0
Totals	9	26	10	13	0	22	23	8	5	1
% of total	15.5	44.8	17.2	22.4	0.0	37.9	39.7	13.8	8.6	1.7

Hospital B had no PM ward rounds and therefore no respondents to this question. A = agree; D = disagree; DK = don't know; SA = strongly agree; SD = strongly disagree.

Of course, the world of patient care is heterogeneous and different units may have subtly different requirements. It may be while units should aspire to undertake the main, formal ward round within good time in the morning, some teams may choose to undertake focused clinical reviews of selected patients in the afternoon, or undertake troubleshooting sessions with junior staff.

Limitations

Unfortunately, our survey does suffer limitations of design and distribution. We were limited in our professional networks to undertake the survey in one geographical region, that which correlates with our postgraduate training deanery. Of course, a multi-regional or national survey would be ideal. However, we feel our region is sufficiently large and varied to provide a useful and interesting sample.

Our survey may have offered a more robust reflection of junior doctor opinion if questions were worded in a more neutral manner with less emotive language. Similarly, the options for agreeing or disagreeing could have been scrambled from left to right to reduce subconscious bias. However, it does not mean we can necessarily dismiss the quantitative or qualitative findings of the survey. Finally, this learning experience of designing qualitative projects will enable more careful future examination of this and related issues.

Table 3. Anonymised comparison between hospitals, proportion of doctors reporting involvement in ward rounds commencing after 1.00pm

Hospital	Proportion of doctors surveyed involved in late ward rounds, % (n)
A	30 (6)
B	0 (0)
C	24 (6)
D	31 (4)
E	12 (2)
F	14 (2)
G	53 (16)
H	70 (7)
I	35 (8)

Conclusion

Within the UK, hospital medicine and indeed the medical profession in general face an existential crisis, with profound workforce[13] and resourcing[14] challenges further compounding the pressures of an ageing population with more expensive and complex therapies. Doctors within our system work hard to deliver the right care for their patients. Our work is not intended as a critique. Rather, we wish to illustrate how current working practices can be streamlined to better manage the challenges of modern healthcare delivery. If we want to attract and retain the best and brightest within the physicianly specialties, we need to ensure we treat junior doctors with due respect. Though consultant-led ward rounds are core to providing optimal patient care, ward systems and processes must be designed to optimise the patient journey with efficiency and safety at the core, rather than fit haphazardly around other ward or consultant activities such as outpatient clinics. Only by learning the lessons of teams which value their junior staff and carefully considering the processes they follow, can we truly claim to be doing the best by patients and doctors. ■

Supplementary material

Additional supplementary material may be found in the online version of this article at http://futurehospital.rcpjournal.org:

S1 – Questionnaire pro forma used to collect data. A separate form was used for each clinician surveyed.

References

1 NHS England. *Delayed transfers of care data 2015–16*. NHS, 2016. www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2015-16.

2 NHS England. *A&E attendances and emergency admissions 2015–16 (monthly and quarterly)*. NHS, 2016.

3 The King's Fund. *What's going on with A&E waiting times?* London: The King's Fund, 2016. www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters#discharging-patients.

4 UK Foundation Programme. *Career destinations report 2017*. UK Foundation Programme, 2017.

5 NHS Health Education England. *Specialty recruitment: round 1 - acceptance and fill rate*. NHS Health Education England, 2017. www.hee.nhs.uk/our-work/medical-recruitment/specialty-recruitment-round-1-acceptance-fill-rate [Accessed 10 May 2017].

6 Royal College of Physicians. *Underfunded. Underdoctored. Overstretched. The NHS in 2016*. London: RCP, 2016.

7 Royal College of Physicians. *Keeping medicine brilliant: Improving working conditions in the acute setting*. London: RCP, 2016. www.rcplondon.ac.uk/guidelines-policy/keeping-medicine-brilliant [Accessed 10 May 2017].

8 Royal College of Physicians. *Being a junior doctor: Experiences from the front line of the NHS*. London: RCP, 2016. www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor [Accessed 10 May 2017].

9 Ahmad A, Purewal TS, Sharma D, Weston PJ. The impact of twice-daily consultant ward rounds on the length of stay in two general medical wards. *Clin Med* 2011;11:524–8.

10 Baryeh KW, Elliott D, Harb Z, Lisk R. Does a daily consultant ward round affect the outcomes of orthopaedic patients? *Br J Hosp Med* 2018;79:41–3.

11 Bell D, Lambourne A, Percival F, Laverty AA, Ward DK. Consultant input in acute medical admissions and patient outcomes in hospitals in england: a multivariate analysis. *PLoS One* 2013;8:e61476.

12 Royal College of Physicians, Royal College of Nursing. Ward rounds in medicine: Principles for best practice. London: RCP, 2012.

13 The King's Fund, The Health Foundation, Nuffield Trust. *The health care workforce in England: Make or break?* London: The King's Fund, 2018.

14 The King's Fund, The Health Foundation, Nuffield Trust. *The Autumn Budget: Joint statement on health and social care*. London: The King's Fund, 2017.

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