Team Ward Rounds

By A/Prof Goh Lee Gan, Deputy Editor

The scenario was the Q&A session of the Medico-Legal Seminar on Good Practices organised by the Medico-Legal Society of Singapore. Three generic preventive measures that could be easily remembered were proposed as a framework to be applied to good practice: engineering, education and enforcement. These can be remembered as the 3 Es.

What was commented on education was I thought worthy of capturing here for all connected with standards, medical errors and medico-legal reform to take note of. Ms Lee Yoke Lan, the Nursing Director of KKWCH, spoke of the lost good practice of doing a ward round together or the team ward round in many hospitals.

Gone are the days when the consultant takes a general ward round to solve all the outstanding problems of the patients lying in the ward. It was also a teaching round. In this way, Ms Lee asserted that the wisdom of the corporate group from consultant to senior registrar to medical officers to house officers could be leveraged for the benefit of the patients and the doctors in various levels of maturity. She could never be more right, I thought.

I too, have often reflected on this loss of transmission of the professional DNA in the ward. Now, in many wards, each consultant or senior staff sees his or her own cases. The house officer may follow along. Often the staff nurse is not around. "Just put the changes on paper," she would tell the house officer. The changes are of course, made – probably a more fragmented decision than before since the rest of the team is not around; the potential for a less than optimal result is in the making.

What is even more sinister is that if one does not pick up something serious, nobody else is there to do it.

Contrast this with the past. The ward round by the consultant could be a bit scary for the house officers or medical officers, especially if he is knowledgeable, sharp and critical. The survival strategy was to go and find out about missing results, check the patient for new changes and read up. Otherwise, when quizzed by the consultant, it could be embarrassing. This benefited the young doctors. Then came the round – one could see who were clever and who were not. Anyway, for both, there were new things to learn – to learn how to be cleverer and how not to be stupid. Thus, professional DNA transmission from one generation to the next took place.

Often, corporate wisdom resulted in a solution of the case. I can remember vividly one patient. He had fever, jaundice, conjunctivitis and his blood urea was raised. The MO was perplexed. So was I. "What work does he do?" asked the consultant. "Sewage worker" was the reply. Connecting this answer with the diagnosis was rapid. He was given penicillin and his renal failure was managed conservatively. He eventually walked home.

I spoke to several senior staff about the loss of this kind of ward round. Some reassured me that it is intact. Some told me it has been dropped because it was thought to take up too much of everybody's time. One told me that the young folks of today could not be bothered.

The loss of the good practices of the past may also have been economic. Administrators and those charged with bottom-line watching may view such team ward rounds to be heavy on resources. Perhaps this is true in micro-management but at the macro level, it will be quite different. It will be productive because there would be less litigation, more satisfaction and more faith in the system because someone is in-charge, not just in name. Additionally, the boon of the long term transmission of professional know-how from one generation to the next will far surpass the cost expended at the micro-level.

Maybe there is something to be done to review this past practice as a way of reducing medical errors for the moment and for the future; and a means of transferring expertise from one generation of doctors and nurses to the next. ■