“Nurses and doctors must stop acting like a divorced couple”

At times, the way doctors and nurses work together on general wards can feel like a divorced couple who are no longer speaking. In a family it is the children who are affected when parents don’t communicate. In healthcare it is our patients and our personal job satisfaction that suffers.

Surgeon and journalist Atul Gawande, in his book Better urges health professionals to “Stop moaning, do something and count”. I had been moaning about ineffective interdisciplinary working on my ward rounds for years, harking back to the good old days when there was always a nurse present. The nurse knew about all the patients, was an active participant and a respected team member. So in April 2009, on my consultant-led ward rounds, we started to count the number of times we received a briefing from a nurse before the patient’s clinical review, the presence of a nurse during the review and, if a nurse was not present, whether we could find one to report back to.

Since April 2009, I have led 348 routine rounds, reviewing 5,175 cases. We have had a nurse briefing before seeing patients in only 20% of these cases and a nurse present at the bedside with only 52% of patients – and the rate is falling. In 16% of these cases we were unable to find a nurse to report to.

Nurse participation in rounds has been disappointing. There is poor understanding of what is wrong with patients and little pro-active contribution of relevant information. When I ask junior doctors to lead the reviews, they often do not even acknowledge the presence of a nurse.

Reduced effectiveness and efficiency in care, risks to patient safety, reduced patient satisfaction, and less job satisfaction are the results of this failure in interprofessional working.

We simply do not have enough nurses, healthcare assistants and ward clerks to care for the majority of our inpatients who are highly dependent, frail and old.

On our side, doctors often schedule simultaneous rounds making it unreasonable to expect a nurse to be on each ward round. We are often late in starting and may not even announce our arrival.

Between us we have allowed a generation of doctors and nurses to develop who have not seen cooperative interdisciplinary working on rounds, and as a consequence of this do not know how to talk effectively and professionally to the patient’s advantage.

The work of our team in Worthing Hospital in “stopping moaning, doing something and counting” resulted in the joint Royal College of Physicians and Royal College of Nursing (2012) recommendations on best practice for ward rounds. The challenge now is to identify and overcome the obstacles to interdisciplinary communications so our patients get the best ongoing care, and we can go home satisfied. It is time to end the great divorce and get back together for our patients’ sake.

Gordon Caldwell is consultant physician at Worthing Hospital

Reference