In terms of throughput as measured by bed use waiting lists may be a more efficient way of admitting patients to hospital than a booked admissions system. But this ignores the costs of uncertainty borne by patients. These uncertainty costs may outweigh the costs of lost throughput and are anyway inconsistent with a consumer oriented health service where explicit decisions are to be made concerning the true intention to treat.

Surgeons are clearly interested in the extension of booking systems despite past failures and present frustration. They are also very explicit about the facilities required to make booked admissions practicable. These facilities are those that permit elective surgery to be protected from the demands of emergency and urgent cases. These predictable barriers have to be

removed if any policy for introducing booking systems as a norm is to be successful.

We thank the consultant surgeons of the South Western region for their help in completing the questionnaires and Mrs Fiona Braddon for her help in analysing the responses.

- 1 Light D. Medical house arrest. *Health Service Journal* 1990;Nov 1:1649.
- 2 *National Health Service and Community Care Act 1990*. London: HMSO, 1990.
- 3 Dean M. Is your treatment economic, effective, efficient? *Lancet* 1991;337:480-1.
- 4 Devlin HB. Programmed elective surgery. In: *Waiting for hospital treatment*. London: DHSS, 1980:18-25. (Harrogate seminar reports).
- 5 Southam JA, Talbot RW. Planned surgical admissions in a district hospital. *BMJ* 1980;iii:808-9.
- 6 Houghton PWJ, Brodribb AJM. Failure to attend for operation: a comparison between booked admissions and the waiting list system. *BMJ* 1989;299:1139-40.
- 7 Frankel SJ, West RR, Farrow A. Non-admission or non-invasion? A case control study of failed admissions. *BMJ* 1989;299:598-600.

How To Do It

Edit a staff round

Robert Winter

Examination of the *BMJ* over its 151 years shows the staff round to be an established forum for clinical teaching, criticism, and advancing ideas. The weekly medical staff round at the then Postgraduate Medical School of London has been recorded in the *BMJ* at various times, the first clinicopathological conference appearing in 1959 and describing a 30 year old man with lupus nephritis and endocarditis.¹ Publication of clinicopathological conferences in the *BMJ* continued more or less regularly until 1960, occasional contributions continuing up to 1978.

Colleagues in North America have had the impressive weekly records of the case records of the Massachusetts General Hospital for 80 years since their foundation by Richard Cabot.² The case records were first published in book form, but in 1915 Cabot's secretary began recording the discussion, including this along with the clinical and necropsy reports in the material circulated to a restricted list of physicians. Later still, these records were published in the *Boston Medical and Surgical Journal* (now the *New England Journal of Medicine*), marking the start of a series which later won world renown and which has continued without interruption to this day—a notable record. The records now form an important part of that journal; the section has a full time staff, and accounts of the records in the form of 35 mm colour slides and other audiovisual material are provided for educational purposes. Discussion of a single case in its wider context has a particular appeal, perhaps because for most the craft of medicine is learnt from treating individual patients and from sharing the experiences of others.

Most hospitals now hold a weekly staff round. This provides a formal occasion for clinical problems and their management to be discussed. Although the standard can vary, these presentations often provide an excellent overview of a clinical subject. This brief account describes how I have edited the medical staff round at Hammersmith for the *BMJ* and gives guidelines to those planning to submit cases for publication.

Selection of cases

Cases published during the past two years have covered most main specialties. Those that have worked well include reports of rare complications of common

conditions such as thrombocytopenia in sarcoidosis,³ or of disorders whose incidence seems to be increasing or whose diagnosis may be easily overlooked—for example, systemic candidiasis.⁴ Advances in the management of common conditions, such as using antibiotics to treat hypergastrinaemia for bacterial colonisation in peptic ulcer disease,⁵ or the application of topical techniques that non-specialists have read of but not seen used, such as the molecular analysis of human genes,⁶ also make good reports. It helps if there are good radiological and pathological features. I have tried to select cases that are appropriate for a general clinical readership as more esoteric cases are better suited to specialist or basic science journals. When uncertain about whether a case is suitable for publication I have sent a synopsis to the journal and left the final decision to editorial staff; this has prevented would be contributors spending time and effort on a case that may not be publishable.

Writing the report

The headings of introduction, clinical history, comment, and discussion have been used throughout the series. The introduction, clinical history, and comment are written by the team presenting the case, who take responsibility for its accuracy. The introduction should state clearly the reason why the case is being reported. What are the interesting points? Why should the reader read on? The clinical history should summarise the salient clinical points giving relevant information about presentation, physical signs, and abnormal and relevant normal results of investigations. Space does not allow the case to be written up as a whodunnit in the style of the *New England Journal of Medicine* and it was not the intention to try to emulate this series. The usual guidelines about good medical writing apply: short words, short sentences, and no abbreviations. The account preferably should be written on a word processor as this helps subsequent editing even though the journal does not accept the final account on disc. The floppy disc can, if needed, be borrowed by other participants, who may wish to add references or to change text. Spell checking (and virus detecting) software is useful to scan the various contributions.

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Discussion

Steering the discussion of a case is a skill, and the Hammersmith tradition, apparent from the earliest accounts, of putting staff on the spot by asking for specific comments leads to interesting and pithy discussion. Responses that do not deal adequately with the subject are picked up on as a matter of course. Seniority provides no immunity here—often the reverse. I have tried to convey some of the cut and thrust atmosphere of the discussion in these reports. Direct rather than indirect speech is used and contributors are identified by their initials, the discussion group being named fully in the footnote.

A tape recording is essential for editing the discussion. Many hospitals have an audiovisual department, and at Hammersmith their assistance has been invaluable. We found that a perfectly good recording could be obtained by using simple, inexpensive equipment, with the presenter using a neck microphone (needed for amplification in our lecture theatre) and by having a single free standing microphone positioned to record audience discussion. If several cases are to be recorded tapes should be labelled clearly with date, title of case, and presenter.

Considerable editing of the discussion is needed as spoken and written English differ. It is a well known journalistic maxim that we use about twice as many words to describe something orally as we would use in writing. I transcribed the discussions directly rather than use secretarial help because it seemed easier to make the transition from spoken to written from the tape rather than from a verbatim transcript.

Figures and illustrative material

With all radiographs and clinical slides it is important to remember that features clearly visible on the original can be lost in the process of reduction and reproduction. An accompanying line diagram can clarify points of interest, and with histological slides annotation on the photograph can help the reader to orientate a figure. Clinical slides and other material submitted for publication should be free from any numbers or names by which the patient could be identified, and the patient's consent should have been obtained for clinical photographs. Most of the illustrations in the staff rounds have been taken directly from 35 mm slides or black and white prints, and I have generally taken a copy of these before sending them in case of loss in the post or mishap at the printers.

Approval of participants

It is important to get the approval of all participants, especially so that they feel that their contribution has not been misrepresented. Sending each person a copy of the report for comments before submission is a good way of checking accuracy and also allows participants to add to their contribution or to include references to support their statements. Circulating the final draft to all concerned is particularly important because, aside from maintaining goodwill for the exercise, the discussion benefits from clarification and additional comments.

Steps for producing a staff round

- 1 Choose case: Suitable for general readership?
Need to send summary for editorial approval?
- 2 Commission article: Agree deadline for first draft
- 3 Illustrations: Will they reduce?
Line diagram or annotation needed?
Patient anonymity maintained?
Check copyright
- 4 Discussion: Abstract from tape recording
Circulate draft to participants
- 5 Merge discussion with the case history and comment
- 6 Check accuracy with participants and contributors
- 7 Acknowledgments
- 8 Check proofs

Those who have made a particular contribution to patient management should be acknowledged. This especially applies to colleagues in radiology, histopathology, echocardiography, and surgery. When appropriate we have also acknowledged the referring physician, to whom a final copy of the report has been sent for comment before publication.

Proofs and editor's responsibility

There is greater potential for error when an article contains several contributions from different individuals. It has therefore been our practice for two people to check the proofs. The system reputedly used by the staff of the *New Yorker* magazine of putting a pencilled dot above each word as it is checked is probably the best advice to those who have little previous experience.

Because each article has many contributors it is also important that one person assumes overall responsibility. The editor is in a position to see an article through from case presentation to the final report in print, and the interval is seldom less than six months. The editor's task is to liaise with all contributors and with editorial staff and to have overall responsibility for the manuscript. The box gives a checklist for those intending to prepare a case presentation for publication.

In summary, staff rounds are an important forum for sharing clinical experiences within a hospital. Clear and well illustrated reports of these discussions will help extend their educational benefit.

I acknowledge the advice of colleagues in the department of medicine in preparing this article.

- 1 Kincaid-Smith PS. A case of many lesions. *BMJ* 1959;i:224-9.
- 2 Cabot RC. *Differential diagnosis*. Vol 1. Philadelphia: W B Saunders, 1911.
- 3 Larner AJ. Life threatening thrombocytopenia in sarcoidosis. *BMJ* 1990;300:317-9.
- 4 Bates J. Systemic candidiasis: an unusual complication of eating mutton. *BMJ* 1989;299:557-8.
- 5 Levi S. *Campylobacter pylori*, duodenal ulcer disease, and gastrin. *BMJ* 1989;299:1093-4.
- 6 Cox T. An independent diagnosis. *BMJ* 1990;300:1512-4.

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