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EDITOR'S CHOICE

Campaign for real healthcare for real people

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Providing parity of care for hospital patients across the whole week is a goal that's hard to oppose, and the Academy of Medical Royal Colleges has been working out the implications (doi:10.1136/bmj.f6716). Its survey suggests that most medical specialties would need to provide about six hours of consultant input per day to review 30 inpatients at the weekend.

But wait a minute, cries Anthony Cohn. Patients aren't receiving anything like that on weekday ward rounds (doi:10.1136/bmj.f6451). "Experience and anecdote indicate that it is typical that 20 or more patients need to be seen in two hours—five minutes per patient on average, assuming all notes, radiographs, and results are immediately to hand. This compares poorly with the often quoted figure of the seven minute consultation in general practice, which itself is generally considered too brief."

He wants the ward round to "return to being the focus of hospital life rather than an inconvenience that disturbs the routine running of the ward and interferes with doctors' other commitments." "Our most precious and powerful tool," he argues, "is spending quality time with our patients."

O, patients! What crimes are committed in your name! There are, of course, the obvious ones—such as wilful neglect and mistreatment, which are soon to become criminal offences (doi:10.1136/bmj.f6972).

But there are not so obvious, ideological ones. In their editorial Paul Hodgkin and Jeremy Taylor (who head up Patient Opinion and National Voices, respectively) cast a jaundiced eye over "the rhetorical lip service to the centrality of the patient." Patient friendly platitudes now "abound in every official document," meaning more or less whatever you want them to. Putting patients first has become "a pick and mix menu from which decision makers can select according to taste." Nevertheless, they applaud NHS England's guidance for commissioners on transforming participation in health and care as "probably the best official articulation to date of putting patients at the heart."

They identify three trends from outside mainstream medicine that may affect patient empowerment in coming years. One is that the growing population of people with multiple long term conditions, disabilities, and frailty will demand a different model of care and support—"a primarily social not medical model."

Multimorbidity looms large in Graham Watt's editorial on caring for people with long term conditions. He discusses the implications of the "house of care," a model promoted by the King's Fund (doi:10.1136/bmj.f6902). Whereas doctors used to "listen to the patient, he is telling you the diagnosis," in future they will need to "listen to the patient, she is telling you her treatment goals." In her article, Tessa Richards describes the many ways of listening to patients—and acting on what is heard (doi:10.1136/bmj.f6872).

Multimorbidity also features in John Oldham's essay, "How NHS reform goes round in circles" (doi:10.1136/bmj.f6716). While most people over 65 have more than one long term condition, "the system is one of specialisms that look after a person's body parts not the person as a whole" The medical directorate of NHS England has 18 national clinical directors of "body parts," leading to "a Monty Pythonesque queue of specialist nurses for single diseases outside the house of a patient with multimorbidity."

The next iteration of reform needs to focus on whole people, not body parts, he argues. In the meantime, the queue of specialist nurses for single diseases will see you now.

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