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ACUTE PERSPECTIVE

David Oliver: A bittersweet farewell to my ward

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Sooner or later I'll have to give up working in a large hospital ward, after many years as a consultant physician and a senior doctor responsible for an inpatient ward all year round.

Doing so requires a very hands-on, accessible presence and sustained continuity. After a quarter of a century (and several more years as a registrar) in which "looking after the ward" formed a huge part of my working life, I'll miss it terribly. It's a big part of my professional identity. But it's also left me increasingly tired, and it may be time for younger doctors with new ideas and more energy to inject new life into how patient care is organised and the ward team works.

Since starting I've seen an exponential rise in the acuity and complexity of patients, pressure on acute hospital beds, imperatives to help people leave hospital ever more quickly, the range of investigations and treatments, and expectations from the public and central performance directives. Many doctors say that working on the acute medical intake or looking after people on wards can be the least fulfilling and most frustrating part of their job. But these have always been what I enjoyed most and had the greatest aptitude for.

In my time as a consultant spanning two hospital trusts, I've looked after anything from 24 to 36 inpatient beds, but usually 28. My current ward has been a "hot" all covid ward for many months in the past two years. I've been fortunate to have largely avoided "safari ward round" models (with patients spread around various wards) and been able to have my inpatients on one home ward, save for mercifully rare excursions into covid "escalation beds." Even in my regular duties in acute medicine, I've been able to spend my 12 hours in the acute medical unit and emergency department, not traipsing round the hospital finding patients. Again, I have that feeling of belonging to a home ward team and an environment I know and love.

The team atmosphere is what I'll miss most. A strong bond and a key leadership "double act" exist between the consultant and the sister or charge nurse managing the ward. I've worked with a series of brilliant colleagues: done right, such a collaboration can set the tone for "how we do things here," ensuring continuity even as an ever changing cast of junior doctors and allied health professionals rotate through placements. I've worked with many colleagues on the same wards for many years, through thick and thin—not least during the pandemic and growing staffing crises—and I feel fiercely loyal to them.

Allied health professionals, such as physiotherapists and occupational therapists, are crucial to my patients' team based care, and I love working with them. But healthcare assistants, ward admin, and domestic staff are also key to making it all work for patients.

I'll miss terribly the camaraderie, humour, mutual support, and working towards a common goal. I'll miss the chance to see and help a patient and their family from arrival on the ward to leaving hospital, and sometimes to as dignified and peaceful a death as we can provide for them. I'll miss being the pet "old man" on the clinical team, helping younger clinicians develop their skills but also learning so much from them and being inspired.

But all things must pass, and the relentless pressure of getting through a multidisciplinary team meeting and a 28 patient ward round by lunchtime, with competing pressures, demands, and priorities, means that in the next few years I'll probably be ready to hand over the baton, even if it's with a mixture of happiness and regret.

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