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The role of the nurse in the medical ward round

Araceli Busby BSc (Hons) RGN
Staff Nurse, St George's Hospital

and Brian Gilchrist BSc MSc RGN
Lecturer in Nursing Studies, Department of Nursing Studies, King's College, London University, London, England

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Communication between hospital staff and in-patients, especially regarding the provision of information, has been found to be inadequate although improving information-giving has been demonstrated to have a number of beneficial effects While the ward round might be a particularly valuable setting for communication, few studies have explored the multidisciplinary nature of rounds This study obtained the views of 33 consultants, 14 nurses and eight patients and observed three ward rounds in order to determine the nature of present round functioning, and the nurse's role in such a round The results showed that the rounds studied were not being conducted in a democratic fashion medical staff dominated and other health care professionals had little involvement Patients received few explanations and had great difficulty understanding the discussion The functions nurses were seen to perform involved primarily providing information for medical staff It is recommended that patients are more involved in rounds and are given more explanations and encouraged to ask questions Nurses should be educated to assert themselves in ward rounds in order to fulfil roles they prescribe for themselves, and all professionals should aim towards more democratic, equal discussion There is a need for further research to determine the effectiveness of nurse intervention on patient involvement and satisfaction with the round

INTRODUCTION

A number of studies testify to the inadequacies of communication between in-patients and the health care team responsible for their care (Cartwright 1964, Raphael 1969, Parkin 1976) One of the most highly implicated areas in this breakdown in communication is information exchange

Apart from the somewhat imprecise benefit of patient 'satisfaction' (which appears to have as many definitions as researchers who have studied it), improved information-giving has been shown to have a number of useful effects patient motivation and compliance with treatment regimes are greatly improved by better knowledge and understanding (Baksaas & Helgeland 1980, Ley 1988), the length of post-operative recovery which levels post-operative pain (Hayward 1975) may be reduced, while significant reductions in stress associated with events such as admission, surgery and special tests have also been documented (Siminov 1970, Elms & Leonard 1966, Wilson-Barnett 1977)

In the study of information exchange and satisfaction with communication, increased satisfaction has been

Correspondence Miss A. Busby 6 Marius Mansions Marius Road Balham London SW17 7QG, England

directly correlated with increased quantities of information given (Stiles *et al* 1979) Quality of information has been criticized on the grounds that written information sheets are frequently beyond the educational level of most patients (Ley *et al* 1972, Lovius *et al* 1973) Verbal information-giving has not been assessed directly

Further studies have found that patients' medical knowledge is poor (Boyle 1970, Gregory 1978) and that patients may be worried, upset and embarrassed by their difficulties Patients may also fail to ask questions when they do not understand or have not received adequate information It has been suggested that patients feel ill or intimidated by their unfamiliar environment (Cartwright 1964), may passively accept their care (Coser 1962), have overdeferential attitudes towards medical staff (Ley 1988), or are reluctant to appear foolish due to their ignorance (Reynolds 1978) All of these factors reduce the likelihood of patients asking doctors or nurses questions about their treatment or progress

While some studies looking at communication have mentioned ward rounds (Cartwright 1964, Anderson 1973), few look specifically at the characteristics of these rounds General comments made by patients reveal many negative views patients often feel excluded from discussion, ignored, intimidated and unable to understand medical jargon used by doctors (Reynolds 1978, Steele & Morton 1978) However, Linfors & Neelan (1980) discovered that 95% of the patients they studied found ward rounds a positive experience, and 66% felt they understood their problems better as a result

The ward round

The ward round may potentially be one of the most valuable times for sharing information, problem solving and planning treatment, both for the professional and the patient It is one of the rare settings in which the patient and many different disciplines are together at the same time However, research indicates a failure to consider the team nature of rounds Medical research (Blanchard *et al* 1983, 1986, Reynolds 1978) focuses on the physician–patient relationship, while nursing research (Cisar 1988, Richard 1989) considers the development of separate nursing rounds The concepts of co-operation and team-work do not appear to have been studied

Two American studies (Rintala *et al* 1986, Sanson-Fisher *et al* 1979) have considered the involvement of non-medical professionals in the ward round. Direct observation of rounds found patterns of communication dominated by physicians, while other disciplines contributed little While the nurse's role in the ward round has not been studied, some authors have examined the more general role of the nurse (Anderson 1973, Coser 1962, Cartwright 1964) Involvement in information-giving and communication is emphasized by writers such as Wilson-Barnett (1981) and Clark (1982), who see such functions as fundamental Indeed much of the research documenting the beneficial effects of information giving has been undertaken by nurses (Hayward 1975, Boore 1979, Wilson-Barnett 1977) Many authors express a belief that patient advocacy is integral to the role of the nurse (Brower 1982, Salvage 1987, Sawyer 1988) and Clark (1982) views patient advocacy as primarily concerned with informing and educating patients

While patients may not view the nurse as a major source of information, often preferring to ask doctors (Mayou *et al* 1976, Oberst 1984, Newall *et al* 1987), nurses are often more readily available (Carstairs 1970) Furthermore, nurses have been shown to be effective communicators (Hayward 1975, Howard & Erlanger 1979)

The functions which nurses perform in ward rounds might also be highly influenced by the physician's view of their role, since rounds are so heavily physician dominated It has been found, for example, that doctors see nurses as their assistants rather than as independent team members (Lee 1979) and frequently have a poor view of nurses' knowledge and capabilities (Prescott & Baren 1985) However, few recent studies exist and nurse roles have undergone great change in the past 10 years Nurse autonomy and independence may have improved and, as a communicator and patient advocate, the nurse would seem to have a valid part to play in a ward round Certainly, as team members, nurses must have a role if the skills and efforts of all members are to be co-ordinated in an egalitarian structure which is essential to effective communication and co-operation (Wise *et al* 1974, Katz *et al* 1975)

THE STUDY

Methodology

In order to investigate the role of the nurse on a medical ward round, a number of rounds have been observed over a period of several weeks and the views of patients and medical and nursing staff were obtained using questionnaires and interviews

Aim

The aim of the study was to investigate the following questions

1 Do doctors, nurses and patients view the round as an appropriate setting for communication and information exchange?
2 Do professionals and patients believe patients should be involved in ward round discussion?
3 What is the nurse's role in the ward round and how appropriate is that involvement?
4 Do different amounts of nurse involvement affect patient understanding, participation and satisfaction with the round?

The ward rounds of three consultants were studied One was chosen for his known attempts to involve the whole multidisciplinary team, a second to provide a comparative sample with a similar patient profile, and a third to provide a setting in which to pilot the research instruments All three were consultants in geriatric medicine

Sixty consultants in various specialities within the same hospital were also sent a questionnaire seeking their views on ward rounds, and the role of the nurse Only those consultants who did not conduct formal rounds (e g pathologists, anaesthetists) or whose speciality was felt to be too different to allow compromise (e g psychiatrists) were excluded

The twenty-one nurses included in the study were those working on the wards where the rounds were conducted Patients included were those present on the wards during the data collection period Nineteen were observed and eight interviewed Only those patients whose Mental Ability Test scores were less than 8/10 were excluded from interviews

It is possible that a sample of elderly patients might give data expressing higher than average levels of satisfaction, as has been demonstrated previously (Halpern 1985, Carstairs 1970) Such a sample might also be less likely to desire information and be less concerned by their lack of understanding (Gregory 1978) However, it was felt that the advantages of observing a consultant who was concerned with involving the whole team would outweigh such disadvantages Thus, all samples were non-random convenience samples because of limitations of both time and resources

Instruments

The research instruments were

1 An observation schedule used to record the verbal interactions which occurred, based on a behaviour analysis schedule developed by Rackham (1977) and successfully adapted for use in the field of communication in nurse education by Marson (1982) The verbal behaviours of all the participants on the ward round were coded directly by the researcher who was present as a non-participant observer during the rounds
2 A semi-structured patient interview schedule which explained the ward round previously observed, ward rounds in general (patient involvement and participation), and demographic data All patients were interviewed within 3 hours of an observed round by the researcher
3 A consultant and a nurse questionnaire which contained a mixture of open, closed and fixed-alternative questions exploring patient involvement in ward rounds, the perceived function of the rounds, staff knowledge of patients, the importance of various team members to the round and the role (both actual and ideal) of the nurse on the round Although all instruments were piloted and amended as necessary, formal testing of reliability and validity were not undertaken

RESULTS

Response rates

Of the sixty-two consultant questionnaires, 38 were returned (61%) and, of those who did conduct rounds, 33 completed the questionnaire (56%) Of 21 questionnaires sent to nurses, 14 (67%) were completed and returned In all, only eight patients were interviewed, since 11 were suffering from confusion or dementia (a larger number than originally anticipated) Problems with consultant availability during the data collection period resulted in only three full ward rounds being observed However, the observations covered discussion with or about 48 patients and generated over 2000 recorded interactions

Patients' views

The patients identified a number of aspects of rounds which they liked or disliked Five identified the round as an ideal setting for learning future plans and finding out about progress and planned treatment Three identified the presence of all the multidisciplinary team members as a particular advantage, as it enabled them to gain a balanced view Four had had particular questions to ask or problems to discuss on the previous round, and all had done so

All eight patients said they very rarely or never had their opinion asked during rounds, but only three wanted this to change Three others also mentioned that patients should be more involved in ward rounds and not excluded from the discussion

Although seven of the eight patients were not nervous during rounds, and six said they were confident asking questions, two who had wanted more information had not asked for it Of three who had difficulty in understanding, two had not obtained clear or any explanations Such lack of enquiry resulted from

1 a belief that medical staff knew best anyway (2),
2 an intention to obtain information by other means (asking the house officer when next present) (1),
3 a lack of understanding too great to allow questions to be formulated (1)

With regard to obtaining information from professionals, more patients expressed a negative view of asking nurses (5 out of 8) than doctors (3 out of 8) Patients felt nurses did not have the knowledge, were not allowed (by medical staff) to answer or were too busy to be questioned Doctors were also seen as too busy and were felt to give misleading or complicated answers

Difficulties in understanding the discussion were said by patients to result from an inability to hear the discussion, problems with unknown medical jargon and from being excluded by the team who stood at a distance and talked among themselves One lady, however, said she did not pay any attention 'They don't take any notice of me Why should I listen to them?'

Nurses' views

All the nurses in the study believed patients should be involved in ward-round discussion and be able to ask questions Almost half (43%) commented that the presence of all the multidisciplinary team members was particularly important 'Everyone can contribute to answering patients will get an answer everyone agrees on'

All the nurses believed, however, that patients were not confident enough to ask questions and 36% believed they rarely or never did so Eleven nurses (79%) felt patients often misunderstood discussion, blaming patient anxiety, hearing difficulties, poor mental ability and poor explanations from staff

The nurses felt that the ward sister and the nurse looking after a particular patient were very knowledgeable about all aspects of that patient's condition and care, more so than any other staff member except for the house officer They were also confident about their ability to answer patient questions Only 5% of qualified staff felt they rarely had adequate knowledge Eighty per cent of nurse responses indicated patients would ask a nurse questions rather than a doctor However, nurses were less confident about asserting themselves in the ward-round situation, finding it difficult to correct staff members if they disagreed with them Such difficulty was greater with medical staff than other nursing staff

Nurses identified a number of roles for themselves on the round, concerned mainly with providing information for medical staff Four of them identified patient advocacy as part of their role, and 57% (70% qualified) said they often asked questions on their patients' behalf during rounds Nurses also identified roles for themselves in improving patient understanding, a third of their comments suggesting that greater support and encouragement by the nurses would reduce misunderstanding and almost half the comments identifying how patient confidence might be improved mentioned encouragement from nurses

With regard to change, half the nurses wished to be present on more rounds even though many were mostly present already However, only five of them (36%) said the nurse's role on the round should definitely or probably alter Seven (50%) suggested changes which should be made, mainly in having the nurse looking after a patient present while that patient was seen, and increasing nurses' assertiveness and medical staffs' recognition of nursing views

Consultants' views

The majority of the medical consultants (82%) also felt that patients should be involved in ward round discussion, but a small number felt that such discussion was better on a one-to-one basis, and that the consultant should make the final decision Only 21% believed patients were not confident in asking questions during the round and only 57% that patients were likely to misunderstand the discussion

They also had a high opinion of nurses' knowledge, indicating that the nurse looking after a patient had more knowledge of that patient than any other professional, followed by the ward sister and the senior house officer/house officer Other nurses were felt to be much less knowledgeable, such that, overall, the knowledge of medical staff was greater than that of nursing staff However, when asked who they would approach for information about patients, 55% of consultant responses indicated a nursing staff member and only 45% a medical staff member During rounds they were less likely to ask nurses, 76% would very often ask the senior house officer/house officer questions, compared with 70% asking the sister, and only 42% the nurse looking after the patient

Consultants also identified nurse roles on the round which were mainly concerned with information giving to medical staff A small number (5) felt the sister or her deputy acted as a team leader and leader of the round, and

three felt she participated in decision making Although only one identified patient advocacy as a nurse's role, 69% indicated that nurses often asked questions on the patients' behalf

Few consultants (18%) felt nurses' roles should change Only one felt nurses should have a more active role in decision making and taking control of the round Two wished for greater co-operation between nurses and doctors, one felt time should be made available to discuss nursing problems, and one felt the nurse looking after the patient should be present more often

OBSERVATION DATA

Patients' interactions

Of 2391 observed interactions, patients contributed only 9%, a mean of four and a half interactions each Of these, only 5% included asking questions or volunteering information or opinions, while 93% were reacting or clarifying, mainly given information in response to questions

Nineteen per cent of all the communications made were directed at patients, compared with 51% directed at medical staff Patients were asked their opinions only 64 times in all three ward rounds, just over once each Only 20% of all interactions directed at patients aimed to give them information or explanations The majority of interactions with patients were made by medical staff

Nurse–patient interactions

Eight per cent of nurse interactions were directed at patients, compared with 75% directed at medical staff Furthermore, 74% of the nurse–patient communications were made by one ward sister during the round at which she was present, other nurses interacted far less frequently Similarly, patients rarely directed comments at nurses 91% of their interactions were with medical staff

Nurses' interactions

Nurses made a limited contribution to ward-round discussion, only 12% of the comments were made by nurses Nurses talked mainly to doctors, and the majority of their comments involved giving information Only 10% of the discussion was directed at nurses, mostly by doctors seeking information Nurses were asked their opinions only four times in all three rounds

Doctors' interactions

Medical staff made 67% of all interactions and 50% were made to medical staff Doctors spent only 13% of their time talking to nurses, 26% talking to patients and 35% talking to each other

Discussion in different subject areas

The majority of the discussion concerned patient symptoms and treatment, while 9% related to social matters and only 3% to emotional or psychological matters This distribution of subjects remained consistent throughout the different disciplines, nurses and allied health professionals discussed social and emotional matters equally as seldom as doctors did

Interactions made by allied health professionals

Twelve per cent of the total discussion was contributed by non-medical/nursing staff Of these, most (65%) were made by the physiotherapist Only 9% of the discussion was directed at such professionals, again more to the physiotherapist than to other professionals

DISCUSSION

In this study a majority of consultants and nurses did believe that it was appropriate and important to involve patients in ward round discussion However, 22% of consultants felt one-to-one communication was most valuable, in contrast, almost half the nurses and patients recognized the advantages of multidisciplinary discussion

Patients also believed it was appropriate for them to ask questions and be involved However, this was not seen to be synonymous with involvement in decision making Many of the patients felt that the professionals should make decisions, as found by other studies (Blanchard *et al* 1986a,b), especially when dealing with more elderly patients (Carstairs 1970, Coser 1962) Whilst nurses felt that patients were under-confident about asking questions during rounds, consultants and patients indicated that this was not so Observation of actual events showed that patients in fact rarely asked questions, and half the patients interviewed had not even asked questions when they had wanted information or explanations These patients intended either to ask their questions in less formal settings, or leave their care entirely in the doctor's hands Such passivity has been reported to be greater in elderly patients (Gregory 1978, Blanchard *et al* 1986a,b)

The reasons for patient misunderstanding appear to be well understood by medical and nursing staff, closely matching that of subjects in this study and others (Joyce *et al* 1969, Cartwright 1964) Poor information-giving with regard to both quality and quantity, poor hearing, difficulty with medical jargon and nervousness and intimidation, were most frequently mentioned About half the reasons given by staff involved factors which could easily be altered, e g ensuring patients could hear the discussion

Nurses and consultants appeared to have a high opinion of the knowledge of both ward sisters and the nurse looking after a patient However, the perceived lesser knowledge of other nurses (as indicated by consultants), and the nurses' low opinion of the knowledge of many medical staff, may indicate a certain amount of inter-disciplinary conflict Coser (1962) found that nurses believed their knowledge to be greater because of their greater contact with patients, while Prescott & Baren (1985) found that doctors often assume that nurses have little knowledge The consultants in this study indicated that qualified nurses, in general, were less knowledgeable than medical students, while nurses indicated that medical students had the least knowledge of all professionals

Nurses themselves felt their knowledge to be adequate to answer patient questions, and felt that patients would frequently ask them, rather than a doctor Consultants did indicate that they would ask nurses about patients more often than other doctors, but felt patients would ask doctors themselves The patients in this study were more positive about asking doctors, especially the house officer This is a similar finding to other studies (Oberst 1984, Newall *et al* 1987) Patients may still see the nurse as subordinate to the doctor and unable to provide the information they require However, it has also been suggested that while patients express a preference for asking doctors, the reality is often very different, since doctors are far less available, and patients do in fact obtain more of their information from nurses (Cartwright 1964, Carstairs 1970)

Nurses' lack of assertiveness

One of the main observations of this study was that nurses were not confident about asserting themselves in the ward-round situation Difficulties which the nurses experienced were greater with more senior staff members in general and with medical staff in particular As such, the nurses seemed to view junior medical staff as equivalent to senior nursing staff, while senior medical staff were at the top of the hierarchy These findings may indicate the different status accorded to each individual and hence would match the picture of medical dominance put forward by writers such as Coser (1962) and Hoeckelman (1975)

Nurses identified fairly subordinate functions for themselves on the round, such as providing and co-ordinating information. They did, however, identify advocacy as part of their role and many felt they should ensure that patients understood information given to them, and create an environment in which patients feel supported As many as one-third felt that their role included ensuring patients understood the discussion

More nurses than consultants felt roles should change during ward rounds Nurses believed they should be more involved and assertive, and that their views should be considered However, none identified an increased role in decision making as necessary Few consultants saw a change in nurse role as necessary Despite over 90% of consultants indicating that the nurse looking after a patient was an important or very important person to be present, only one suggested she should be present more often The consultants and many of the nurses appeared to consider the round the province of medical staff, with other professionals present in a subordinate, information-giving capacity

This study was able to draw on observed professional and patient behaviour during three ward rounds The picture that emerged was of minimal nursing involvement in a ward round dominated by medical staff, who acted as the central focus for all discussion The percentage interactions were very similar to those found in the American studies (Rintala *et al* 1986, Sanson-Fischer *et al* 1979)

Little effort was made to ease problems experienced by patients, even though such problems were well understood by professionals Patients were largely excluded from discussion, much of which took place out of their range of hearing Patients were given few explanations and little information

Nurses' roles and involvement

Nurses' roles were very limited and the nurse looking after the patient was rarely present Even though nurses were seen as providers of information, they gave information less often than medical staff

However, the largest discrepancy between professional views and observed behaviour was seen in nurses' interactions with patients Nurses gave information to doctors 10 times as often as they did to patients, and only one-fifth of information and explanations given to patients were provided by nurses Contrary to the belief of both doctors and nurses, nurses were not seen to ask questions on behalf of their patients

Nurses were certainly justified in wishing to be more involved, since their present level of involvement is so limited However, it was particularly interesting to note that nurse involvement was no different on the ward round of the consultant who expressed a positive view of nursing involvement This consultant had even suggested that the ward sister should lead the round and was extremely receptive to nurses' views This suggests that it is nurses themselves who need to be educated to assert themselves and assume those roles which they believe to be so appropriate, being both part of their ideology and of greater benefit to the patient and the team

Limitations of research

Observations data were limited to three ward rounds, one conducted by one consultant, the other two by a second consultant The people attending each round also varied considerably Thus the effects of different individuals as well as different disciplines may have also been present

The patient sample size was smaller than expected since a greater proportion of the patients than had been anticipated had Mental Ability Test scores of less than eight out of ten All samples were convenience samples and hence results may not be generalized to other situations

The use of an interview to obtain information from patients may have resulted in biased responses, since patients may have felt obliged to give good accounts of their care while in hospital This is particularly true when information giving is studied (Houston & Pasanen 1972)

The use of an observation method also entails a number of biases The extent to which professionals altered their behaviour as a result of an observer's presence could not be determined, as the number of rounds observed was limited Observer drift may also have biased the recorded observations, since each ward round was 2 hours long and observation was continual It was not, however, possible to use recording equipment since identifying which individual was speaking would have been too difficult

RECOMMENDATIONS

While small sample sizes preclude drawing definite conclusions, the following tentative recommendations are made on the basis of the evidence acquired

1 Professionals should use their awareness of problems experienced by patients to facilitate better involvement and understanding on the patient's part
2 It should be recognized that the lack of desire of some patients to be involved in decision making does not necessarily indicate a lack of desire to be involved in discussion Most patients wish to be able both to hear and understand the discussion and wish to have the opportunity and be encouraged to ask questions
3 It must be recognized that all the members of the multidisciplinary team are equally valuable in ward-round discussion and should participate in an egalitarian, democratic discussion to improve communication, planning, decision making and patient care
4 Nurses should develop greater assertiveness and actively participate in discussion and decision making They must be aware of their strengths and have more conviction in the value of their contribution if they are to fulfil their own aims of acting as support, advocate and giver of information to patients
5 The medical profession should be encouraged to relinquish control of the ward round and be encouraged to understand the advantages of full participation by all team members

There is a need for further research in this area, especially in exploring the effects of increased nursing involvement Larger samples in a number of different settings (especially those in which patients may be younger and more assertive), and intervention studies in which different methods of team functioning are tested, may yield more information on the effectiveness of nurse intervention and involvement Methods to improve patient involvement, by using the knowledge which professionals have of existing problems, may also be of value

Education of professionals and patients may also result in greater involvement of both nurses and patients, and in a movement towards better team functioning and improved patient care

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