

MEDICAL EDUCATION: PART I

BEDSIDE ROUNDING: ROLLING WITH RESISTANCE

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Introduction

Assessing physician competence has changed markedly in recent years as accreditation bodies and training programs have adopted competency-based education and training (CBET), focusing on educational outcomes rather than processes.¹ Systematic direct observation of trainees' clinical skills is now required by the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education as part of the Next Accreditation System. Direct observation of trainees is a cornerstone of CBET and a prerequisite for learner assessment. Certain core competencies, such as Interpersonal and Communication Skills and Patient Care, cannot be adequately assessed without direct observation. Nevertheless, studies indicate that little time is spent conducting direct observation during an average medical workday, faculty report rarely using direct observation as an assessment tool, and a substantial percentage of residents and students state that they have *never* been directly observed doing certain important clinical tasks.²

Bedside rounding (as opposed to "table rounds") represents an under-utilized strategy to increase direct observation and assessment of trainees' clinical skills. Recently, there has been a rekindling of interest in bedside rounding and in developing techniques to do so effectively. The authors address 5 commonly cited concerns with the aim of advancing the conversation about how to effectively implement and sustain bedside rounding.

"It Takes Too Much Time."

Studies of perceived barriers to bedside rounding frequently report that it takes too much time. However, most show the duration of inpatient medicine rounds is independent of rounding location.³ A recent trial of structured inpatient attending rounds found that trainees felt bedside rounds took longer despite measured time being no different,⁴ a finding seen in previous studies as well. We hypothesize that trainees and attendings rounding at the bedside may *perceive* time differently compared to in the conference room, leading to a mismatch between actual elapsed time and the experience. There are several possible explanations. First, team members may sense a loss of control when a patient interrupts a presentation, even for a few seconds. Second, physicians at the bedside can't as readily turn away from the conversation to return a page, answer a phone call, or divert their attention to a computer—activities that may require leaving the patient room. Third, trainees may feel unengaged and impatient when seeing patients cared for by other team members. We suggest the following strategies:

1. Explicitly acknowledge the importance of time perception and management and commit to mitigating strategies like those listed below.
2. Leverage the Electronic Medical Record (EMR) to enable brief and targeted bedside presentations, focusing on the HPI, exam findings, synthesis, and

continued on page 2

**MEDICAL EDUCATION: PART I** (continued from page 1)

plans. Overnight admission presentations are ripe for redesign. Reconsider presentation content and organization based on goals: repeating information already known to team members is inefficient and can suggest time is not highly valued.

3. Deliberately involve all team members as best as possible, creating a paradigm of shared learning and problem solving. Active engagement creates educational opportunities for a return on the listening investment.

“My Residents Don’t Want to Go to the Bedside.”

The literature around resident and student preferences for bedside rounding is mixed. Residents may view bedside rounds as beneficial for patients but less educational for themselves.⁴ In addition to concerns about efficiency, they may feel underprepared to present at the bedside, uncertain of what the expectations are, what language to use, what the repercussions might be of coming to an errant conclusion, and even where to position themselves at the bedside. Residents may worry about how they are perceived, especially by their patients. We suggest the following strategies:

1. Communicate a clear set of goals, objectives, and expectations with your trainees to orient them to the bedside rounding process. Include your thoughts on language and on ‘blocking,’ namely, how the team should assemble at the bedside to best achieve its goals. Talk about approaching mistakes in a way that supports resident autonomy.
2. Prepare teaching points prior to rounds, especially if doing so extemporaneously does not yet come naturally.
3. Be explicit about the care you model: say out loud how you approach a problem, what you

find on physical examination, and how you reason through that patient’s care. Trainees place high educational value on such contributions.

“Isn’t This More Stressful for Patients?”

While the literature is heterogeneous regarding patient-centered outcomes, multiple studies show high patient satisfaction with bedside rounds, including patients viewing the team as more respectful and compassionate, and reporting that their concerns elicit more attention from the medical team.⁵ Preparation of the patient and preparation of the medical team are important to successful bedside rounds. We suggest the following strategies:

1. Introduce team members and roles, the purpose of rounds, and request permission from the patient to discuss their care at the bedside.
2. When summarizing for the patient, key elements of patient-centered communication should be reinforced—understandable language, pausing to check for understanding, and non-verbal cues.

“Orders and Discharges Will Be Delayed.”

Delayed order entry can impact hospital length of stay, lead to medical errors, and even impact outcomes. Furthermore, resident fatigue and interruption of order entry contribute to order-entry errors in the EMR and result in patient safety issues. Therefore, real-time order entry is important. We suggest the following strategies:

1. Bring handheld tablets and computers on wheels during rounds to allow for real-time order entry.
2. Specify roles during rounds. For example, when Resident A is presenting a patient at the bedside,

Resident B will take notes of outstanding tasks for that patient’s care and, if time allows, place those orders in the EMR.

3. Allow for periodic, brief (<5 minutes) scheduled breaks during rounds to call consults or enter orders, while the attending provides focused teaching to medical students.
4. After each patient or at the end of morning rounds, briefly review the specific plans for each patient, offering to help with order entry or phone calls.

“OK, I See Your Points. But I’m Just Not Osler...”

This is a true barrier for many junior *and* senior faculty members. We suggest the following strategies:

1. Use a structured approach to bedside rounds. Consider MiPLAN or other frameworks. Most of these approaches consist of several common components:
 - a. Faculty preparation: Review patient information and data *prior* to rounds—this allows for identification of key teaching points beforehand and focuses the bedside presentation on patient engagement, teaching, and directly observing learners’ communication and clinical reasoning skills.
 - b. Team preparation: Elicit and address concerns from team members and establish mutual expectations regarding presentations and rounds. Set time targets based on clinical workflow (e.g., 5-minute presentations with an additional 10 minutes for discussion with patient and teaching) and specify roles for team members prior to entering the room (e.g., presenter, order entry, summary for the patient).

continued on page 3

**MEDICAL EDUCATION: PART I** (continued from page 2)

- c. Prepare and invite the patient and other healthcare professionals to participate; make focused/prepared teaching points and actively engage learners; respond to patient emotions in the moment; confirm patient understanding of plan; elicit questions from patient, family, other team members.
 - d. Debrief: elicit and provide feedback and follow up patient or learner questions.
2. Start small and grow deliberately, perhaps with established patients who are familiar with the team members and plans for their care or with new patients.
 3. Approach bedside rounding with a mindset of deliberate practice. With even a few repetitions, elements like streamlining presentations, providing diplomatic adjustments to plans of care, and navigating challenging situations will become more natural.

Faculty who teach bedside skills to students strongly endorse that their own skills improve in doing so. Patients, learners, and faculty all have opportunities to benefit from bedside rounds.

Discussion

Bedside rounds provide an opportunity for direct observation of trainees, can be done effectively and efficiently through selection of a method and deliberate practice, and are generally preferred by patients, but can still be met with resistance by trainees. The evidence shows that faculty and residents can adapt and benefit over time, but conversations about real and perceived barriers are needed, especially around the experience of time.

Awaken and develop your inner Osler by joining the authors at SGIM 2020 in Birmingham, Alabama, for a TEACH workshop covering these and other strategies for effective bedside rounding!

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