Patient-Centered Bedside Rounds and the Clinical Examination

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KEYWORDS

• Bedside rounds • Relationship-centered communication • Physical examination • Interprofessional • Patient centered • Medical education

KEY POINTS

- Patients and families prefer bedside case presentations and care discussions.
- Bedside rounds are venues to integrate relationship-centered communication and physical diagnosis skills into the work flow of clinical care.
- Efficient bedside rounds require team and patient preparation.
- Patient and provider experience can improve with bedside rounding.

VIGNETTE 1: THE TEACHING SERVICE

Dr Julie Wells is a newly appointed faculty member at an academic medical center who is preparing for her first block as an inpatient attending. She would like to round at the bedside, but her new hospital has a tradition of conference room or hallway rounds. Dr Wells is wondering how she can convince her new team to give bedside rounding a try.

VIGNETTE 2: THE NONTEACHING SERVICE

Dr George Johnson is a hospitalist at a community hospital. He greatly values the contributions of interprofessional team members in augmenting his evaluation of patients. However, he almost always rounds separately from other providers. Dr Johnson wishes the hospital culture provided more support for interprofessional bedside rounds. He thinks this practice would benefit the team, improve safety, and enhance the patient experience.

Both Drs Wells and Johnson are motivated to conduct bedside rounds with their clinical teams to connect effectively with patients, integrate valuable aspects of the

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clinical examination into the daily workflow, and make the experience beneficial for patients and their loved ones. They want rounds to be both “patient proximate” (at the bedside) and truly “patient centered” (inviting patient participation; Eric Warm, personal communication, 2017.) This article reviews practical considerations and suggestions to conduct efficient, high-yield bedside rounds. Many of the approaches were developed at Wake Forest Baptist Health with funding from the Josiah Macy Jr. Foundation and the Institute on Medicine as a Profession. The strategies for relationship-centered communication grew out of collaboration with the Academy on Communication in Healthcare.

THE DECREASE IN BEDSIDE ROUNDING

Over the past 50 years, bedside rounding has all but disappeared from the wards of teaching and nonteaching services.[1,2] Changes in medical systems, workflow, hospital culture, and values make Osler’s admonition that there be, “No teaching without a patient for a text, and the best teaching is that taught by the patient himself,” seem like a relic from a prior era.[3] In many academic medical centers, bedside rounds have been replaced by presentations of newly admitted patients in a conference room or hallway followed by a brief visit to the bedside to meet the patient and confirm key findings. Care discussions of follow-up patients are relegated to “card flip” without the team laying eyes or hands on their patients. Time at the bedside is estimated to account for 8% to 19% of total rounding time.[4,5] On nonteaching services, the situation is similar. Providers round separately on their patients, rather than as a team, and care discussions occur in the hallway or conference room rather than at the bedside. As a result, it often seems that attention devoted to the “iPatient” housed in the electronic medical record takes precedence over care of the actual sick person in the bed.[6]

Many factors contribute to the trend away from the bedside. When care discussions focus primarily on reviewing and interpreting laboratory and imaging studies, teams understandably prefer the relative comfort, privacy, and computer access provided in a conference room.[7,8] In medical systems where efficiency rules, providers may eschew bedside rounding if they think they take more time than hallway or conference room rounds.[9] Work compression owing to duty-hour restrictions for house staff and hospital mandates for early discharges and decreased durations of stay mean that all providers have less time to talk with and listen to patients and families. One study estimates that interns, on average, spend only 7 minutes per day with each of their patients.[10] The bulk of their day is spent in front of computers rather than with patients.

Patient expectations and preferences are rarely a barrier to bedside rounding.[11] Teams are often worried that patients will be overwhelmed by bedside discussions of complex medical issues or upset when sensitive topics, such as substance abuse or pain management, are mentioned in the presence of a large rounding team. Providers may feel uncomfortable about how to manage strong patient emotions, such as anger or grief, and are apprehensive that rounds will be derailed by prolonged discussions of psychosocial issues.[12] Beginning learners are often anxious about making mistakes during bedside presentations.[12] Finally, a generation of clinicians with few or no role models from their own training lack confidence in their own bedside teaching and communication skills.[13]

RETURNING TO THE BEDSIDE

The renewed interest in bedside rounding is evidence based. It reflects the re-envisioning of clinical care that is taking place in many health systems and practices.

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