

Returning to the Bedside: Notes From a Clinical Educator

Peter R. Lichstein

Over the past 3 decades, teaching rounds have drifted away from the bedside in favor of management discussions in a conference room or hallway. As a result, patients and families—2 of the most valuable resources in health care—are being left out of the loop. This trend is now being reversed by bedside presentations of newly admitted patients and structured interdisciplinary bedside rounds.

Every teaching attending is familiar with the daily decisions about how to conduct rounds. What is the correct balance between teaching and patient care? Between the purely technical and the more human dimensions of medicine? Who should be included in rounds to encourage care integration across an interprofessional team? What strategies promote patient-centered care while also providing necessary access to computers and the electronic medical record? Where should new cases be presented: in a conference room, in the hallway, or at the patient's bedside? These decisions express, often unconsciously, the culture and values of the care team—what educators refer to as “the hidden curriculum” [1]. They impact patients, clinicians, and the professional development of tomorrow's physicians. By intentionally re-envisioning rounds, care teams can choose processes that actualize patient and family engagement and that value the patient as a person with unique goals and perspectives on his or her illness and care.

Over the last 30 years, bedside rounding has all but disappeared from most teaching hospitals. On the typical medical service, newly admitted patients are presented in a conference room or hallway where computers are readily accessible, and visits to the bedside tend to be brief—mainly for the attending physician to meet the patient and confirm important findings [2]. Discussion of the remaining patients is relegated to “card flip” around a table, without the team actually laying eyes or hands on the patient. Nurses see their patients separately and rarely round with the medical team. An unintended consequence of regulations restricting resident duty hours is that efficiency has become the highest priority, thus reducing the amount of time trainees have to talk with and listen to patients and families, let alone reflect and discuss the experiences of the clinical day. In fact, an intern's schedule allows, on average, only 8 minutes per day with each of his or her patients [3]. Teaching phy-

sicians also admit to discomfort discussing complex issues in front of patients and feel unprepared to round efficiently while addressing both the technical and human dimensions of care. They prefer the relative privacy and informality of the conference room to the unpredictability of the bedside, where new patient concerns or strong emotions may emerge.

Patients and families overwhelmingly prefer to have their case presented at the bedside so long as there is reasonable privacy, medical jargon is limited (or interpreted), and their concerns are heard and questions answered [4]. Fundamentally, patients simply want their doctors to spend more time with them, and they view bedside rounds as a welcome step in that direction. If cases are presented in the hallway or conference room, patients are not privy to and cannot contribute to the presentation of their case or the discussion of their management. During bedside conversations, if clinicians listen closely, patients nearly always provide important insights into their disease and how best to manage it. This is not rocket science or magic. These fundamental human relationship and communication approaches come more naturally to some than others, but they can be successfully acquired with practice and coaching [5].

Abraham Verghese eloquently describes how rounds conducted in a workroom are dominated by care of the “iPatient,” the surrogate patient housed in the computerized medical record, rather than the actual sick person in the bed [6]. Consider how trainees may be impacted by the discrepancy between what they hear about patient-centered care and what they see in actual practice. Compared with hallway rounds, bedside rounds place the actual patient, rather than the “iPatient,” at the center, literally, of the team's attention, concern, and study (see Figures 1 and 2). As Hafferty noted over 2 decades ago, “many of the ‘messages’ transmitted via the hidden curriculum may be in direct conflict with what is touted in formal courses” [1]. Verghese, among others, also notes that, without bedside instruction, clinical skills atrophy, with a resultant over-reliance on costly tests [7].

Electronically published July 1, 2015.

Address correspondence to Dr. Peter R. Lichstein, Wake Forest School of Medicine, Medical Center Blvd, Winston-Salem, NC 27157 (plichste@wakehealth.edu).

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Watkins sidebar

There is clear evidence that time spent listening closely to patients and families, engaging them in conversations about decision making, and responding empathically to their concerns improves medical outcomes, promotes patient self-management, and enhances patients' experience of being cared for and prepared for their transition home [8]. Unfortunately, hospitalized patients often complain that doctors do not spend enough time with them, do not listen

carefully, do not provide information in a clear and understandable fashion, and sometimes are downright rude and condescending [9, 10]. In *Crossing the Quality Chasm*, the National Academy of Medicine defines patient-centered care as "respecting and responding to patients' wants, needs, and preferences, so that they can make choices in their care that best fit their individual circumstances" [11]. Levinson notes that while attention to infrastructure can

facilitate these goals, the real key is skilled interpersonal communication with patients and families, which cannot be accomplished in the conference room or hallway [8].

In 2013, Wake Forest Baptist Health received a 2-year grant from the Institute on Medicine as a Profession and the Josiah Macy Jr. Foundation to train attending physicians, residents, and students to conduct daily rounds at the patient's bedside, rather than in a conference room or hallway. We felt this would provide a venue to role model, teach, and assess patient-centered communication during actual patient encounters, and we preferred this approach to relegating instruction on professionalism to conferences

or lectures separate from clinical care. The Macy Foundation asked that all grantees use a behavioral definition of professionalism that states that it is "not simply a set of text-based ideals for practice, rather it is an approach to the practice of medicine that is expressed in observable behaviors" [12]. We aimed to transform the bedside into a venue where the entire team can embody whole-person care and "walk the talk" of professionalism. We realized that in order to be successful, attention to the patient's needs must be balanced with efficiency in rounding, and there must be high-fidelity communication among members of the interprofessional team to enhance quality and safety.

FIGURE 1.
Hallway Rounds



FIGURE 2.
Bedside Rounds



Culture change was surprisingly rapid. Within 6 months of the project's inception, most patients on 4 general internal medicine floors and 1 geriatric floor were being presented at the bedside. It appeared that the grant tapped into a strong desire for change; students, residents, and attending physicians seemed hungry to return to the bedside to learn and provide care. The Macy curriculum, as it came to be known, emphasizes relationship-centered communication skills across the educational continuum, beginning in the first weeks of medical school and extending through interactive seminars for internal medicine residents and faculty development workshops. The communication model PEARLS (Partnership, Empathy, Apology, Respect, Legitimization, and Support) was chosen from among many possible models to provide a common language to facilitate teaching, feedback, and assessment (see Table 1) [13]. The curriculum emphasizes reflective listening, empathic responses to patient distress, clear and understandable explanations using minimal medical jargon, inquiry about the patient's

perspective, shared decision making, and teach-back techniques. During rounds, one team member is tasked with noting which PEARLS are employed and what opportunities may have been missed. After the encounter, the team pauses for a moment to receive feedback and discuss how they communicated. With this approach, teaching and assessing professional communication are seamlessly linked to other dimensions of the clinical encounter.

Medical students at Wake Forest are introduced to bedside patient presentations (BSPPs) early in their first year as part of the introductory course on the doctor-patient relationship. By their third year, they are fully prepared for bedside presentations. The clerkship director noted, "The students enjoy being able to tell the patient's story to the team, at the bedside, in a patient-centered fashion. The more bedside presentations they do, the more comfortable they become and the more effective and patient-centered the process feels to them." Student feedback was also positive. One third-year student reported, "I felt that with BSPPs patients were more directly involved in their own care. They were more aware of their medical plan and more likely to ask questions." Another third-year student said, "I was reminded of why I entered into medicine to begin with—to interact with patients and provide comprehensive care ... [BSPPs] renewed my interest in medicine."

Each year, about 115 internal medicine residents at Wake Forest Baptist Health are exposed to the Macy approach to rounding. The residency program director reported, "They definitely appreciate how it connects the team to the patient and how it showcases to the patient the thought processes going into their care ... Bedside rounds allow residents to learn from each other, our students to learn from residents, and our faculty to observe both." Similarly, an internal medicine resident said, "It is a very efficient and useful way to learn clinical skills ... decisions can be made and orders placed at the same time. It is also very useful for residents and students to have physical exam maneuvers explained and demonstrated."

To date, 39 teaching physicians at Wake Forest Baptist Health, including general internists, hospitalists, geriatricians, and subspecialists, have been trained to conduct effective bedside rounds and intentionally emphasize professional communication and patient-centered values [14, 15]. The PEARLS communication model was new to most of the faculty and was practiced during each of 3 devel-

TABLE 1.
PEARLS of Communication

Partnership: "We'll work on this together."
Empathy: "I can see this has been a difficult time for you."
Apology: "We apologize for all the mixed messages and delays."
Respect: "Your opinion and input are important to us."
Legitimization: "Many patients have similar reactions."
Support: "What can we do to support you in preparing to go home?"

opment workshops. Faculty learned to manage challenging bedside interactions and debrief after rounds to reinforce teaching points. They explored how to balance purposeful rounding strategies with flexibility and responsiveness to what emerges at the bedside: the unexpected twist in a patient's history, a new physical finding, or a strong emotion. They were encouraged to always set aside brief intentional pauses during and after rounds to engage in thoughtful reflection about the team's observations and responses to patient encounters [16].

Implementation

Bed Geography

Locating all service patients on one ward is the literal groundwork for efficient rounding and facilitation of teamwork. It is essential.

Getting Buy-in From the Team

Ask the team what can be learned by going to the bedside. How can going to the bedside contribute to high-quality, safe patient care?

Patient Selection

Bedside rounding may not be appropriate for a select group of patients (those with advanced dementia or paranoia, for example). At the same time, bedside rounds on "difficult patients" often provide unique opportunities to teach and influence care.

Flexibility

Attending physicians should hold their rounding strategies lightly and be open to new circumstances as they arise.

Choreography

Choreography is essential for balancing attention to the patient's needs with the team's need for efficiency (see Table 2). BSPPs should last no longer than 5 minutes, with a total of 15 minutes in the room. Before going into the room, everyone should know where to stand and what his or her role is. One resident opens the computer in the room to access data as needed, enter orders in real time, and read them back to the patient. Patient and family input is elicited and, before leaving, patients are asked to summarize the discussion in their own words.

Structured Interdisciplinary Bedside Rounding (SIBR)

Interdisciplinary rounds are the Holy Grail of process redesign. However, in most hospitals, including ours, nurses traditionally see their patients independent of the physician team, and nurses usually step out of the room as soon as the medical team enters. Care is further fractured when other disciplines—consulting physicians, physical therapists, social workers, dieticians, and care managers—are filtering in asynchronously throughout the day to visit the

patient. It is no wonder that patients and families frequently complain that they have heard mixed messages. Not surprisingly they ask, "Doesn't the left hand know what the right hand is doing?" Multidisciplinary huddles are critical for integrating care and communication but, when conducted in a conference room, the voice of the patient and family are excluded. Structured interdisciplinary bedside rounding (SIBR) transposes the huddle—including the bedside nurse, charge nurse, discharge planners, care managers, pharmacist, and physicians—from the conference room to the bedside. At Emory University, the impact of SIBRs has been impressive; they have decreased mortality, shortened length of stay, improved patient satisfaction, reduced nursing turnover, and improved clinicians' happiness [17]. Like with bedside presentations, careful attention to choreography during SIBRs promotes efficiency and inclusiveness. Coordinating schedules across disciplines is one of the biggest challenges to getting everyone to the bedside at the same time.

At Wake Forest, conducting a SIBR on patients the afternoon prior to discharge (D-SIBR) has been particularly effective, especially for complex and challenging cases. Everyone on the team, including the patient and family, has a unique line of sight on the issues, and insights and strategies often emerge unexpectedly. To succeed, diverse perspectives must be respected and physicians must be responsive to input. In our experience, D-SIBR has played a vital role in

TABLE 2.
Bedside Rounds Choreography

- **Prepare the team:** Get buy-in and address concerns; "What can be learned best at the bedside?"
- **Set expectations:** Patient selection, positions at the bedside, amount of time allowed for bedside presentation (5 minutes), total time at bedside (less than 15 minutes). Decide who opens the computer and enters orders.
- **Prepare the patient:** Get permission from patient in advance; assure confidentiality; explain what to expect, size of the team, and teaching.
- **Begin well:** Make introductions, including family and visitors; pay attention to etiquette.
- **Communication pitfalls:** Limit medical jargon and avoid pejorative labels.
- **Bedside teaching:** Engage all learners, limit the number of teaching points (eg, one each from history, physical examination, and clinical reasoning). Less is usually more.
- **PEARLS:** Use at least one of the communication PEARLS in each patient encounter.
- **Ask about the patient's perspective:** "How has this illness impacted your life?" "We're interested to hear your perspective regarding the treatment plan."
- **Confirm patient's understanding (teach-back):** "Doctors aren't always good at explaining things, so what is your understanding of the plan?"
- **Ask for questions and concerns:** "What are your questions and concerns?"
- **Check back with patient:** A team member checks back with the patient after rounds to get the patient's response to rounds and to answer any additional questions.
- **Debrief and feedback:** Team reflects on the interaction.

crafting a safe discharge plan for patients previously labeled as “rocks” (because no single team member could envision a path forward). As the D-SIBR concludes, patients and families are asked to restate their understanding of the medical problem and the discharge plan. Anticipating that new questions may arise after discharge, we typically offer to “round on the patient by phone” the next day. This offer has been well received, and it has been generally accepted and helpful for ensuring patient confidence and safety.

Assessment

Re-envisioning rounds and piloting clinical innovation can be viewed and assessed through the lens of translational science. The roadmap for translational research encompasses a continuum from how understanding of disease derived from the basic sciences is translated into new approaches to diagnosis and therapy in humans (stages 1 and 2 - “bench to bedside”) to the implementation of results from controlled clinical trials into the “how” of actual day-to-day clinical practice (stage 3) [18]. Stage 3 is where innovative processes, such as interprofessional bedside rounding, are measured, assessed, scaled, and disseminated to new settings—essential steps in process improvement. In contrast to randomized controlled trials, the gold standard for research at stages 1 and 2, assessment at stage 3 must carefully examine, rather than exclude, rich accounts of the local, contextual factors that determine success or failure in the real world of practice [19, 20]. We are assessing the Macy project with narratives and surveys of learners, teachers, and patients. Data on patient satisfaction, length of stay, and readmission rates are also being collected.

For bedside rounding, one size will not fit all. What works for general medicine patients may need to be tailored to work for surgery patients or pediatric patients. Change at this level of complexity is not simply a matter of implementing care maps. To bring rounding to the bedside, culture, context, and relationships must be considered. The next steps at Wake Forest include dissemination of BSPPs and SIBRs to other clinical services and, eventually, to other teaching hospitals. Finally, in keeping with our commitment to patient and family engagement, patient advisors should be included to make certain the patient’s voice is heard. **NCMJ**

Peter R. Lichstein, MD, FACP, FAACH professor of medicine, Wake Forest School of Medicine, Winston-Salem, North Carolina.

Acknowledgements

I would like to thank the study coordinators, Emily Ansusinha, MA, and Karamie R. Bringolf, MPH, for their invaluable support of the project and the physician planning team, including Hal Atkinson, Cynthia Burns, and Ramon Velez.

Financial support. Supported in part by a grant from the Institute on Medicine as a Profession.

Potential conflicts of interest. P.R.L. has no relevant conflicts of interest.

References

1. Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. *Acad Med.* 1994;69(11):861-871.
2. Wachter RM, Vergheze A. The attending physician on the wards: finding a new homeostasis. *JAMA.* 2012;308(10):977-978.
3. Block L, Habicht R, Wu AW, et al. In the wake of the 2003 and 2011 duty hours regulations, how do internal medicine interns spend their time? *J Gen Intern Med.* 2013;28(8):1042-1047.
4. Lehman LS, Brancati FL, Chen MC, Roter D, Dobs AS. The effect of bedside case presentations on patients’ perceptions of their medical care. *N Engl J Med.* 1997;336(16):1150-1155.
5. Chou CL, Cooley L, Pearlman E, White MK. Enhancing patient experience by training local trainers in fundamental communication skills. *Patient Experience Journal.* 2014;1(2):36-45.
6. Vergheze A. Culture shock – patient as icon, icon as patient. *N Engl J Med.* 2008;359(26):2748-2751.
7. Elder A, Chi J, Ozdalga E, Kugler J, Vergheze A. A piece of my mind. The road back to the bedside. *JAMA.* 2013;310(8):799-800.
8. Levinson W, Lesser CS, Epstein RM. Developing physician communication skills for patient-centered care. *Health Aff (Millwood).* 2010;29(7):1310-1318.
9. Wofford MM, Wofford JL, Bothra J, Kendrick SB, Smith A, Lichstein PR. Patient complaints about physician behaviors: a qualitative study. *Acad Med.* 2004;79(2):134-138.
10. Kahn MW. Etiquette-based medicine. *N Engl J Med.* 2008;358(19):1988-1989.
11. Institute of Medicine of the National Academies. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press; 2001.
12. Lesser CS, Lucey CR, Egener B, Braddock CH 3rd, Linas SL, Levinson W. A behavioral and systems view of professionalism. *JAMA.* 2010;304(24): 2732-2737.
13. Clark W, Hewson M, Fry M, Shorey J. *Communication skills reference card.* St. Louis, MO: American Academy on Communication in Healthcare; 1998.
14. Fitzgerald FT. Bedside teaching. *West J Med.* 1993;158(4):418-420.
15. Gonzalo JD, Heist BS, Duffy BL, et al. The art of bedside rounds: a multi-center qualitative study of strategies used by experienced bedside teachers. *J Gen Intern Med.* 2013;28(3):412-420.
16. Wear D, Zarconi J, Kumagai A, Cole-Kelly K. Slow medical education. *Acad Med.* 2015;90(3):289-293.
17. Stein J, Murphy DJ, Payne C, et al. A remedy for fragmented hospital care. *Harv Bus Rev.* November 20, 2013.
18. Dougherty D, Conway PH. The “3T’s” road map to transform US health care: the “how” of high-quality care. *JAMA.* 2008; 299(19): 2319-2321.
19. Berwick DM. The science of improvement. *JAMA.* 2008;299(10):1182-1184.
20. Suchman AL. Organizations as machines, organizations as conversations: two core metaphors and their consequences. *Med Care.* 2011;49(suppl):S43-S48.