Addressing Resident Concerns About Rounding Without Extending Rounds

The article "Rounds Today: A Qualitative Study of Internal Medicine and Pediatrics Resident Perceptions" by Rabinowitz et al[1] compiles resident focus group quotes that contrast the ideals of an Osler-era bedside rounding experience with a disillusionment about how patient care has overshadowed resident education. In particular, the authors reference residents' perceptions of (1) the lack of teaching due to clinical volume; (2) the reduced ability to learn from communication with patients and families; and (3) the desire to present both an assessment and plan without losing a patient's trust during bedside rounds. In this response to Rabinowitz et al, I propose a way to address these 3 concerns without extending the already limited time allotted to hospitalist rounds.

The way residents perceive the quantity of teaching moments on rounds closely mimics residents' perception of feedback. In describing ways to give effective feedback, Kogan[2] suggests "signposting" feedback with overt statements, such as "I am going to give you a little feedback now." Similarly, residents often fail to recognize an informal teaching moment by the attending physician unless it is signposted as a teaching moment. Not doing so makes what is otherwise a deliberate effort by the attending to teach appear to be just another part of clinical decision making and patient care. Signposting takes only a few seconds, and it can significantly change a resident's perception of teaching quantity without extending rounds.

To address the second concern about communication with families, it can be particularly useful to have the primary provider (the intern or student) lead the rounding team into the patient's room and to introduce the whole team. Asking the person who prerounded on the patient to drive the conversation during bedside rounds reduces rounding time by not reinventing the prerounding conversation and preliminary plan discussion with the patient. In addition, it gives the attending the ability to witness and critique the use of jargon and the display of empathy, neither of which would be learning opportunities if the attending drives the bedside conversation.

Finally, residents in the Rabinowitz et al focus groups emphasized the desire to display their confidence and competence in formulating the assessment and plan, but they feared losing the trust of patients if their initial thoughts were corrected by the attending. To assuage this concern, an attending may choose to allow the resident to finish the entire assessment and plan before speaking, while taking notes on the side. Interrupting presenters in front of a patient's family can damage confidence and trust, and can veer focus away from an otherwise concise presentation. On the other hand, waiting until the end to give input allows for the appearance of a discussion to the patient and family, rather than a correction.

With the information about residents' perceptions of what does and does not work on hospitalist rounds provided by Rabinowitz et al, we must now work to address these concerns in a way that promotes education and patient care while staying within the unforgiving limitations of rounding time.

Flint Y. Wang, MD
Assistant Professor of Clinical Medicine, Section of Hospital Medicine, and Co-Leader, Organization and Efficiency Division, Clinical Coaching Committee, Perelman School of Medicine, University of Pennsylvania

References

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