



MEDICAL EDUCATION

Ward rounds – bedside or conference room?

H L Chauke, R C Pattinson

Traditionally bedside clinical rounds have been the centre of clinical teaching and patient care. The advantages of these rounds include, among others, the opportunity to: (i) conduct clinical assessment; (ii) teach medical students clinical examination; and (iii) provide students with an opportunity to learn doctor-patient interaction and acquire clinical attributes that are indispensable in practising the art of medicine.^{1,2} However, concern about adverse effects on patients' perception of their health care and clinical wellbeing has resulted in a trend of translocating clinical activities to the conference room.¹⁻⁵

What we did

A qualitative study was therefore conducted at Kalafong Academic Hospital during 2004 to determine the preferences of patients, doctors and medical students with regard to morning labour ward handover rounds, student teaching rounds, patient management rounds and grand rounds.

Patients were randomly allocated either to bedside or conference room groups on a daily basis for the labour ward aspect of the research project. Presentation, discussion, management decisions and communication took place around the patient's bed in the bedside group. The same format was adhered to in the conference room group but in the absence of patients. After the conference room round the consultant and incoming and outgoing registrars walked through the labour ward to greet patients, communicate and discuss management plans, and answer any questions that patients might have.

Patient satisfaction with grand rounds and patient management rounds was assessed using a sample of patients admitted to the maternity unit. Because of small numbers, all patients who participated in the student teaching rounds were included. Interviews were conducted by the first author (HLC) using a structured format and a standardised questionnaire to assess patients' perception of the clinical round not more than 6 hours after each round, for all types of rounds. The questionnaire was developed after a focus group discussion in the same unit during 2003 and was tested on pregnant women

and nursing staff during November 2003.

Separate focus group discussions were conducted with students, registrars and consultants to ascertain their preferences with regard to the types of rounds. All participants gave consent before entry into the study and ethical approval was obtained from the Ethics Committee of the Faculty of Health Sciences at the University of Pretoria.

What we found

A total of 138 patients, 11 medical students, 10 registrars and 5 consultants took part in the study. The literacy rate was 100%, and 85% had either secondary or tertiary education. The majority of participants spoke one of the indigenous South African languages. Only 48 (35%) were local residents, a reflection of the referral nature of the hospital, which caters for other regions of Gauteng and Mpumalanga provinces.

Seventy-four patients took part in the labour ward handover round; 39 (52.7%) experienced the bedside round and the remainder the conference room round. Significantly more patients were satisfied with the bedside round (37, 94.9%) than with the conference room round (24, 68.6%) (p -value < 0.01). The reasons given for satisfaction with the bedside round were as follows: 21 patients enjoyed the attention of a big group and felt that the doctors were interested in them (53.8%), 13 patients believed that these rounds presented the doctors with an opportunity to share ideas that would translate into quality care for them (33.3%), and 5 patients (12.8%) felt that doctors could carry out clinical assessment and therefore make a correct diagnosis with resulting proper management plans. A further 9 patients (23.1%) found the round educational, while another 2 (5.1%) enjoyed being part of the discussion. Only 2 patients disliked the round, both because of poor manners on the part of the doctors.

The majority of patients (12, 34.3%) who were satisfied with the conference room round felt that the round allowed the doctors to discuss freely and hence come to a consensus concerning diagnosis and management. Ten patients (29.2%) felt that it was part of the doctors' daily tasks, 4 patients (11.4%) disliked crowds, while another 4 were not concerned as long as they were given feedback. All 11 patients who were dissatisfied with the conference room round wanted to be part of the discussion. They stated that participating in the discussions would help them understand their condition better. In addition they viewed discussions on a person in his/her absence as being inhuman.

Ten of 11 patients who took part in the student teaching

Dr Lawrence Chauke is a consultant in the Department of Obstetrics and Gynaecology, Kalafong Hospital and University of Pretoria. Professor R C Pattinson is the head of the Department of Obstetrics and Gynaecology and head of the MRC unit at Kalafong Hospital. Both authors have a special interest in patient care and student education.

Corresponding author: R C Pattinson (rcpattinson@kalafong.up.ac.za)



round were satisfied with the round; they perceived it to be educational, and 1 patient went further to say that it was the duty of responsible citizens to participate in student teaching to ensure that the country produces quality doctors. The 1 patient who disliked the round did so because of the language barrier (the round was conducted in English and there was no attempt on the part of the doctors to explain proceedings to the patient).

Nineteen of 21 patients (90.5%) who participated in the grand round were satisfied with the round. The presence of senior staff (professor/consultant) was viewed as an assurance that junior doctors were receiving advice on management, and hence that better patient care was likely. One patient disliked the round because no one explained to her what was going on (the patient didn't understand English). Another patient was unhappy that her CD4 count was mentioned after the clinician indicated that she had been counselled and tested (HIV didn't feature in the discussion).

All 30 patients who took part in the patient management round were satisfied with the rounds. They felt that the doctors were supportive, caring and easy to relate to. Management decisions and communication between doctors and patients with regard to clinical progress occurred on a daily basis.

All consultants and registrars preferred bedside rounds. They all felt that subtle or gross physical signs that would have been missed by the examining clinician might be picked up by senior staff, in addition to providing the consultants with a platform to demonstrate clinical signs. The consultants also felt that they were able to form a mental picture of the patients, something invaluable if later consulted for a clinical opinion telephonically.

Students were divided, with 55% and 27% preferring bedside and conference room rounds respectively. The remainder were undecided. Of note is that 3 visiting students, from the USA, the Caribbean and Holland, preferred bedside rounds. The group that preferred bedside rounds indicated that patients were not just abstract hosts for disease but individuals and should be included in the discussions pertaining to their health. They believed they could learn doctor-patient interaction through watching their teachers in action during bedside rounds. Furthermore they found bedside rounds interesting. They went on to say that clinical examination techniques are not learnt from textbooks, and that bedside rounds address that need adequately.

The group that preferred conference room rounds believed that doctors get ample space to discuss freely, debate certain aspects of patient management and carry on academic activities without unduly upsetting the patient. This group disliked being embarrassed in front of patients in situations

involving inaccurate assessment or wrong conclusions. They viewed conference room rounds as reinforcing patient privacy. The students who were undecided suggested a hybrid between the two types, with brief discussion at the bedside and detailed academic deliberations in the conference room.

Discussion

The overwhelming preference for bedside teaching in this study differs from the findings of studies conducted in medical wards.^{1,2} The results make sense as obstetrics is a unique discipline where patients have high expectations and are anticipating giving birth. Issues of support and caring are critical. The educational and supportive nature of bedside rounds (as viewed by patients) remains the same throughout studies.^{1,2,5}

The positive perception of obstetric patients with regard to student teaching was encouraging as issues of privacy pose a problem in this context. Rizk *et al.*⁶ reported similar findings in the United Arab Emirates. Doctors also preferred bedside rounds, contrary to the findings from other studies where conference room rounds were preferred for the sake of patient comfort.¹ However, one study¹ reported that these doctors had a tendency to hide the true diagnosis from patients as a way of protecting them from emotional trauma.

Poor manners and not involving patients during the discussion emerged strongly as the main reasons for dissatisfaction, and these areas therefore need attention. Students felt humiliated in the way that tutors corrected them in front of patients, eroding their self-esteem. The dictum 'learning medicine through humiliation' should no longer apply in the context of a new South Africa! Students will not learn if they feel they are in a threatening environment.

Overall, the results are encouraging. Attention needs to be paid to how these rounds are conducted, and should involve patients even if this means employing the services of an interpreter. The issues raised here by medical students are very familiar – a shift in the philosophy of medical education to one that respects the individual, promotes human rights and minimises abuse in all forms is necessary, even if this means letting go of deeply entrenched medical traditions.

1. Seo M, Tamura K, Morioka H, *et al.* Impact of medical rounds on patients' and residents' perceptions at a university hospital in Japan. *Med Educ* 2000; **34**: 409-411.
2. Lehmann LS, Brancati FL, Chen M, *et al.* The effect of bedside case presentation on patients' perceptions of their medical care. *N Engl J Med* 1997; **336**: 1150-1155.
3. Anonymous. The trauma of being a patient. *Lancet* 1989; **2**: 1309-1310.
4. Shakel SW, Mazzaferi EL. Teaching the resident in internal medicine: present practices and suggestions for future. *JAMA* 1986; **256**: 725-729.
5. Linfors EW, Neelon FA. The case for bedside rounds. *N Engl J Med* 1980; **303**: 1230-1233.
6. Rizk DEE, Al-Shebab A, El-Zubeir MA, *et al.* Women's perceptions of experiences with medical students involvement in outpatient obstetrics and gynaecological care in the United Emirates. *Am J Obstet Gynecol* 2002; **187**: 1091-1010.