Teaching in a Family-Centered Care Model: The Exam Room as the Classroom

“To study the phenomenon of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.”

Sir William Osler, 1903

Although Osler challenges us to study disease in the context of patients, family-centered care (FCC) challenges us to study disease in front of and alongside our patients. This article focuses on teaching in the presence of patients and families, at the bedside and during outpatient encounters, as part of the ongoing Council on Medical Student Education in Pediatrics series on skills and strategies used by superb clinical teachers.

WHAT IS FCC?

FCC is rooted in collaboration among patients, families, physicians (including those in training), and nurses. It is guided by the principles of respecting the patient and family, building on each family’s strengths, being flexible, offering choices about care when possible, being transparent, and collaborating with families to make shared decisions. Long before the term was coined in the second half of the 20th century, FCC was practiced by many pediatricians and family physicians.

FCC in practice has decreased length of stay and readmission rates, but benefits to learners have been less well documented. FCC is difficult to teach in a traditional classroom setting and is better demonstrated through role modeling and including learners in the partnership of care. One method of incorporating FCC into teaching is through family-centered rounds (FCR) or family-centered discussions both at the bedside and in the examination room.

Sisterhen et al defined FCR as “interdisciplinary work rounds at the bedside in which the patient and family share in the control of the management plan as well as in the evaluation of the process itself.” FCC with FCR provides an opportunity for learners to observe attending physicians’ bedside manner, physical examination techniques, and interactions with patients in both inpatient and outpatient settings. Preceptors can also directly observe students taking histories, examining patients, and counseling children and families, all of which are more effectively taught in the presence of a patient. By teaching at the bedside in the context of a real patient, students are more likely to receive immediate, relevant knowledge that will “stick with” them. Having role models who teach, and learn, in front of patients assists students in developing their own communication skills and bedside manner.

IN THE CLINIC

A common concern of busy preceptors is finding the time to teach while running a hectic clinic. A study by Baker et al in the clinic setting found that examination room presentations (in which the student presents the case in front of the patient, family, and preceptor in the examination room rather than to the preceptor alone outside the examination room) took a similar amount of time and resulted in higher patient satisfaction than conference room presentations. Anderson et al showed that clinic patients who experienced examination room presentations by learners preferred this method when offered a choice for future visits.

Teaching in an FCC environment also affords preceptors an opportunity to role model, and teach, different styles of communication. Although it is difficult to explain to a student how to be empathic or reassure a worried
parent or discuss a complex medical problem, it is possible to demonstrate these skills by talking to patients and families in the presence of students. In a 2008 focus group by Williams et al,7 a medical student stated, “It’s very powerful if you see the example on an actual person, and especially if you know more about their story, their background, you’re more likely to take something away from that experience, whether it be some kernel of knowledge about a disease or a certain way of interacting with patients.” The family and the patient, when approached with respect, become an integral part of the teaching process.

ON INPATIENT ROUNDS
Teaching in an inpatient FCC environment is beneficial in the inpatient setting as well. A 2003 American Academy of Pediatrics policy statement recommended that FCR be standard practice.8 Since then, FCR has become the predominant method by which inpatient rounds are conducted on pediatric wards around the country.9 Although Muething et al10 found that it took 20% longer for FCR in the inpatient setting, there were other time savings downstream, such as less frequent call backs to answer questions from families or nurses. With FCR, the student has the opportunity to practice effective ways of communicating with families by using understandable language, avoiding jargon, and involving families in the decision-making process.

LEARNERS’ PERSPECTIVES
Learners, though, are not convinced. Although 85% of patients prefer presentations in their rooms, only 53% of learners think that presenting in the presence of the family is more educational than conference room rounding.11 In a randomized controlled trial, learners were significantly more comfortable asking questions (84% vs 69%) and being asked questions (85% vs 67%) when presenting in the conference room; only 4% of students felt comfortable presenting in front of families.12 Wang-Cheng et al,13 in a 1989 survey, found that 95% of residents preferred to do presentations away from the patient. Many reported a fear of looking foolish in front of a parent. This fear is especially acute in students, many of whom are struggling to develop their basic presentation skills. The additional task of trying to maintain rapport with families leads to added discomfort. In a focus group on FCR of students from the University of North Carolina rotating at Cone Health, a medical student noted, “I think it’s very hard to earn the respect of the patients and family as a student. I think giving constructive feedback to junior members of the team is easily and often misconstrued by families as a lack of confidence in those team members, which consequently makes it hard for families to trust their judgment.” Although these concerns are valid, students do become more comfortable presenting in front of patients with practice and experience in FCR.10,14 In Cox et al’s14 survey of medical students who had completed a 6-week pediatric clerkship that included presenting in front of patients, only 17% were concerned about being “pimped.” Many come to believe that teaching is more relevant during FCR and that they learn in ways that are not practical in the conference room.10,15

TIPS FOR TEACHERS
For FCR to succeed as an educational tool, these legitimate learner concerns need to be addressed. A resident in Williams et al’s7 focus group stated, “If teachers can set the tone and what the expectations are and say that ‘it is okay to make mistakes, we all make mistakes, but the great doctors are the ones who take those mistakes and use them to improve themselves; that’s the best way to learn in that stressful environment.’” The preceptor can set the tone for a safe learning environment with the following practical steps:

- Set expectations at the beginning of the learner’s rotation.
- Introduce the members of the health care team and acknowledge their level of training.
- Acknowledge to the learner the stress of presenting in front of patients and families along with the preceptor’s goal of supporting the learner without humiliation.
- Give the learner permission to “not know” and ask for help.
- If a learner says something incorrectly or inappropriately, use positive reinforcement to acknowledge what was correct and then explain what the actual plan will be.
- Offer direct constructive feedback outside the patient’s room.4
- Direct Socratic questioning to the group instead of an individual whenever possible.

Teaching in an FCC environment does, however, have limitations. Some important discussions, such as reviewing extensive differential diagnoses or considering highly sensitive topics, such as abuse, may be better held outside the patient’s room.

CONCLUSIONS
FCR in both inpatient and outpatient settings benefits patients and learners. It has the potential to assist in creating a supportive environment in which trainees learn by watching and listening to their attending physicians, by making mistakes and correcting them, and by connecting with patients and families.
ACKNOWLEDGMENTS
We gratefully acknowledge Drs Janice Hanson, Robert Dudas, and Susan Bannister for their extensive comments and editing.

REFERENCES

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.
FUNDING: No external funding.
Teaching in a Family-Centered Care Model: The Exam Room as the Classroom
Suresh Nagappan, Angela Hartsell and Nicole Chandler

Pediatrics 2013;131:836; originally published online April 15, 2013;
DOI: 10.1542/peds.2013-0489

The online version of this article, along with updated information and services, is
located on the World Wide Web at:
/content/131/5/836.full.html