Improving Trainee Education During Family-Centered Rounds: A Resident’s Perspective

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At 8:00 AM on a busy morning, the pediatrics team begins rounds. The team of 12 providers dons gowns and gloves before entering the room of the first patient, a 9-month-old girl with bronchiolitis. They enter slowly, introducing themselves one-by-one to the patient’s mother. The intern relays the patient’s history, examination, and plan for the day, speaking quietly to avoid waking the patient while the attending carefully examines her. “She seems improved. We will keep monitoring her, but we hope to get you home soon.” The next few minutes are spent answering the mother’s questions. After 10 minutes, the team files out of the room quietly. “Alright, let’s keep moving,” says the senior resident once they re-enter the hallway. “We have 24 patients left and mandatory conference at noon.”

In 2003, the American Academy of Pediatrics deemed family-centered rounds (FCR) to be the standard of care. Defined as conducting attending rounds, including patient presentations and discussions, in the patient’s room with nursing and family present, FCR has improved multiple aspects of patient care. However, both trainees and attending physicians have debated the impact FCR may have on medical education. Although studies have demonstrated residents’ belief in FCR as a forum to hone skills such as communication and professionalism, they have frequently acknowledged a weakness in didactic teaching. Before proposing remedies to this issue, one must ask: why are FCR less conducive to didactic teaching than traditional rounding styles?

Literature on trainee perception of FCR universally cites fear of appearing less knowledgeable in front of patients and families as a barrier to didactic teaching. This fear may lead trainees to forgo asking questions or offering answers to those posed by attending physicians, which results in suboptimal discussion about patient management. In addition, fear of sharing sensitive patient information on FCR also serves as a barrier because trainees attempt to balance the emotional needs of patients and families with the need for frank clinical discussion. Anecdotally, this is particularly true when it comes to discussion of appropriate differential diagnoses, especially when a difficult diagnosis such as malignancy is possible. These fears often lead to a modified presentation of the patient’s clinical picture, with more emphasis placed on patient and family comfort than trainee education. Residents should feel
empowered to express concerns about discussing these issues in the room and encourage appropriate discussions before entering. Although the American Academy of Pediatrics definition of FCR does not include these types of modifications, we believe that reworking this definition to tailor FCR to particular clinical scenarios will be an important step in improving the educational quality of rounds.

Another barrier to didactic teaching on FCR is lack of time, a problem compounded by the fact that residents cite FCR as a less efficient method of rounding.2, 4 One of the strengths of FCR is the forum it provides for direct communication with patients and families, a time-consuming but critical aspect of patient care that should not be sacrificed. Although families should not be denied the opportunity to participate in rounds, recent literature demonstrates that individual patient and family expectations of FCR vary dramatically.5 For example, one patient may prefer to hear the entire presentation, and another may prefer to hear only the plan. Outlining these expectations before rounds, perhaps through a standardized process of education about FCR at the time of admission, would not only increase satisfaction but create more time for teaching. In addition to improving efficiency on a patient-to-patient basis, we believe that teaching on rounds would be optimized by reducing patient censuses through the creation of more inpatient teams and enforcement of census caps. Decreased numbers of team members and fewer patients would allow for more intimate patient discussions and increased time for teaching. Although we recognize that this would be challenging because more attending physicians would be required on service, it is an important consideration in the current climate of underfunding of graduate medical education, particularly when the next step may be a costly increase in the length of residency to ensure adequate training. Regardless of the intervention, changes that address time management issues are incredibly important to provide ample opportunity for teaching on rounds.

We have certainly experienced these barriers to didactic education on rounds; however, we have also been privy to excellent bedside teaching, highlighting the variability of the FCR experience. Although resident discomfort and time constraints are consistently recognized as the greatest barriers to teaching, studies have cited attending style as the key factor in determining residents’ satisfaction with their educational experience.2-4, 6 Although it would be difficult to standardize rounding, further study to identify specific skills that promote educationally effective FCR could allow for training in these areas. We believe that skills such as bedside physical examination teaching, effective communication, and encouragement of trainee autonomy would be viewed by residents as strengths of educationally stimulating attending physicians. In particular, when an attending is able to help set family expectations of FCR as a means for simultaneous communication and learning, the trainee is often empowered to share their clinical impressions more freely, providing opportunities for bedside education. Although it may be difficult to adjust attending style, identifying and developing these qualities may help to accommodate learners and should be a top priority in medical education.

Although attending physicians are generally responsible for education on rounds, trainees are also key players in improving the educational value of FCR and should continuously seek teaching, even when not readily offered. If it is not appropriate with the patient or family present, questions should be posed between patient rooms. If time constraints are limiting these discussions, we should aim to identify modifiable inefficiencies of rounds. For example, residents at our institution found the time it takes our large hospital medicine teams to enter and exit patient rooms as a frequent source of wasted time and developed a quality improvement initiative targeting easier access to personal protective equipment in an attempt to expedite these processes. Although seemingly small, remedies for these issues can result in more time for teaching, particularly on days with high censuses. Finally, providing feedback to attending physicians and senior residents about education on rounds is an important responsibility of the trainee because addressing issues in real time allows for immediate improvements to be made. Although this is understandably uncomfortable, having mechanisms in place for this type of feedback to occur regularly and without fear of punishment is critical if continuous improvement is to be made to FCR.

There is no denying that FCR have become an integral part of pediatric medicine since becoming the standard of care more than a decade ago. However, nearly 13 years and several duty-hour reforms later, the practicality of maintaining the status quo is called into question when attempting to balance resident education with safe and effective patient- and family-centered care. With barriers such as time constraints in mind, trainees and attending physicians must seek to find new ways to incorporate teaching into rounds. Perhaps most important, teams must work with families to determine what “family-centered” means to them, providing them with a rounding experience that is tailored to their needs, while simultaneously reducing wasted time
REFERENCES


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ABBREVIATION

FCR: family-centered rounds
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