Things We Do for No Reason™: Card Flipping Rounds

Daniel N Ricotta, MD, FHM[1,2,3]*, Jason A Freed, MD[1,2], Andrew J Hale, MD[4]

[1]Department of Medicine, Beth Israel Deaconess Medical Center, Boston Massachusetts; [2]Harvard Medical School, Boston, Massachusetts; [3]Carl J. Shapiro Institute for Education and Research, Boston, Massachusetts; [4]Department of Medicine, Larner College of Medicine, University of Vermont, Burlington, Vermont.

Inspired by the ABIM Foundation's Choosing Wisely® campaign, the "Things We Do for No Reason™" (TWDFNR) series reviews practices that have become common parts of hospital care but may provide little value to our patients. Practices reviewed in the TWDFNR series do not represent "black and white" conclusions or clinical practice standards but are meant as a starting place for research and active discussions among hospitalists and patients. We invite you to be part of that discussion.

CLINICAL SCENARIO

A 32-year-old man with a history of polysubstance use disorder is hospitalized with endocarditis. The senior resident on the inpatient medical team suggests that the team "card flip" on this patient, citing a large number of patients on the team census, time constraints, and concerns that his substance use history will make bedside rounds uncomfortable.

BACKGROUND

"Rounds" is an inpatient care model in which teams of practitioners assess patients, determine care plans, and communicate with patients, families, and other healthcare professionals.[1] One form of rounds is bedside rounding (BSR) through which an entire patient presentation occurs at the bedside, analogous to family-centered rounds common in pediatric inpatient care.[2] This style of rounding is distinct from "walk rounding" that involves presentations occurring separately from a patient followed by a brief team bedside encounter. BSR is also different from "card flipping" or "table rounding" that involves presentations of a case separately without a team–patient encounter. The frequency of BSR at academic institutions has markedly decreased across the United States, and the time spent at the bedside is only a small fraction of rounding time.[3]

WHY YOU MIGHT THINK CARD FLIPPING IS HELPFUL

There are several reasons to employ strategies such as card-flipping or walk-rounding for discussing patient care away from the bedside. These BSR risks can be organized into patient harm, inefficiency, and risks to healthcare professional training.

First, BSR may result in patient harm. For example, discussing private health information in a semiprivate room may not only be uncomfortable for patients but may also violate patient privacy.[4] Care teams are often large in number and rounding at the bedside can simultaneously trigger anxiety among patients, cause confusion about plans, or result in lack of clarity on the role of each provider.[4] Furthermore, delivering bad news during BSR, or discussing sensitive topics such as substance use, psychiatric illness, or concerns of malingering behavior, may be difficult and uncomfortable.[4,5] Additionally, some potential diagnoses, such as cancer or human immunodeficiency virus, even if unlikely, could induce panic among patients when they hear them being discussed.[5] Trainees may also lose situational awareness because they focus on the agenda of bedside rounds and fail to respond to patients' emotional needs.[6]

Efficiency is another reason to avoid BSR. The systemic factors of changing hospital demographics, such as short length of stay and increasing patient volumes, generate a substantial administrative burden on trainees.[7] Modern trainees are also constrained by work hour restrictions, engagement with mandatory curricula, and other professional development opportunities. Furthermore, changes in a medical work environment cause trainees to rely heavily on electronic health records, which forces them to be at a computer instead of in a patient's room.[8] This confluence of factors results in substantial time pressure, and BSR is perceived as an inefficient use of time.[9]

The impact on education and trainee development is another concern of BSR. Rounding away from a patient ensures a safe environment for learners to interpret data and articulate clinical reasoning without the risk of embarrassment in front of a patient. This time outside a patient room also allows the team to have a shared mental model so that communication is aligned when a patient encounter does occur. Card flipping may result in improved trainee autonomy because the constant presence of attending supervision, particularly in front of patients, can risk undermining resident leadership and patient trust.[9]

WHY WE SHOULD RETURN TO THE BEDSIDE

The cited reasons for provider hesitancy to BSR, including possible patient harm and inefficiency, may be mostly related to individual perceptions and have recently been questioned.[10,11]

Several studies have suggested that bedside rounds may be

*Corresponding Author: Daniel Ricotta, MD; Email: dricotta@bidmc.harvard.edu; Telephone: 914-584-7228; Twitter: @DanielRicottaMD

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better for patients' experience over traditional walk-rounding or card-flipping models. In these studies, patients signal a preference for bedside rounds and suggest that discussing sensitive issues or concerning differential diagnoses during BSR may not be as concerning as physicians worry.[11] For example, one randomized trial found that 87% of patients are untroubled by bedside discussions,[12] and another trial revealed no difference between rounding models in emotional distress to patients or families.[11] Patients and families also report higher levels of clarity from physicians, and they cited significantly improved levels of understanding their illness[10] and test results.[9] Furthermore, patients describe that physicians spend about twice as much time on their care when BSR is used.[12] In many related studies, patients report a preference for BSR as a rounding strategy.[2,11-13] For example, one study found that 99% of patients prefer BSR.[13] Another study showed that 85% of families request to be part of bedside family-centered rounds over traditional walk rounding.[2]

Rounding away from a patient via card flipping or walk rounding seems more efficient, but this idea may be illusory. Although these strategies may seem faster, the lack of communication and coordination between team members and the patient may cause inefficiencies and delays in care throughout the day.[14] For example, one study has demonstrated that family-centered bedside rounds are about 20% longer than walk rounding, but everyone involved, including housestaff, felt it was more efficient and saved time later in the day.[2] Additionally, a study comparing BSR with walk rounding[13] found no difference in time spent per patient, and another study has shown similar results in terms of family-centered rounds.[15] Both studies have reported a similar amount of time spent per patient.

Physicians should return to BSR not only to improve patient experience but also to develop the clinical skills of trainees. The direct observation of trainees with patients allows high-level impactful clinical feedback and provides a basis for calibrating how much autonomy to allow.[16] Trainees also indicate that teaching is more impactful during BSR than during walk rounding or card flipping, and clinical skill training during BSR is superior to a discussion in a conference room or a hallway context.[2,3,15,17,18] One study has even suggested that the education of bedside rounds may help improve clinical skills in comparison with traditional models.[18]

The lack of BSR during medical school and residency training results in a deleterious cycle. Trainees become less proficient and less comfortable with BSR skills and therefore graduate as faculty members who are unskilled or uncomfortable insisting on BSR. As such, the cycle continues. As a result and as the traditional cornerstone of clinical training and inpatient care, BSR is recommended as standard practice by some professional organizations.[19]

WHAT WE SHOULD DO INSTEAD

Developing buy-in is an important first step for engaging in BSR. We recommend starting by demonstrating the value of BSR to overcome initial team or trainee hesitancy. Regardless of systems established to improve the efficiency of BSR, it is our experience that learners hesitantly engage if they do not understand the value of a given activity. We also urge attendings to demonstrate value by articulating how BSR fits in a patient-centered approach to emphasize the evidence-based positive impacts of BSR on patients.[9] Beyond reviewing the benefits, faculty should set an expectation that the team will carry out BSR.[9] Doing so sets an informal curriculum showing that BSR is important and sets the standard of care, which allows an inpatient team to adapt early in a rotation.

Next, faculty should ensure that BSR remains efficient.[9] We believe that efficiency starts by setting expectations with patients. Patient expectations can be set by an attending or a supervising resident and should include a preview about how each encounter will progress, who will be in the room, how large the team will be, and what their role is during the encounter. Patients should be invited to be part of the discussion, offered an opportunity to opt out, and informed that questions arising from or clarifications needed following encounters can be addressed later within the day or after BSR. Nurses should be invited to actively participate during patient presentations. Each bedside encounter should be kept brief and standardized.[20,21] To maximize efficiency, we also believe that roles should be delegated ahead of time and positioning in the room should be deliberate.[22] Team members should know who is speaking when and in what order, who is accessing the electronic health record, and who will be examining the patient. Ideally, goals should be set ahead of time and tailored to each individual encounter. Finally, ensure everyone is on the same page by huddling briefly before each encounter to establish goals and roles and huddle afterward to debrief for learning and teamwork calibration.

In order to mitigate the learner's anxiety about presenting in front of patients, build a partnership with the trainee, and time should be allotted to establish a safe learning environment.[9] Sustain a supportive learning environment by providing positive feedback to learners in front of patients and teams. Faculty members should demonstrate how to bedside round effectively by leading initial encounters and generate momentum by selecting initial patient encounters that are most likely to succeed.[23] Checklists can also be useful cognitive aids to facilitate an encounter and manage the cognitive load of learners.[24] Ultimately, hesitancies can be overcome with experience.

Faculty members should ensure that bedside encounters are educationally valuable for an entire team.[9] This initiative starts by preparing ahead of time, which allows the mental energy during encounters to be directly observed by learners in action.[16] Preparation also allows the presentation to focus more on clinical reasoning rather than data gathering.[20] Faculty members should also consider ways to foster resident autonomy and establish the role of a supervising resident as the team leader. Positioning in the room is critical[22]; we suggest that faculty members should position themselves near the head of the bed, out of a patient's direct eyesight. In this way, they can observe how individual team members and the team as a whole interact with patients. The supervising resident should be at

the foot of the bed, central to the team and the focal point of a patient's view. The presenting intern or student should be seated near the head of the bed and opposite the supervising attending. Clinical teaching should also be kept short and pertinent to the patient, and questions should be phrased as "how" or "why" rather than "what" to reduce the risk of "wrong" answers in front of patients and the team.

WHEN IS CARD FLIPPING APPROPRIATE?

We believe that bedside rounds are most consistent with patient-centered inpatient care and should be considered the first-line approach. We also acknowledge that it is not always possible to bedside round on every patient on an inpatient census. For example, at an average of 13-15 minutes per patient,[2,13] a census of 16 patients can take up to 4 hours to round. This timeline is not always feasible given the timing of training program didactics, interprofessional or case management rounds, and pressure for early discharges. Similar to all aspects of medicine, many approaches have been established to provide patient care, and context is important. Therefore, card flipping and walk rounding are beneficial to patients in some instances. For example, consider BSR for new, sick, or undifferentiated patients or when the history or exam findings need clarification; walk rounding or card flipping is suitable for patients with clear plans in place or when an encounter will be too disruptive to the rounding flow.[21] Census size and individual patient or family concerns should dictate the style of rounding; in most situations, BSR may be equally efficient because it offers significant benefits to patients and families.

RECOMMENDATIONS

- Expectations should be set early with both trainees and patients. Patients should be informed that the team can come back later for more in-depth discussions.
- Trainees should be taught evidence-based approaches supporting the value of bedside rounds for patients.
- Faculty should consider leading initial encounters to demonstrate how to bedside round and to model behaviors.
- Positive feedback should be provided in front of patients and the team to build confidence.
- Encounters should be kept brief and efficient.
- A sufficient space for resident autonomy should be ensured through deliberate positioning, delegation of responsibilities, and huddling before and after encounters.
- Bedside rounds should be educationally worthwhile.

CONCLUSION

BSR is a traditional cornerstone of clinical training and inpatient care. Teaching at the bedside has many established benefits, such as connecting with patients and families, affording educators a valuable opportunity to assess learners and role model, and solidifying medical content by integrating teaching with clinical care. Concerns about bedside rounding may be based more on conjecture than on available evidence and can be overcome with deliberate education and proper planning. We propose several recommendations to successfully implement efficient, patient-centered, and educationally valuable bedside rounds.

For this (and most) patient(s), we recommend BSR. If this BSR is the first encounter, we suggest that the team should start with a more straightforward patient and come back to the new admission after the team has a chance to practice with other patients.

Do you think this is a low-value practice? Is this truly a "Thing We Do for No Reason™?" Share what you do in your practice and join in the conversation online by retweeting it on Twitter (#TWDFNR) and liking it on Facebook. We invite you to propose ideas for other "Things We Do for No Reason™" topics by emailing TWDFNR@hospitalmedicine.org.

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