

Time for change: teaching and learning on busy post-take ward rounds

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Introduction

In the UK, patients admitted to hospital as acute medical emergencies are reviewed by a consultant physician within 12–24 hours of admission. This occurs on a post-take ward round where a problem list is identified, a provisional diagnosis made and a management plan outlined. They have usually been initially assessed by a trainee who then presents the patients to the consultant and other members of the team on the ward round. However, the reality of many post-take rounds is trainees on shifts, who are about to go off duty, with large numbers of patients to be seen many of whom may have been assessed by trainees absent from the round. Nonetheless, the post-take ward round still represents an ideal opportunity to judge how well the trainees are assessing patients, to give feedback to them on their initial management plans and to offer teaching around these acutely ill patients in real-life clinical settings.

There have been recent major changes in UK postgraduate medical education (Modernising Medical Careers) and a change in working patterns influenced by a reduction in working hours by the European Working Time Directive.^{1,2} These have led to a move away from the apprenticeship style of teaching and learning towards a professionalisation of medical education, where an explicit curriculum has been introduced, mapping educational activities onto clinical activities with supervisors who are ‘trained’ in these areas and recording these activities.³ Better educational use of clinical encounters between patients, trainees and their teachers is therefore essential if beginners are to make the best use of their clinical practice.⁴

Literature about learning on post-take ward rounds

For such an important and central activity, surprisingly little has been written or researched regarding learning opportunities on post-take ward rounds.⁵ Most papers have focused on the characteristics of a ‘good’ teacher or ward round. Empathy to the needs of trainees, interest in facilitating their learning, improving time management, presenting succinctly, providing feedback, encouraging questions, allowing a degree of trainee autonomy and the importance of role models have been

stressed.^{6–8} Video recording of ward round styles confirmed the role of questions in enhancing learning by trainees.⁹ Planning before ward rounds, understanding (‘diagnosing’) the learner’s starting point and post-round reflection have all been seen as important.^{10,11}

More recently, Fish and de Cossart have explored clinical thinking and how to develop it in trainees.¹² They advocate moving towards a research model of education where the aim is to enable learners to explore understanding. However, time pressure preventing reflection often militates against this.

Viewing consultants as role models has demonstrated the importance of a positive attitude to trainees, compassion, good relationships with patients, enthusiasm, clinical competence and openness and integrity.¹³ Learning from role models occurs through observation and reflection and is a complex mix of conscious and unconscious activities.¹⁴

With all these factors in mind, this piece of research explored the learning opportunities on post-take ward rounds, from the learner’s (trainee) perspective and how these might be incorporated into the realities of current clinical practice.

Methods

Context

The context for this research was a small-to-medium sized UK district general hospital serving a population of 250,000, providing a full range of acute services. The department of medicine at the time typically admitted approximately 35 patients over a 24-hour period. The medical staffing comprised 16 foundation year 1 (F1) doctors, 17 senior house officers (SHOs), 10 specialist registrars (SpRs) and 15 consultants.

Participants and methods

The author facilitated five groups of trainees (with individual trainees chosen randomly) at three different levels using a series of focus group interviews to explore their experience of post-take ward rounds. These three groupings represented the three main phases of hospital training and were as follows:

- two groups of F1 doctors (four in each). These doctors were chosen as they had only recently qualified (nine months earlier). These doctors carry out much of the ‘routine’ day-to-day care of medical inpatients, who form the main patient group assessed on the consultant post-take ward rounds, the central focus of this research

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- two groups of SHOs, comprising five doctors
- one SpR group of four doctors (whose experience and needs differed from the other groups as they were in their higher specialty training years).

There were 11 female and six male doctors, a reasonable reflection of the current gender mix in hospital medicine. All of the F1 doctors had worked for at least two different consultant physicians. Three of the F1 doctors had worked with the author in the past but also for a least two other consultant physicians. None of the SHOs had worked for the author and only one of the SpRs had done so.

The group interviews took place in seminar rooms in the postgraduate education centre. A number of pre-prepared topics to discuss were available, but the discussions were allowed to flow as much as possible, as issues arose on the day. Each session of approximately 1.5 hours was audiotaped. A written transcript of these interviews was produced and checked by participants for accuracy. Ethical approval for the study was obtained.

Method of analysing transcripts data

Each focus group transcript was analysed line by line to develop the emerging themes. These were then grouped into 10 broader categories for further analysis. From these categories a general outline of the findings from a trainee's perspective of post-take ward rounds was acquired, using weightings obtained from the frequency with which they occurred in the transcripts.

Methodological considerations

A flexible research design was used to pursue the research question, using a single case study focus group approach.^{15–17} This was the most suitable method as the question continually evolved as data gathering began. Focus group interviews, in common use, are an efficient way of getting people talking about a subject. In addition, more sensitive issues can be raised and discussed by the group providing a degree of mutual support.^{18,19} The author was also aware of (and strove to allow for) his own potential influences on interviewees given his interest in medical education and position within the organisation.

Results and analysis

Time and preparation

Major time pressure felt by all members of the teams was one of the most frequent themes, thus F1 M commented '...so I guess there is a mentality on post-take ward rounds just to get through it as quickly as you can anyway...'

None of the trainees interviewed had ever had their purpose or what to document from them in the patient's notes made clear at the start of their posts. The F1 doctors remarked on the

lack of preparation at medical school for post-take ward round activity with SpR G recalling:

We had a medical student just before Christmas who had never been attached to a firm or been on a ward round...she actually gained an enormous amount just by being able to be part of the team and learning how doctors do work together.

Teamwork

There were several times in the discussions when the SpRs spoke of the value of teamworking with many commenting that they learnt from their team, particularly by the other members of the team being aware of their starting point of understanding in a clinical situation or on a post-take ward round. Thus SpR K remarked '...that is how you learn and that's how your team know what you need help with'.

Trainee autonomy

Post-take ward rounds occurring shortly after admission reduced the opportunities for trainees to institute a management plan thereby reducing trainee autonomy. Thus F1 M commented '...you feel that everything you do is because you have been told to do it'.

Teaching and learning

All the trainees valued the opportunities to learn which arose from seeing a consultant re-take part of the history or re-examine the patient. Thus SHO J remarked '...you asked about that, he listened to this, he did that and you think I will pinch that – I will use it next time'. However, F1 F commented 'I do not think anyone has ever seen me examine anything. I could be doing it all wrong'.

Consultant's thinking out loud was valued, thus SpR S said:

Yes I think a defining moment for me as a house officer [an F1 doctor] was when I realised that the registrar and consultant went through exactly the same process in their mind as I do to reach a decision.

The trainees valued feedback when they (infrequently) received it. SHO P stated, '...yesterday he [the consultant] saw 4–5 of my patients [in the afternoon] and it was brilliant because I got the chance to get some feedback'.

A consultant admitting uncertainty was also important for trainees, as SHO A observed:

A more experienced consultant with a lot of experience will feel confident to say that (admit 'I don't know the diagnosis'), others may not want to say that they don't know what is going on.

Regarding discussion away from the patients, F1 L recalled:

Dr Y is very keen on teaching and every time we have done a ward round she wants to sit down with us afterwards and teach us a bit of stuff and have a coffee and go through the list.

Presenting by trainees

All were keen to present to consultants as SHO J commented:

Yes, that's where your learning comes from, because if you say 'well I asked about this' and they [the consultant] will say 'but did you check the other', then you can go 'no' and the next time you will.

However some consultants preferred to read the patient's notes as explained by SHO S, 'I think so they do not get your opinions, they just want the hard facts then they can start to form their own picture'.

Trainee and consultant involvement

Many of the more junior (F1) trainees felt uninvolved in the post-take ward round, seeing their role as one of ensuring that the mechanics of the round ran smoothly, often resulting in their absence organising investigations or finding forms. Only one consultant appeared to insist that all his trainees remained on the round for its whole duration unless a major crisis intervened. His trainees spoke highly of this approach but F1 L felt 'It required a certain "strength of character" on his behalf to bring it about' which he felt some other consultants did not appear to demonstrate.

From the comments and observations of the trainees in the focus groups it is clear that they perceived a wide range of consultant involvement. F1 F remarked:

It really depends on the consultant – if he is just observing [author's emphasis] then you can see that team whiz through in just half an hour. Others you can see that they take more time – you may end up with more jobs to do, but you get a better feel of what is going on.

Consultant styles and role models

Many trainees remarked that some consultants were more holistic than others, for example SHO S who stated:

I think also there are some consultants that you know you trust and you know that they will look at everything [concerning a particular patient] and you do not need to worry yourself about going back and looking at things and some who you might have run into problems with their management plans in the past, particularly if they do not admit this.

Several of the trainees were clearly aware of the influence of role models. F1 E cited consultant R, 'who often bends down and strokes the patient's hand and asks questions in the right way, it's nice' while F1 L remarked:

[Consultant] T has a bit of a chat and a laugh with everybody and discusses the patients and what he was thinking as well – everybody is beautifully sorted out and all is done.

Asking questions

F1 trainees reported that they were rarely asked questions on ward rounds and when they were they found it stressful because

they were often preoccupied or doing other things. The effect of not being asked questions can be quite significant as recounted by SHO P:

...at the start of this year when the house officer was brand new I noticed that the consultant always asked me all the questions and would not ask the house officer anything and the house officer said do you think they just don't like me?

The finding of many junior trainees' reluctance to ask questions of consultants was also striking. When asked whether they were encouraged to ask questions, F1 F replied 'Sometimes – but you don't want to be a pest'. The SpRs were more questioning: 'We ask questions and we get asked questions back'.

Discussion

The major findings from this study were a lack of time, preparation and consultant awareness of the many learning opportunities that were available (and indeed demonstrated by some consultants) on post-take ward rounds. In addition, the less experienced trainees felt uninvolved and therefore unable to benefit from these opportunities. There were many examples of good educational practice occurring but these appeared to be absent from many of these ward rounds.

Post-take ward rounds did not seem to be approached in the same way by many consultants as would an outpatient clinic or special procedure list, yet are just as important clinically and educationally for trainees. Furthermore, the more holistically orientated consultants who would try and take an all round view of their patients, including their social and functional needs, were generally regarded as offering better learning opportunities by trainees. All the trainees were aware of the powerful educational effects of consultant's as role models but were uncertain if consultants themselves were.

The less experienced trainees enjoyed presenting and obtaining feedback and were aware of a variety of consultant styles and involvement. Presenting patients offers an opportunity for a professional conversation between the learner and teacher and affords insight into the trainee's understanding and thought processes, which reading a set of notes rarely does. However, overall they felt uninvolved in the post-take ward rounds and not asking or being asked questions reinforced and reflected this feeling. There may be several explanations as to why consultants do not ask trainees questions, including not wishing to embarrass them in front of their patients and peers, avoiding alarming patients by raising other potentially worrying diagnoses or issues (although this could be overcome by discussions away from the patient eg at handover), the inexorable pressure of time, lack of interest in teaching, trainees not being present on all portions of the ward round and some consultants not appreciating the teaching potential of questions.

The more experienced trainees enjoyed the ward rounds as they were aware of the benefits to be gained from observing consultants practising in an area outside their own field and

especially of 'thinking out loud', which gave them access to a consultant's clinical thought processes.

A key finding to emerge from this research was the concept of the memory of the team being helpful in learning for trainees and is in keeping with the idea of the team being part of a 'community of practice' as previously discussed. This further reinforces the benefits gained by all members of the team remaining on the post-take ward round as was appreciated by trainees

That many trainees were rarely observed interacting with patients by consultants is problematic, particularly as workplace-based assessments are meant to include consultants assessing trainees' history and examination techniques. This is especially troubling as the post-take ward round could achieve this yet the formal (often separate) assessment process usually takes precedence over these informal teaching opportunities in a trainee's eyes.²⁰

Conclusions

This study has demonstrated that a wide range of learning opportunities are available on post-take ward rounds but that many participants appear unaware of them and do not incorporate them into their everyday practice. By sharing this good practice, ensuring adequate time is available and being aware of the power of role modelling, consultants can significantly enhance the learning of young doctors and improve patient care, even on the busiest of ward rounds.

Further research into consultant awareness of these learning opportunities, including themselves as role models and the use of questions in teaching is planned along with an observational study of post-take ward rounds to triangulate these findings.

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