Bedside Interactions from the Other Side of the Bedrail

Kathlyn E. Fletcher, MD, MA,[1,2] David S. Rankey, BS,[3] David T. Stern, MD, PhD[4]

[1]Clement J. Zablocki VAMC, Milwaukee, WI, USA; [2]Division of General Internal Medicine, Medical College of Wisconsin, Milwaukee, WI, USA; [3]University of Cincinnati School of Medicine, Cincinnati, OH, USA; [4]Departments of Medicine and Medical Education, University of Michigan Medical School and VA Ann Arbor Healthcare System, Ann Arbor, MI, USA.

OBJECTIVE: To assess the importance to patients of various aspects of bedside interactions with physician teams.

DESIGN: Cross-sectional survey.

SETTING: VA hospital.

PATIENTS: Ninety-seven medical inpatients.

INTERVENTION: Survey of 44 questions including short answer, multiple choice, and Likert-type questions.

MEASUREMENTS AND MAIN RESULTS: Data analysis included descriptive statistics. The sample was predominantly male, with a mean age of 62. Overall satisfaction with the hospital experience and with the team of doctors were both high (95% and 96% reported being very or mostly satisfied, respectively). Patients reported learning about several issues during their interactions with the teams; the 3 most highly rated areas were new problems, tests that will be done, and treatments that will be done. Most patients (76%) felt that their teams cared about them very much. Patients were made comfortable when the team showed that they cared, listened, and appeared relaxed (reported by 63%, 57%, and 54%, respectively). Patients were made uncomfortable by the team using language they did not understand (22%) and when several people examined them at once (13%). Many (58%) patients felt personally involved in teaching. The majority of patients liked having medical students and residents involved in their care (69% and 64%, respectively).

CONCLUSIONS: Patients have much to teach about what is important about interacting with physician teams. Although patients' reactions to team interactions are generally positive, patients are different with respect to what makes them comfortable and uncomfortable. Taking their preferences into account could improve the experience of being in a teaching hospital.

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Team time at the bedside represents a potential opportunity for learners. Physical examination skills, interviewing skills, and bedside manner are examples of what can be learned at the bedside.[1] On the other hand, patient-centered care is a goal outlined by the 2001 Institute of Medicine report Crossing the Quality Chasm.[2] Becoming more patient centered at the bedside leads to the question, "What do patients stand to gain from bedside interactions with their teams?"

Prior research gives us some insights into patients' perceptions of interacting with their teams. Patients generally report enjoying the bedside experience.[1,3–5] They also feel that they learn during the interactions,[3] but would like to have a more active role in the process.[4]

The prior research on patient-team interactions has some important limitations. Specifically, structured surveys or questionnaires were used, and none of those studies performed rigorous qualitative analysis of the unstructured comments made by patients. Therefore, issues of importance to the patients may have been left uncovered because of the closed nature of the study designs. In response to these limitations, we performed a qualitative interview study in order to determine issues of importance to patients during bedside interactions.[6] In that study, we interviewed 17 patients at 2 hospitals after they had participated in team bedside rounds. The audiotapes of the interviews were transcribed verbatim and analyzed using grounded theory methodology to identify areas of importance to patients about bedside interactions.[7]

Patients identified two major domains: patient-team interactions and team characteristics. Within the two domains, several interesting themes emerged. In patient-team interactions, patients discussed exchanging information with the team, evidence of team caring, involvement in teaching, knowing the team, and bedside manner. In team characteristics, patients discussed team attributes and intrateam communication/collaboration.[6] Using these themes, we designed a survey to provide quantitative evidence about what patients stand to gain from the common occurrence of bedside rounds.

METHODS

The subjects were medical inpatients at the Ann Arbor VAMC during May to June 2003. We obtained lists of internal medicine inpatients from the hospital on days that we collected data. Exclusion criteria included being non–English speaking, under 18, or unable to give consent. The physician teams were contacted to ensure eligibility. Each day after collecting data, we destroyed the patient lists. Hence, the total number of available patients (461) contains overlap because some patients' names appeared on more than 1 day. Bedside interactions at the Ann Arbor VAMC occur at variable frequency, depending on the team. Most patients see at least part of the team together postcall as well as on other days during their hospital stay (e.g., the attending physician may round with the interns on the resident's day off).

The survey consisted of 44 questions including short answer, multiple choice, and Likert-type questions (see Appendix A available online at www.jgim.org). The survey was divided into 9 different sections (see Table 1), including sections about general information from the hospitalization, content areas based on the preliminary qualitative study, and demographic information. Many of the possible answer choices were based on the information from the qualitative study as well.

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Address correspondence and requests for reprints to Dr. Fletcher: Primary Care Division, Clement J. Zablocki VAMC, 5000 W. National Avenue. Milwaukee, WI 53295 (e-mail: kathlyn.fletcher@med.va.gov).

Table 1. Content of the Survey

Survey Section	Question Content
General information	Current hospitalization
Information exchange	Type and amount of information exchanged between patient and team
Caring	Importance of and evidence for team caring
Teaching process	Feelings about bedside teaching
Knowing team members	Familiarity with team
Bedside manner	Aspects of interaction causing comfort or discomfort
Communication between team members	Observations and feelings about team members interacting with each other
Team characteristics	Feelings about team size and composition
Background	Demographic information

We approached eligible patients, and if they were interested in participating, we obtained consent without written documentation. We gave them an information sheet about the study, a pencil, a copy of the survey, and an envelope in which to place the survey upon completion. Patients received a $5 gift certificate for participating. When patients requested help with reading the survey, we read it out loud to them. Analyses included descriptive statistics. We used Stata 8.0 (Stata Corporation, College Station, TX) for all analyses.

This project was approved by the Ann Arbor VA Human Studies Committee.

RESULTS

A total of 461 patient names were recorded on the data collection days. Patient names could have appeared on more than 1 day, because the lists were destroyed daily, making it impossible to calculate a true participation rate. Forty-six patients did not meet eligibility criteria, 29 patients refused, and 187 were unavailable during times the survey was administered (patients were unavailable if they were out of their room, otherwise occupied with medical testing/treatment, or if they requested that we return later, but did not refuse). We collected anonymous surveys from 97 patients who were eligible, available, and willing to complete them. Not all patients answered every question, but the percentages reported represent the entire sample (i.e., the missing data were counted in the denominator).

Demographic information is presented in Table 2. The mean age was 62, 60% were white, and nearly all were men. Mean health status was rated between good and fair. Overall satisfaction with the hospital experience and with the team of doctors were both high (95% and 96% were very or mostly satisfied, respectively). Table 3 shows the issues that patients reported learning about during interactions with the teams, including tests to be done (reported by 79% of patients), new medical problems (75%), treatments to be done (75%), and reason for hospitalization (74%). The 3 most highly rated areas of learning in terms of importance (1–4 scale, 1 =very important) were new problems (1.10), tests to be done (1.14), and treatments to be done (1.16). Most patients (76%) felt that their teams cared about them very much (1–4 scale, 1 =very much), and 84% said that the team caring about them was very important (1–4 scale, 1 =very important) (see Table 4). Patients cited the following as evidence of the team caring about them: when the team seemed concerned, seemed to understand how the patient felt, and demonstrated warmth (reported by 76%, 59%, and 56%, respectively). Many (58%) patients felt very or somewhat personally involved in teaching; only 6% did not like the teaching. Eighty-two patients reported that the team could learn something from them. Based on a multiple-choice question with 7 possible answers including, "nothing" and "other," the most commonly cited points to be learned from patients were information about that patient's medical problem, what it is like to have that medical problem, how patients are different from each other, and examination skills (reported by 59%, 46%, 44%, and 43%, respectively). The majority of patients liked having residents and medical students involved in their care (69% and 64%, respectively, reporting "really like" or "like"). Patients were made comfortable when the team showed that they cared, listened, appeared relaxed, and seemed cheerful (reported by 63%, 57%, 54%, and 50%, respectively). Patients were made uncomfortable when the team used language they did not understand (22%) and when several people examined them at once (13%). Sixty-eight percent of patients prefer to be present when their doctors talk about them, and 88% of those patients wanted to be involved in the conversation.

Table 2. Demographics of Sample

Characteristics	
Mean age, y (n=81)* (range)	62 (22–84)
Race, n (%)	
White	58 (60)
African American	10 (10)
Other/mixed/no answer	29 (30)
Gender, n (%)	
Male	83 (86)
Female	1 (1)
No answer	13 (13)

Not all respondents answered every question.

DISCUSSION

In 1989, Matthews and Feinstein surveyed patients about the importance of certain attributes in physicians.[8] They found that the most important attributes were skill in clinical activities, discussion of findings (e.g., test results), preparation for events (e.g., what will be happening next), and showing concern for the

Table 3. What Do People Learn About During Team Bedside Rounds?

Topic	# (%) Patients Who Learned About This	How Important Is It to Learn About This?* Mean (SD)
Old medical problems	50 (51)	1.87 (0.99)
New medical problems	73 (75)	1.10 (0.45)
Reason for hospitalization	72 (74)	1.31 (0.68)
Tests to be done	77 (79)	1.14 (0.51)
Treatments to be done	73 (75)	1.16 (0.49)
How the hospital works	28 (29)	1.67 (0.81)
How patient is doing	61 (63)	†
What to expect from the condition	57 (59)	†
Nothing	5 (5)	
Other	7 (7)	

1 = very important, 4 = not at all.
†*Did not ask about the importance of these items.*
SD, standard deviation.

Table 4. How Patients View "Caring" from Their Teams

How much does team care about you as a person?*	1.2 (0.46) (74% very much)
How important it is that they care?†	1.11 (0.40) (84% very important)
How do you know that the team cares?	
Aspect of Interaction	**Reporting It as Evidence of Caring, n(%)**
Concern about personal life	34 (35)
Seemed concerned	74 (76)
Seemed to understand how patient felt	57 (59)
Warmth	54 (56)
Don't seem to care	3 (3)

*1 = very much.
†1 = very important.

patient. Several of these themes were voiced again in our study, but this time with respect to attributes of the physician team rather than the attributes of a single physician. In academic medical centers, most patients are cared for by physician teams rather than by a lone physician, making it important to understand patients' expectations from the group interaction. We have confirmed that patients consider important many of the same attributes for the team as they do for individual physicians. We have also been able to take these ideas a step further by showing which attributes make patients feel comfortable and contribute to their sense of the team caring about them.

In our study, we were able to determine some specific actions that made patients feel comfortable with group rounds, a finding which has not been previously reported. Patients were comfortable when the team demonstrated caring, listened, appeared relaxed, and seemed cheerful. On the other hand, some patients felt uncomfortable when the team used language that they did not understand. Previous research has also reported that some patients find the terminology used in bedside presentations confusing.[4] A few patients in our study (13%) felt uncomfortable when several people examined them at once. In addition, patients in our study preferred to be included in the conversations about their care, a finding that is corroborated by other studies.[9,10]

Most patients felt that their teams cared about them as a person, and 84% thought that was important. Patients used different aspects of the interaction as evidence of caring. All the available options were chosen frequently, including the team showing concern, understanding, warmth, and concern about the patient's personal life. Caring is certainly a hallmark of our profession and may be related to trust, as suggested by its inclusion in the Trust in Physician scale.[11] Therefore, knowing how to demonstrate caring could result in greater trust.

In previous studies patients have reported that they learned during bedside rounds, and in our study we have expanded that idea by demonstrating *what* patients think that they learn. Specifically, in four prior studies[1,3–5] patients reported increased understanding about their problem, but no other information about what patients learned was provided. In our study, more than half the patients reported learning about medical problems, but they also often reported learning about the reason for their hospitalization, the tests and treatments to be done, how they are doing, and what to expect from their condition. They especially valued learning about their new medical problems and the tests and treatments to be done in the hospital.

Of particular interest to medical educators is how to involve patients in the teaching process.[12] Although many barriers to bedside teaching exist,[13] previous work has demonstrated that patients generally enjoy being involved in teaching.[3] Our study expands that concept by documenting what patients feel could be learned from them. Aspects of teaching that involved them personally (e.g., information about their medical problems and what it is like to have a specific medical problem) resonated the most with patients. Patients also thought that the team could learn from them about how patients are different from each other as well as physical examination findings. It is important to note, however, that even though many patients felt that the physical examination could be learned from them, having the whole group visit occasionally resulted in feelings of being on display, uncomfortable, overwhelmed, and nervous, which is corroborated by a prior study that reported 8% of patients felt that fewer physicians should be at the bedside together.[4] Of note, our study demonstrates patients' acceptance of students and residents as participants in their care, also extremely important in the educational process.

This study has several limitations. First, it was conducted at a single site with medical inpatients. In addition, most of the participants were male veterans. Because of these sample characteristics (nearly all men and veteran status), the findings may not be generalizable to other settings. However, the sample did contain some heterogeneity in that the age range was 22–84 and several racial groups were represented. The other major limitation is that because the patient lists were destroyed each day, it is impossible to know for certain the exact participation rate. However, in order to have some idea of participation, each day we recorded the number of patients that we thought had been previously approached, and based on that number, we calculated that approximately 64% of available patients participated.

This study sets the stage for future research. Specifically, test-retest reliability of the survey instrument should be established, and its usefulness in other populations should be explored. Ultimately, this survey could be used to assess the efficacy of educational interventions designed to improve bedside communication between patients and teams. It could also be used for evaluating different rounding strategies in various inpatient populations.

In conclusion, this study expands on previous research to make several concrete suggestions for how best to include patients in bedside rounds. First, patients want to be part of the conversations about their care. Second, they appreciate the opportunity to learn about their medical problems and what to expect in terms of tests and therapy. Third, patients look for evidence of caring from their teams, and seeing it makes them comfortable. Fourth, most patients like being involved in teaching, and they have ideas about what can be learned from them. Actively engaging patients in the process of teaching about the experience of (and information about) their illness may be more rewarding for them. Patients have much to teach us about their experience of bedside interactions. To become more patient centered, we must incorporate their insights into our practice of medicine.

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