Physician experiences from patient-centered and team-based ward rounding
- uncovering and exploring emerging paradoxes

Fredrik Bååthe
Sahlgrenska Academy at Gothenburg University
Senior Project Leader / PhD candidate, Region Västra Götaland
The Institute of stressmedicine, Region Västra Götaland

In medias res...

• We need to stop regarding ward rounds as “ordinary and unremarkable”, but in need of our focused attention just as much as the most expensive technology or complex drug treatment. The benefits to quality, safety, effectiveness, efficiency and staff satisfaction would be enormous, and patients would be hugely happier as well.

• Gordon Caldwell, Presentation to NHS Emergency care intensive support team, 2013
Background

• Naturally, as medical practice has changed over the years, the 21st Century ward round will need modification
  — The Lancet, editorial, Oct 2012
• Ward rounding is a central and well establish praxis in hospital care, however methods for running ward rounds effectively and ethically has been given very little attention
  — Launer, 2003
• Research how professionals view changes to ward rounds is important, but very sparse
  — Fiddler et al, 2010

Aim

• To explore physician experiences, after changing to a patient-centered and team-based ward round, in an internal medicine department at a Swedish mid-size hospital.
**Setting**

- Middle sized Swedish emergency hospital
  - A&E, Orthopedics, Surgery, An/Op/IVA, Internal medicine, Geriatric, Psychiatric, Lab, Radiology
  - 1500 employees, 200 beds
  - Care responsibility for 118 000 citizens
- **Internal medicine department**
  - 140 employees, 2 wards with 25 beds each
    - Four 4-bed rooms, three 2-bed rooms and three single rooms
    - Average length of stay approx. 4 days
  - 4000 patients yearly
    - Balance between males and females
    - Average patient age, 67 years

**Context**

- Many unsatisfied with traditional 4-bed rounding
- Physicians outlined a new structure, fall 2008
  - increase patient integrity
  - minimize info-handovers between health prof.
  - finalize tasks related to each patient
- Co-evolution with nurses and Ok! by Head of Dept.
- Pilot-testing during summer 2009
- Launch of new ward round concept, fall 2010

...change of rounding was (and still is) an active process.
Key differences, Previous round vs. New round

<table>
<thead>
<tr>
<th></th>
<th>Previous round</th>
<th>New round</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td>Every day</td>
<td>When there was a special cause</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>4-beds ward-room</td>
<td>Dedicated rounding room</td>
</tr>
<tr>
<td><strong>Patient position</strong></td>
<td>Lying in bed</td>
<td>Sitting in chair (whenever possible - 80%)</td>
</tr>
<tr>
<td><strong>Physician position</strong></td>
<td>Standing next to bed</td>
<td>Sitting in chair</td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td>Each health professional</td>
<td>Team documentation (physician resp.)</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td>Loose, physician decides</td>
<td>Tight, pre-defined work plan</td>
</tr>
</tbody>
</table>

Methods

- Semi-structured individual interviews (45-120 min)
- 13 physicians, variation in seniority and gender
  - 6 consultants (överläkare), 3 female /3 male
  - 3 residents (ST-läkare), 3 female
  - 4 interns (AT-läkare), 2 female/2 male
- Interviews dec 2011-feb 2012 (12+ month of experience)
- Qualitative analysis of transcribed material
  - According to Miles & Huberman, 1994
Results summary

• Physician experiences centered around the changed (humanized) relation with patients
  – A more leveled relation combined with working in a multi-professional team contributed to
    • better informed clinical decisions,
    • less follow up questions from the patients
    • increased professional fulfillment for the physicians

• However, physicians also experienced
  – autonomy reduced with a defined round structure
  – uneasiness exposing potential knowledge gaps

Relational change – physician and patient

• The hierarchical distance between physician and patient was reduced – better interpersonal exchange
• Patients came across more as persons (subjects) compared to previous round experiences (objects)

The patient is now on more equal terms with us, sitting in a chair, instead of us standing next to the bed looking down. Patients can actually ask questions. (Consultant, överläkare)

I believe the patient conversation is much better now. It’s more beneficial, both for me and for the patient. (Resident, ST-läkare)
Working in multiprofessional team
(nurse, assistant nurse, junior doctor, senior doctor)

- More complete patient info, and thus better informed clinical decisions
- Fewer follow up questions from patients
- Shared office limiting quiet-space for pondering

Everything is said in the same room and everyone has heard it. Perhaps the nurse realizes why it’s really important for the patient’s wellbeing to get out of bed as soon as possible. Maybe a nurse asks me what happened with a certain x-ray order, and I had simply forgotten. Care becomes safer in many subtle ways through this way of working. (Consultant, Överläkare)

We talk about things that are really important for the care-process. Like what capabilities does the patient strive for when returning home. Things like that never came up before. (Resident, ST-läkare)

Increased professionell fulfilment

- Working closer to physicians’ professional identity
  – experiencing doing what you were trained to do
- Learning and developing more
- Better relationships with ward personell
- Patients expressions of content

This new way of rounding is patient-centered of course, but also employee-centered, since we all learn and develop better within this new team-based structure. Patients, nurses, assistant-nurses and I as physician get a more solid sense of coherence. (Resident, ST-läkare)

We have had care professionals as patients who have commented. This senior physician, old surgeon, he felt ashamed of never rounding in the way that we now did, during his professional life. (Consultant, överläkare)
Reduced physician autonomi

- Previously the loosely defined rounding structure, provided very limited feedback on individual praxis
  - Senior physicians had previous experiences of "my-way of rounding is the normal way", since everyone around used to adopt to different senior physicians’ individual styles
- New rounding principles - structured and defined

The new round is a defined system, which does not give room for my own way of rounding. It is well known doctors work very differently and always have rounded in very different styles. And here and now we are all supposed to fit in the same model. And that perspective might not suit everybody; comply, do it this way; period!

(Consultant, överläkare)

Exposing potential knowledge gaps in front of others

- There was an experience of new risk as (senior) physician to expose a limit to medical knowledge.
- Previously managed by “humming and walking away”, to consult a colleague, or check literature.

The patient meeting becomes more challenging. Since I can get a question I don’t know, I risk to expose a knowledge limit in front of the patient, but even worse, my colleague, a nurse and an assistant nurse.

(Consultant, överläkare)
Conclusions and further research

- Patient-centered and team-based ward round is a fertile development journey for hospital care!
- Also the “right model” has negative consequences!
- Further research:
  - Physician’s autonomy seems to be impacted, what does a change of autonomy do to the professional identity?
  - How can we better understand the two dichotomies that emerged from equally senior physicians?
  - What experiences do nurses and assistant nurses have of a patient-centered and team-based ward round?
  - What experiences do patients have of patient-centered and team-based ward rounding?

Looking into ongoing research about paradoxical dimensions from the ward round study
Paradox in senior physician understanding of round praxis

I centered (Bio-medical) We centered (pat)
"We need to get a good grip on the situation. And the core source for that is the written documentation. Not only the last notices but, history, lab, x-ray, you name it. Also we need to check with the patient. Gather all the data and then act!"
Consultant (X)

"For me there is a point in meeting the patient without reading the documentation, without a pre-understanding. I focus mostly on the meeting with the patient to get a solid conversation/anamnesis."
Consultant (Y)

Two dimensions in responding

• Seemingly large individual variation, amongst senior physicians about good round-praxis
  – When the new round principles match individual perception (how “I” as physician should act when rounding to be a good doctor) adopting is easier
  – When individual perception does not match the new round principles, adopting seem harder (resistance potentially from challenging professional identity?)
Tentative conclusion...

• A change in knowing and doing, is likely to impact a change in being

• Change processes about the “inner core of clinical praxis”...impacting professional identity, need to acknowledge and organize to facilitate epistemological and ontological development:
  – what knowledge or activities “I need to learn and manage”, in the new ward round (episte.)
  – who “ I am becoming”, in the new round (onto.)

Thank you for listening!
...ways to find out more


• Short film showing the new ward round in praxis
  – http://www.youtube.com/watch?v=o4uD4stBtZo,
  – in Google, simply search for “andra ronden Kungalv”

• Contact: Fredrik Bååthe, +46 (0)736-60 17 10, fredrik.baathe@vgregion.se

Related articles:

• Physicians and managers different mindsets, impact on relation and ways forward: http://www.emeraldinsight.com/journals.htm?articleid=17094267
This study was part of Tvärkraft

Tvärkraft: Trans-disciplinary research about trans-professional development processes in health care organizations
– Granted by VINNOVA 2009-2013

Research group
Lars Erik Norbäck, Project leader, Professor Emeritus, Handelshögskolan, University of Gothenburg
Lotta Dellve, Professor, KTH Stockholm, Professor Borås Högskola
Fredrik Bååthe, Project coordinator, PhD Candidate, VGR, Sahlgrenska Academy, Institute of Stressmedicine, Göteborg
Gunnar Ahlborg, Associated Professor, Institute of Stressmedicine, Göteborg
Åsa Lindgren, Research assistant, PTP-Psychologist, Occupational and Environmental medicine, University Gothenburg

Institutet för stressmedicin

Tack!
fredrik.baathe@vgregion.se
+46 736 60 17 10