Bedside Rounding Strategies Used by Bedside Teachers

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Authors' Reply—We thank Drs. LeFrancois and Leung for their thorough review of our articles and for raising important issues in regards to the definitions of "bedside rounds."

We intentionally chose a purposeful rather than more extreme sampling of bedside teachers for two reasons. First, we sought an information-rich sample of locally identified bedside teachers who have incorporated bedside rounds into their routine, and thus, are most generalizable to academic teaching hospitals. Second, given the paucity of bedside rounds documented in past studies, we were uncertain if the more strict definition would allow for the identification of enough participants without enlisting an insurmountable number of institutions.[1] Ultimately, however, despite the applied definition, most participants included bedside case presentations in their style, and subsequently fulfilled the more strict definition from our prior study.[2]

This group of bedside teachers, already in the minority in that they perform a significant degree of bedside rounds, was experienced with and dedicated to this care delivery method. They agree that *patient engagement*, *progressive problem-solving*, *shared decision-making*, and a *collaborative thought process* are vital to achieving patient-centered care.[3] However, participants were clear that bedside rounds for all patients were neither possible nor optimal. Given the increasing demands of inpatient medicine, including duty hours, clinics, high census loads, increased turnover, high patient acuity etc., time management is not an option, but rather a necessity.[4,5] Attending physicians modify their style (e.g. round on certain days, focus encounters on particular aspects, "read up" prior to encounters) and routinely triage patients for inclusion not because they want to be less patient-centered, but rather, because of the external pressures that require it. Their employed strategies reflect the tailoring and judgment required to integrate bedside rounds into the current structure of inpatient medicine. With 2 hours to round on a team with 14 patients and amidst all the external pressures, are the 15 min for bedside rounds on the clinically stable diabetic patient the *best use* of the team's time? Our participants are telling us "no."

How can we transform inpatient care to achieve a shared decision-making model? The answer should focus on potentially modifiable systems or process factors that can be addressed at the unit-level, divisional-level, and hospital-level and promote bedside rounds for more patients, particularly with less experienced clinician–educators. As identified by Drs. LeFrancois and Leung, this qualitative work has generated numerous hypotheses, investigation of which could assist in the sought-after transformation.

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