Perceptions of Academic Hospitalists Regarding Rounding Methods

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ABSTRACT

Background: Bedside rounding remains a cornerstone of medical education and patient care, yet there are concerns about its efficiency and feasibility. This study explored hospitalists' perspectives on rounding methods and strategies to balance education with effective patient care.

Methods: Academic hospitalists at a Midwest academic medical center completed a survey assessing preferred rounding methods and perceived benefits and barriers.

Results: Of 36 respondents, 33% preferred table rounds followed by bedside rounds, 24% favored bedside rounds, and 21% chose table rounds. Reported benefits of bedside rounds included improved communication, empathy, and shared decision-making. Common barriers included duty-hour restrictions (89%) and scheduled educational activities (86%).

Discussion: Hospitalists value bedside rounding for its educational and patient-centered benefits but also reported several barriers. Findings highlight the need for innovation in rounding methods to overcome these challenges.

BACKGROUND

Historically, bedside rounding has been regarded as a fundamental component of patient care and medical education. It provides physicians an opportunity to enhance direct patient contact while fostering a clinical teaching environment. These bedside interactions between patients and physicians have been shown to improve patient engagement, enhance communication, and increase satisfaction with care, while also benefiting medical trainees' education and contributing to better health outcomes.[1-3]

However, in recent years, there has been a shift away from traditional bedside rounding in favor of alternative methods. This transition has been driven by factors such as time constraints, increasing complexity of patient cases, and the widespread integration of electronic health records (EHRs). The adoption of EHRs, in particular, has placed a greater emphasis on documentation-related tasks, such as early discharge processes and clinical documentation, which often compete with clinical responsibilities during rounding. Patient-related barriers have also contributed to this transition. Specifically, concerns about patient privacy have led some clinicians to question the effectiveness of bedside rounding, particularly in certain clinical settings. Bedside rounding can also increase patient anxiety due to the medical jargon used when discussing clinical cases in front of patients and their families.[4]

Nonetheless, studies have demonstrated the effectiveness of bedside rounding in achieving key clinical metrics, such as improved patient satisfaction. Bedside rounding has also been shown to enhance trainees' clinical skills.[4] Furthermore, research suggests that targeted educational interventions can increase the frequency of bedside rounding without significantly prolonging rounding duration.[5]

Given ongoing challenges in medical education and patient care, this study aimed to explore hospitalists' perceptions of various rounding methods—specifically bedside rounding—and to identify strategies that balance the evolving health care landscape with the educational and clinical needs of trainees and patients.

METHODS

Participants were selected from the Division of General Internal Medicine at a large, tertiary-care academic medical center in the Midwest, known for its high patient acuity and diverse patient

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Box 1. Descriptions of Rounding Approaches

Bedside Rounds
This method involves the physician team conducting rounds at the patient's bedside, directly engaging with the patient to discuss their care. It fosters patient involvement in decision-making and provides trainees with the opportunity to observe clinical exams and practice communication skills.

Table Rounds
In this approach, discussions about patient care take place in a conference room or common area, away from the patient's bedside. It is often more time-efficient and allows for a more structured discussion but may limit patient engagement and the opportunity for hands-on training.

Geographic Rounds
These rounds are organized based on the geographic location of patients within the hospital, grouping patients by their unit or ward. This method aims to optimize time efficiency and minimize walking between patient rooms but may reduce opportunities for interdisciplinary collaboration or personalized care discussions.

Walking Rounds
Rounds in which the health care team discusses patient cases while walking between patient rooms or in hallways, without engaging patients directly in the conversation.

population. Rounding teams typically consisted of attending physicians, residents, medical students, and allied health care professionals, such as pharmacists and social workers.

Inclusion criteria were as follows: participants had to be academic hospitalists currently practicing within the institution. There were no specific exclusion criteria; however, hospitalists on leave or not actively involved in patient care during the survey period were ineligible. We aimed to include a diverse sample to capture a broad range of perspectives.

The survey sought to explore hospitalists' perceptions of rounding methods, including benefits and barriers. Quantitative data were analyzed using descriptive statistics, with all analyses conducted using R version 4.1.2 (R Core Team, 2021). Respondents were asked about their preferred rounding methods (descriptions of rounding approaches are included in Box 1) and their perceptions on suggested benefits and barriers of bedside rounding, using a 5-point Likert scale (strongly disagree, disagree, neutral, agree, and strongly agree). Percentages of respondents selecting "agree" and "strongly agree" were reported. The survey also included an open-ended section for free-text responses, which were reviewed and thematically coded to identify key patterns and insights.

RESULTS

Of the 86 hospitalists surveyed, 36 responded (response rate, 41%). Among respondents, 53% were male and 47% were female; nearly half (49%) had fewer than 5 years of experience as hospitalists. The most preferred rounding method was "table rounds followed by bedside rounds" (33%), then "bedside rounds" (24%) and "table rounds" (21%).

Key perceived benefits of bedside rounds included enhancing communication skills (94%), fostering empathy (92%), and greater patient involvement in shared decision-making (91%). Significant barriers included residents' duty-hour restrictions (89%) and scheduled educational activities (86%) (Table).

Respondents' free-text comments offered several suggestions for improving bedside rounding to better fit modern hospital workflows while maintaining educational value. These included standardizing the format and duration of bedside rounds, aligning patient location with portable computer access, and reinforcing the importance of bedside rounds (Box 2).

Box 2. Key Themes From Bedside Rounding Survey

Educational benefits
- Enhances communication, empathy, and clinical skills.
- Promotes hands-on learning and real-time feedback.
- Increases patient involvement in decision-making.

Barriers to implementation
- Time constraints due to duty hours and workflow demands.
- Geographical distance between patients.
- Technological challenges, such as limited computer access.
- Absence of residents and nonclinical responsibilities.

Preferred rounding models
- Hybrid approach: table rounds for stable patients, bedside rounds for complex or unstable ones.
- Support for walk rounds and interdisciplinary teams.

Recommendations for improvement
- Involve interdisciplinary teams at the bedside.
- Improve scheduling, including early rounds and localized patient grouping.
- Utilize technology effectively (eg, portable computers).
- Consistently reinforce the value of bedside rounds in training.

Institutional support and cultural change
- Need for institutional backing to overcome logistical barriers.
- Promote bedside rounds as a core practice in medical education and patient care.

Table. Hospitalists' Perceptions of Bedside Rounding

Preferred method of rounding (first choice)	
Table followed by bedside rounds	33.3%
Bedside rounds	24.2%
Table rounds	21.2%
Other innovative methods	12.1%
Hallway/walking rounds	9.1%
Benefits of bedside rounds (agree/strongly agree)	
Teaching communication skills	94.4%
Teaching empathy	91.7%
Keeping patient in decision-making	91.4%
Better time management/improved efficiency	40.0%
Sharing medical knowledge/clinical skills	91.4%
Improving patient satisfaction	57.1%
Improving communication with patients with challenging diagnosis	94.3%
Barriers to bedside rounds (agree/strongly agree)	
Time constraints due to resident duty hours	88.9%
Residents' educational activities/didactics	86.1%
The absence of residents (expected or unexpected)	64.9%
Other nonclinical responsibilities of hospitalists	33.3%
Not feeling comfortable/confident as an attending	5.6%

DISCUSSION

Bedside case presentations are recognized as a beneficial teaching tool in medical education while simultaneously improving the patient experience. Our study found that the benefits of bedside rounding included greater patient engagement, improved communication, and enhanced trainee education. These findings align with previous research emphasizing the patient-centered, collaborative environment fostered when patients are directly involved in care discussions.[1,3] This approach cultivates shared decision-making and trust.

We also found that bedside rounding provides opportunities for residents and medical students to develop essential skills—including physical examinations, professionalism, and empathy—critical to their growth as future physicians.[1]

One notable contrast is that while some studies have shown no significant impact on patient satisfaction or decision-making in certain settings, our findings suggest that bedside rounding still plays a crucial role in fostering shared decision-making and patient empathy. This underscores the variability in how bedside rounding is perceived and implemented across health care contexts.

Despite its importance, bedside rounding may not always be feasible. Participants noted that for critically ill patients or those unable to participate in discussions, bedside rounding may offer limited value or raise concerns regarding privacy and consent. Additionally, discussing complex cases using medical jargon can confuse both patients and their families—especially those with language barriers—potentially causing emotional discomfort and misinterpretation of medical information. Furthermore, resident duty-hour restrictions may limit the feasibility of bedside rounding for all patients, consistent with challenges described in prior studies.[4]

In such cases, table rounding offers a structured alternative that facilitates organized education and decision-making in a time-efficient manner. It minimizes time spent walking between different patient locations and discussing cases in busy hospital hallways. Table rounds also allow sensitive patient information to be shared without privacy concerns, which is critical in certain clinical scenarios. Additionally, table rounds can be used effectively for teaching and coordinating care by involving pharmacists, social workers, and case managers to facilitate collaborative care.[2] They also optimize completion of time-sensitive tasks, such as consultations, order entry, and discharges. However, table rounds can disengage patients from the decision-making and reduce opportunities for direct clinical observations.

A balanced approach incorporating both bedside and table rounds is likely the most effective for optimizing patient care and education. Bedside rounds are ideal for acutely ill or undifferentiated patients, whereas table rounds work best for those with clear plans or when minimizing disruption is necessary. By considering patient needs, preferences, and contextual factors—such as overcrowding or case complexity—health care teams can make informed decisions that prioritize high-quality, patient-centered care and effective learning. Our study emphasizes the need for structured hybrid rounding that is effective, efficient, and tailored to faculty experience, learner expectations, and the need to balance teaching, patient care, and resident work hour restrictions. Standardized guidelines and onboarding training for faculty are essential. Rounding methods should also be individualized based on patient lists and learner availability throughout the day.

Recommendations

We recommend implementing hybrid rounding models, developing standardized guidelines, providing faculty training, leveraging technology for efficient rounding, introducing scheduling flexibility, and enhancing patient and family involvement. These strategies can help balance educational needs and patient care while adapting to modern health care challenges.

Nonetheless, the study's mixed-methods approach allowed deeper exploration of qualitative insights, offering a comprehensive and foundational understanding of rounding practices. Survey respondents acknowledged the benefits of bedside rounding for education and patient care, along with significant challenges related to logistics and time management. Addressing these factors through research and institutional policy can refine rounding methods to achieve optimal patient care and medical education outcomes.

Limitations and Future Research

This study has several limitations. First, the sample size was relatively small (36 academic hospitalists), and data were collected from a single institution, limiting generalizability. Second, perspectives of residents and medical students were not included, which would provide a more holistic understanding of this topic. Future research should include longitudinal, multicenter studies or randomized controlled trials to examine logistical barriers—such as coordinating interdisciplinary schedules and securing necessary technology—as well as cultural barriers related to changing long-standing practices or faculty resistance.

Future iterations of this project will aim to collect quantitative data on metrics such as rounding duration, workflow efficiency, patient experience, and clinician/learner well-being. Specific measures include time spent per patient during bedside versus table rounds, patient satisfaction surveys, and assessments of trainee engagement and stress. Combining qualitative and quantitative data will provide a more balanced understanding of the impact of rounding methods, evaluate hybrid models, and explore integration into diverse hospital environments to optimize patient outcomes and education.

CONCLUSIONS

This study underscores the continued value of bedside rounding in medical education and highlights the need for standardized

guidelines, institutional support, and faculty training. Despite variations in experience, academic hospitalists generally view traditional bedside rounding as an essential educational tool. However, they also advocate for innovative structures—such as conducting table rounds before bedside rounds—along with efforts to improve efficiency and effectiveness.

Adjusting rounding methods based on patient needs and learner availability and addressing barriers such as duty-hour restrictions and logistical challenges can enhance both education and patient care. Further research is needed to refine these approaches and improve care quality and educational outcomes. Overcoming barriers to bedside rounding will provide insights into how this practice can evolve, ultimately enhancing patient care, medical education, and overall efficiency.

Financial disclosures: None declared.

Funding/support: None declared.

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