

Questioning Family-Centered Rounds: A Pediatric Resident's Challenge

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With a growing appreciation for patient- and family-centered care (PFCC), pediatrics has eagerly embraced family-centered bedside rounds as a “gold standard.”¹ Family-centered rounds (FCR) are “multidisciplinary rounds that involve complete case discussion and presentation in front of the patient and family so as to involve them in the decision-making.”² Although there is great variability in the execution of bedside rounds in pediatric and adult medicine, the underlying intention is universal: to preserve our focus on our patients and their families.

I agree entirely with this sentiment. And yet, through my training, I have come to realize how FCR may be a disservice to our patients and families as well as an injustice to our learners. As a medical student, I studied PFCC with teen and parent advocates through advisory councils, collaborative research, and educational initiatives. As a resident, I became acutely aware of how FCR may create an illusion of PFCC that fails to meet not only the needs of patients and families, but also the needs of learners.

To be fair, the literature largely supports FCR. Improved patient and family satisfaction, interdisciplinary communication, patient safety, and bedside teaching have been described with FCR in pediatric and adult medicine.^{2,3} However, gaps in our evidence prevail, specifically pertaining to vulnerable patient, family, and learner perspectives.^{4–10} Have we adopted FCR as a standard of care prematurely?

Family-centered rounds aim to incorporate patient and family perspectives into shared decision-making by information sharing at the bedside, but FCR may not optimize this collaboration.¹ I worry that FCR do not respectfully meet vulnerable patients and families at their level (a majority of my patient population), from lower socioeconomic classes, immigrant populations, those with poor health literacy, or those who do not (or minimally) speak English. Several parents have shared with me being unable to recall questions and process medical details in real time during lengthy discussions with large groups on rounds. We know families with limited English

proficiency are often uncomfortable asking for interpreters: How might they feel asking about complicated medical ideas within this daunting setting?^{5,11} Sometimes we adjust who is present at the bedside based on parental requests, but I fear that the structure of FCR does not equitably enable patients and families to know that they can even advocate for such accommodations.

And what about our patients, supposedly at the center of our care? In pediatrics, for example, only 2 studies have explored patient experiences of FCR.^{4,6,11} Children and adolescents had wide-ranging responses to bedside rounds, so shouldn't our default be to tailor FCR to best meet the needs of each patient?⁶ Adolescent patients have apologized to me for feeling too overwhelmed and embarrassed to ask their questions during rounds. I suspect bedside rounds do not empower all kinds of patients and families to participate as we may hope. I acknowledge that these concerns are based on my perception of patient and family experiences as a provider. While including their firsthand perspectives is outside the scope of this article, patient-centered outcomes research invoking the voices of a diverse patient and family population is clearly needed.

Family-centered rounds model communication and demonstrate examination findings, but the bedside may not be an optimal environment for all education.^{7–10} When we promote transparency by discouraging conversations away from patients and families, teaching about what differentiates each patient and the broader context of population-based medical decision-making may be missed. One might argue that this education should be at the bedside, but in my experience, extensive discussions about medicine extraneous to an individual's care can be anxiety provoking for families and may not be in their best interest. Plus, many of my pediatric and family medicine resident colleagues have shared my concern that we cannot comprehend the breadth of an attending's medical thought process through patient-friendly conversations alone. Only by understanding the nuances of individualizing medical management can I someday extrapolate these experiences to the full spectrum of patients I encounter.

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Moreover, FCR may not create psychological safety for learners in medical education. I understood this as an intern when I stood before the parents of a medically complex patient admitted overnight and realized how little I understood about him. I fumbled through our team's plan, struggling to understand our medical decision-making yet feeling unable to ask about it at the bedside. Trainees have expressed concern about appearing less knowledgeable in front of patients,^{7–10} and I worry because parents and I share the expectation that I as a physician will understand the medical decision-making informing their child's care. In fact, 67% of residents were less likely to ask an attending a question about patient management in front of a family, which is concerning, since optimal patient care and education may be stifled at the bedside.⁹

I fear that asking educational questions during FCR risks undermining my patients' trust in me, and I am not alone: 75% of pediatric residents felt "answering questions incorrectly in front of families affects rapport with patients" (I admit that no research exists to say whether families agree, though).⁹ One trainee stated they "hated it when people asked me stuff and I didn't know, and the family's like, 'Wow, there goes all your credibility.'"⁸ Many medical students have confided in me as a senior resident about how distressing FCR can be for early learners when expected to use jargon-free, patient-friendly language with families on rounds while they are still making sense of the medicine. If rounds do not encourage us to embrace our vulnerability as learners by asking questions and making mistakes, are they a safe space that adequately prepares trainees to practice independently?

Somehow, in an effort to resist paternalism, to encourage shared decision-making, and to promote transparency among patients, families, and providers, FCR have become an inadequate compromise between "competing priorities."⁸ In our attempt to satisfy all parties by consolidating communication, we inadvertently sacrifice the needs of each target audience and accept something I feel is suboptimal.

Instead, during brief presentations outside of patient rooms, trainees can safely practice the precise language of medicine that enables us to be meticulous in our understanding and discussion of each patient. When focused bedside conversation is geared entirely toward the patient and family, we can gauge their understanding and adapt our patient-friendly communication to meet their needs. While some may feel that this method reverts to a paternalistic approach, when done thoughtfully, this method can be patient-, family-, and learner-centered.

I believe we can meet our vulnerable patients where they are and create a supportive learning environment for our trainees. For those skeptical, we can start by changing the bedside culture, since FCR are largely shaped by attending styles. Team leaders can mindfully personalize FCR for each patient and family and intentionally create a safe space for trainees to learn. For the sake of our patients, families, and learners, further research is needed to optimize FCR as a standard of care. In the meantime, perhaps we should reconsider the accepted adage of FCR and continue exploring how we can adapt this practice to better train physicians of the future and better care for patients and families of the present.

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