Ideal ward round making in neurosurgical practice.

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Abstract

The success of a perfect ward round lies in the role of the consultant leading the 'round making group' (RMG) as well as the hallmark of effective questioning and participation of each member. Twelve senior consultants with more than 10 years' experience in neurosurgical practice at three different university hospitals were observed during round making by a participant observer. Observations were made on the group climate of the RMG, the leadership pattern and language expressed by the clinician conducting the round and the effectiveness in his performance as a leader during clinical discussions. The group climate showed evidence of good productivity and flexibility with 92% and 75% consultants, pleasantness of climate was above average with only 50% (6/12) and poor objectivity with 42% (5/12) consultants. Forty percent of the consultants were not always very well comprehensible, while only 50% (6/12) spoke exactly fitting the occasion. Only 33% (4/12) of the consultants used humour effectively, while 42% (5/12) spoke unnecessarily in between discussion and were poor in introducing the problems of patient to the round making group. Ward round making in neurosurgical practice needs a holistic approach with motivation, planning, leadership skills and structured curriculum to fulfill its objectives.

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Introduction

Ward round is an integral part of neurosurgical training, as in any other branch of clinical medicine. However, problems inherent to neurosurgical practice make them distinct from other specialities. At one end of the spectrum, a patient with an extradural haematoma would require instant management decision while on the other end, a patient with a congenital anomaly might require a slow wait-and-watch protocol. Hence a neurosurgical ward round needs to be planned with due consideration to these factors and calls for greater organisational skills.

Ward round making does not entail a mere routine visit to the patients but entrusts the clinician with a holistic approach to the patient, the environment around him and the group working for patient welfare. Therefore, ward round making needs motivation, planning and adequate time on part of the treating clinician in order to make it as perfect as possible.

The time table of a ward round should preferably be a defined programme based on the size of the ward, nature of patients and availability of nurses, resident doctors and ancillary staff, e.g. speech therapist, physiotherapist, etc. A closer look at the overall activities involved in a ward round reveals the importance of the role played by the clinician who conducts the round. A perfect ward round would expose various skills involved in the entire process. The present study aims at analysing various factors needed to convert a routine ward round into a perfect one.

Material and methods

The study was conducted on twelve senior consultants with more than 10 years' experience in neurosurgical practice, working at three different university hospitals. For obvious reasons, the concerned neurosurgeons as well as their institutions have been kept anonymous to avoid any sense of criticism.

Observations were made on (i) various aspects of group climate maintained by the consultant-in-charge (CIR) of the round, (ii) leadership pattern and language, and (iii) the effectiveness in performance of CIR as a leader of the group during clinical discussions. Group climate was observed based on various factors, e.g. (a) pleasantness, (b) sense of security, (c) cohesion, (d) purposefulness, (e) objectivity, (f) sense of involvement, (g) communicativeness, (h) productivity and (i) flexibility. These were graded from 1 to 5, 1 being unsatisfactory, and 5 being outstanding.

The CIR had an overall control over the round, hence observations were made on leadership and language pattern. These have a direct bearing on group climate and teaching atmosphere during the round. Leadership pattern was based on qualities like (a) acceptiveness, (b) pleasantness, (c) friendliness, (d) flexibility, (e) liberal attitude, and (f) support for comments by others. These were graded from 1 to 4, 1
being poor and 4 being excellent. The language and comments made by the CIR were judged on (a) fluency, (b) fitting to the occasion, (c) temperateness, (d) comprehensibility, and (e) clarity. These were graded from 1 to 5, 1 being the worst and 5 the best.

The effective performance of CIR during bedside teaching was judged from various angles, like (a) clear introduction of a problem, (b) keeping discussion on beam, (c) speaking only when necessary, (d) depth of knowledge, (e) introducing relevant points when missed, (f) use of humour, (g) acting democratically, and (h) summarising frequently. The performance was scored from 1 to 5, where 1 was the worst and 5 the best score.

Observations were made by a participant observer (who had more than 10 years' experience as a consultant neurosurgeon) on 10 different occasions. The mode value was then found out and tabulated (Tables I to IV).

Analysis of Results

Group Climates [Table I]

Analysis of results show that pleasantness of climate was above average with 6 out of 12 consultants (50%). An equal number of consultants failed to infuse a sense of security in the group while conducting the rounds. Though there was good cohesion amongst members in the majority of the situations (8/12), the feeling of purposefulness was average in 8 out of 12 (66.6%). The group climate demonstrated poor objectivity with 5 out of 12 (42%) consultants and the involvement of members was average with 6 out of 12 (50%) consultants. Cooperativeness in the group was also average with 6 out of 12 (50%) consultants. However, the group climate on the whole showed evidence of good productivity and flexibility with 92% (11/12) and 75% (9/12) of consultants respectively.

Leadership patterns [Table II]

Seven consultants were not acceptive in their attitudes while 6 out of 12 (50%) had poor evaluative nature. Half of the CIR lacked friendliness and flexibility. Only 6 (50%) CIR were liberal in their attitudes, while 5 (42%) were supportive of comments by others.

Language and comments [Table III]

All, except 2 CIR, were very fluent in their expression, while 6 (50%) spoke exactly befitting the occasion. Five CIR (42%) maintained perfect temperate nature of their speech, while 5 consultants (42%) were not always very well comprehensible when they talked. Clarity of speech was above average in all except two.

Effectiveness of leadership [Table IV]

The effectiveness of leadership amongst CIR seemed to vary. Five consultants (42%) were poor in introducing the problems clearly, while 7 (58%) consultants were able to keep the discussions on beam. Five consultants (42%) had the habit of speaking unnecessarily, while two seemed to be ill-informed about their topics. Seven consultants (58%) were above average in their alertness to introduce missed points. Only 4 consultants (33%) seemed to practice humour effectively and also acted democratically. A majority (7/12) had the habit of summarising the facts at the end of discussions.

Discussion

Ward round making is a routine affair in any hospital. However, the skills and personality of the CIR determines the effective conduct of a ward round. Analysis of various facets of round making reveals the possible lacunae in this process.

Being a small close group, interaction of the RMG has a close similarity to a private discussion[1] which provides an ideal situation for effective communication, critical thinking, leadership, good interpersonal relationship and objectivity. Medical students and trainee doctors, who are constituents of the RMG, have an opportunity to integrate the theory and practice of clinical medicine while going through the history and clinical findings of patients. They are constantly stimulated to seek the underlying mechanism behind clinical observations. This forms the basis of problem based medical education.[2][3][4]

Although a serious affair, the ward round should preferably commence on a pleasant note. The entry into the ward should initiate a sense of survey in the clinician's mind. A conscientious clinician should not hesitate to suggest improvements in nursing care and other facilities in the ward.

Doctor-Patient Relationship

The doctor-patient relationship consists of three types of interaction: (i) active passivity, (ii) guidance cooperation, and (iii) mutual participation.[5]

In active passivity type of interaction, the doctor is active and the patient is passive, e.g. in severe head trauma, subarachnoid haemorrhage (Grade IV), and other neurosurgical conditions leading to coma or delirium. The patient is helpless and the doctor carries on emergency management with minimum interaction between the doctor and patient, who is submissive to the doctor and medical staff. However, even if the patient is not in a condition to participate in decision making, the nearest kith and kin must be kept informed about the management plan and time to time progress. The situation is less desperate in guidance cooperation type of doctor-patient relationship. The patient may be ill or in agony, but would like to be aware of what needs to be done for cure, e.g. acute disc prolapse with or without bladder involvement, subarachnoid haemorrhage (Grade I), traumatic paraparesis, etc. In this relationship it is presumed that the doctor knows the best, but the patient should be told the full details about management plans and prognosis. The last relationship is one of mutual participation. This is seen in management of chronic illnesses where the doctor needs the patient and the patient needs the doctor. Conditions like chronic backache, seizure disorders and chronic infections demand such a relationship. However, there can be situations where the doctor simply does what he is told by the patient.[6] This situation is commonly seen where the patient demands a referral to some other hospital or centre.

The CIR needs to keep these types of interactions in mind during round making while establishing rapport with the patient.

Theoretical discussion on clinical problems is a routine affair during rounds. It is essential to forewarn this patient that all the discussion is keeping discussion on beam, (c) speaking only when necessary, (d) depth of knowledge, (e) introducing relevant points when missed, (f) use of humour, (g) acting democratically, and (h) summarising frequently. The performance was scored from 1 to 5, where 1 was the worst and 5 the best score.

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Effective Questioning

Motivation of pupils is the foremost important factor in teaching. As effective learning is based on the formula of perspiration versus inspiration,[10] intrinsic motivation should be aroused in the learning process which would make the pupil perspire willingly. Some persons may be accustomed to speak in small groups while others are timid, shy or afraid of ridicules. Many participants get involved intellectually in the discussion during the rounds, follow what is being said, think about it, but tend to remain silent. The latter must be drawn into active participation by the CIR. The art of questioning is useful to control the discussion and test for consensus. It is necessary to make statements or comments from time to time in order to draw out the silent members, encourage need for personal experience, call attention to consider untouched points and keep discussion focussed on the subject. Two way communication between a teacher and a pupil is classified in terms of interaction analysis technique into teacher talk, pupil talk and silence.[11][12] The teacher talk may constitute phrases, accepting points or statements, asking questions, lecturing and directives or criticism. A judicious use of all these components must be made by the CIR during round making.

In case the CIR finds it difficult to conduct the round, he may modify his attitude through practice of microteaching, in which the whole process of teaching is broken up into a number of separate skills and training[13] and one can analyse the deficits in a better way. Any monopolisation of conversation is to be avoided. Inviting comments through questions are helpful. Discussion amidst a group tends to wander away from the main point. It is very important to keep the discussion focussed on the subject, which was not done properly by 42% of CIR in the present study. Missed points have to be highlighted during the discussion. In the present series, 58% of the consultants maintained this habit. Comments like 'Does every body agree to all what has been said?', 'Can anyone add something more' or some other major (minor) points need to be mentioned. These questions test the strength of a point or view at the same time. The relationship between the status and interperson distance has always been important.[7] The CIR should occupy the right side head end of the bed. The spatial position which members of the RMG occupy have important consequences on their active participation. Position status relationship make some members of the group positively rewarding and others negatively rewarding through conditional avoidance [Figure. 1].

Using Conflicts Constructively

Conflicts situation may arise in a discussion out of aggressive activity related to personality status, obstructive activity by blocking progress through irrelevant talking and sticking too long to a point, recognition seeking by claiming credit for an idea or demanding to be heard, withdrawal from discussion by remaining silent or having side conversation or presenting tangential ideas, competitive activity by arguing and seeking favour from the CIR, or playboy like activity, e.g. cracking jokes or creating distraction.[1] Any situation of conflict during discussion should be dealt with constructively by compromising and mediating activity. Avoidance of conflicting argument is possible by improving communication pattern and giving ample time for participants to clarify, repeat or restate their view points. Willingness to accept criticism with addition of some jokes and humour to the discussion may help to relax the group climate. Both these aspects were not well looked after in the present study (Tables II and IV). It is nice to summarise the talk and make concluding remarks at the end.

Making a perfect neurosurgical ward round is a time consuming and elaborate task requiring adequate planning and leadership skills. It might not be possible to be perfect on the very initial occasions. The need for training in education methodology for consultants and a structured curriculum for any teaching exercise cannot be overemphasised.[8][9] However, with repeated efforts and recognition of one's own lacunae, the CIR may improve upon his skills to make the rounds more enjoyable, effective and attractive for the RMG.

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Ideal ward round making in neurosurgical practice. Article. Oct 2000. Ashis Pathak. N Pathak. Vijay Kak. The success of a perfect ward round lies in the role of the consultant leading the 'round making group' (RMG) as well as the hallmark of effective questioning and participation of each member. Ward round making in neurosurgical practice needs a holistic approach with motivation, planning, leadership skills and structured curriculum to fulfill its objectives. View. 9 Reads. A mathematical outcome prediction model in severe head injury: A pilot study. Article. Apr 2000. Kanchan K Mukherjee. The Ideal Ward Round Group is a Co-Production group and was formed in August 2014. The membership of the group consists of service users, carers, Involvement team staff, advocacy services, the University of Nottingham, consultants, clinical psychologists, nurses, OTs, consultants, peer support workers and other Nottinghamshire Healthcare Trust staff that have not already been included in these groupings. In order to understand the current experience of ward rounds/reviews on mental health wards the group developed questionnaires aimed at four groups; carers, inpatients, patients discharged from hospital, and patients in the community. Twelve senior consultants with more than 10 years' experience in neurosurgical practice at three different university hospitals were observed during round making by a participant observer. Observations were made on the group climate of the RMG, the leadership pattern and language expressed by the consultants. CONTINUE READING. Save to Library.