The business of learning: exploring the junior doctor’s perspective of the medical ward round

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Introduction

The ward round is perhaps one of the best-known activities of the physician. Although the format has evolved over time the enduring image of the Consultant leading the team of juniors from patient to patient, imparting knowledge and wisdom persists. Changing work patterns and the breakdown of the traditional ‘firm’ mean that the teaching round is frequently replaced by the ‘business’ round. Time-pressured junior doctors prioritise getting their work done over participating fully in the ward round.

Is this because they attach limited educational value to the ward round? Do they recognise any learning opportunity from this activity? How do they perceive learning in this environment?

Both Dewhurst (2010) and Claridge (2011) cite time as a barrier to education on ward rounds. Perhaps junior doctors do not recognise the different (and more subtle) learning opportunities that arise from participation. Contrary to the traditional viewpoint that teaching does not occur on ‘business’ rounds, Stanley (1998) demonstrated that it is a feature of all types of ward rounds.

The objective of this study was to gather data through participant observations to evaluate the learning opportunities and barriers to learning on the ward round. This data was then analysed inductively to seek common themes to gain insight into how learning ‘happens’ on the medical ward round.

Learning theory

Lave and Wenger (1991) postulated a model of situated learning that suggested social relationships, participation and situation impact upon the process of learning. They coined the phrase ‘communities of practice’ to describe the way groups of people share a craft or profession.

Within the profession of medicine, professionals of varying years of experience or expert knowledge, mix to share learning. Junior doctors are nearer to the peripheries of these communities of practice and while tacit knowledge (in the form of facts, for example) may be easy to recognise as teaching, the more subtle ‘hidden curriculum’ of unintended lessons may not be so obvious. Role-modelling is a key feature of medical education and perhaps this is where the main focus of the ward round lies.

Materials and methods

This was an ethnographic study. A selection of ward rounds lead by different consultants was observed. Anonymous field notes were made in real-time, whilst the participants carried out their usual duties. These notes were reflected upon immediately afterwards.

Results

A number of common themes that potentially impacted on learning emerged as the data was analysed:

- Number of junior doctors on the ward round
- Junior doctor multi-tasking whilst focused on documentation/jobs
- Fragmented ward round with multiple interruptions
- Consultant-junior doctor relationship influences conduct of ward round
- Learning opportunities may not be obvious
- Rarely more than two doctors (consultant and junior) on the ward round, limited group discussion
- At the bedside, junior doctors completed tasks and documentation rather than observing the consultant
- Interruptions from many sources (nurses, bleeps) causing junior doctors to break from ward round
- Behaviour and engagement of junior doctor markedly different depending on the consultant leading the ward round
- Role-modelling, professional behaviour and the ‘hidden curriculum’ all provide potential learning opportunities during the ward round

Conclusions

The most significant observation emerging from this study is that persistent ‘multi-tasking’ by the junior doctor appeared to pose a barrier to learning during ward rounds.

This could be a consequence of fewer doctors attending the ward round and so therefore having more tasks to complete.

It was also noted that frequent interruptions and an apparent desire to get jobs done during the ward round hindered learning opportunities during ward rounds; this perhaps was occurring as an attempt to reduce workload later in the day.

To the participant observer there were multiple and continuous opportunities for learning during the ward round. However, the junior doctors observed appeared more concerned with task completion and documentation, rather than engaging in case discussion.

This study is limited by the relatively low number of ward rounds in one specialty that were observed. In addition, the author has not directly questioned any of the participating junior doctors about their actions or behaviours on the ward round, but has simply interpreted observations from the author’s perspective.

This perspective is influenced by the author being a junior doctor themselves and from having participated in numerous ward rounds, some of which were conducted by the consultants participating in this study.

The findings of this study may therefore only be applicable in the context of ward rounds within this acute medical unit.

This study could be strengthened by following up the observations with one-to-one interviews with each of the participants, enquiring about their thoughts on the ward round. The interpretation of the observations made by the author may be different to the conscious decisions made by the participants during the ward rounds.

This would not only help to reduce researcher bias, but would also add a further dimension to the data, allowing deeper levels of critical reflection and more objective conclusions to be made.

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References


