

Patient-Centered Bedside Rounds and the Clinical Examination



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KEYWORDS

- Bedside rounds • Relationship-centered communication • Physical examination
- Interprofessional • Patient centered • Medical education

KEY POINTS

- Patients and families prefer bedside case presentations and care discussions.
- Bedside rounds are venues to integrate relationship-centered communication and physical diagnosis skills into the work flow of clinical care.
- Efficient bedside rounds require team and patient preparation.
- Patient and provider experience can improve with bedside rounding.

VIGNETTE 1: THE TEACHING SERVICE

Dr Julie Wells is a newly appointed faculty member at an academic medical center who is preparing for her first block as an inpatient attending. She would like to round at the bedside, but her new hospital has a tradition of conference room or hallway rounds. Dr Wells is wondering how she can convince her new team to give bedside rounding a try.

VIGNETTE 2: THE NONTEACHING SERVICE

Dr George Johnson is a hospitalist at a community hospital. He greatly values the contributions of interprofessional team members in augmenting his evaluation of patients. However, he almost always rounds separately from other providers. Dr Johnson wishes the hospital culture provided more support for interprofessional bedside rounds. He thinks this practice would benefit the team, improve safety, and enhance the patient experience.

Both Drs Wells and Johnson are motivated to conduct bedside rounds with their clinical teams to connect effectively with patients, integrate valuable aspects of the

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Med Clin N Am 102 (2018) 509–519

<https://doi.org/10.1016/j.mcna.2017.12.012>

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clinical examination into the daily workflow, and make the experience beneficial for patients and their loved ones. They want rounds to be both “patient proximate” (at the bedside) and truly “patient centered” (inviting patient participation; Eric Warm, personal communication, 2017.) This article reviews practical considerations and suggestions to conduct efficient, high-yield bedside rounds. Many of the approaches were developed at Wake Forest Baptist Health with funding from the Josiah Macy Jr. Foundation and the Institute on Medicine as a Profession. The strategies for relationship-centered communication grew out of collaboration with the Academy on Communication in Healthcare.

THE DECREASE IN BEDSIDE ROUNDING

Over the past 50 years, bedside rounding has all but disappeared from the wards of teaching and nonteaching services.^{1,2} Changes in medical systems, workflow, hospital culture, and values make Osler’s admonition that there be, “No teaching without a patient for a text, and the best teaching is that taught by the patient himself,” seem like a relic from a prior era.³ In many academic medical centers, bedside rounds have been replaced by presentations of newly admitted patients in a conference room or hallway followed by a brief visit to the bedside to meet the patient and confirm key findings. Care discussions of follow-up patients are relegated to “card flip” without the team laying eyes or hands on their patients. Time at the bedside is estimated to account for 8% to 19% of total rounding time.^{4,5} On nonteaching services, the situation is similar. Providers round separately on their patients, rather than as a team, and care discussions occur in the hallway or conference room rather than at the bedside. As a result, it often seems that attention devoted to the “iPatient” housed in the electronic medical record takes precedence over care of the actual sick person in the bed.⁶

Many factors contribute to the trend away from the bedside. When care discussions focus primarily on reviewing and interpreting laboratory and imaging studies, teams understandably prefer the relative comfort, privacy, and computer access provided in a conference room.^{7,8} In medical systems where efficiency rules, providers may eschew bedside rounding if they think they take more time than hallway or conference room rounds.⁹ Work compression owing to duty-hour restrictions for house staff and hospital mandates for early discharges and decreased durations of stay mean that all providers have less time to talk with and listen to patients and families. One study estimates that interns, on average, spend only 7 minutes per day with each of their patients.¹⁰ The bulk of their day is spent in front of computers rather than with patients.

Patient expectations and preferences are rarely a barrier to bedside rounding.¹¹ Teams are often worried that patients will be overwhelmed by bedside discussions of complex medical issues or upset when sensitive topics, such as substance abuse or pain management, are mentioned in the presence of a large rounding team. Providers may feel uncomfortable about how to manage strong patient emotions, such as anger or grief, and are apprehensive that rounds will be derailed by prolonged discussions of psychosocial issues.¹² Beginning learners are often anxious about making mistakes during bedside presentations.¹² Finally, a generation of clinicians with few or no role models from their own training lack confidence in their own bedside teaching and communication skills.¹³

RETURNING TO THE BEDSIDE

The renewed interest in bedside rounding is evidence based. It reflects the re-envisioning of clinical care that is taking place in many health systems and practices.

PATIENTS AND FAMILIES

Contrary to concerns raised by providers, patients and families overwhelmingly prefer bedside rounds as long as they are conducted tactfully and sympathetically with reasonable attention to privacy and limited use of medical jargon.^{12,14} Patients value time with their providers, and bedside rounds achieve this by transposing discussions from the hallway to the patient's room, where they are literally the center of the team's attention. During bedside presentations, patients are privy to and can contribute to the presentation of their case. By conducting care discussions at the bedside rather than in the hallway, patient understanding is enhanced. Seeing that their team is "on the same page" builds confidence and trust.¹⁵ Most patients are willing participants in bedside teaching and actually enjoy contributing to the education of tomorrow's professionals.

HEALTH SYSTEMS AND TEAMS

Health systems that recognize how bedside rounds can enhance patient experience and facilitate interprofessional teamwork are more likely to promote this model of care. Institutional buy-in is needed to facilitate the systems and infrastructure changes that make bedside rounding possible. For instance, regionalization of patients for each rounding team is essential for efficient rounding and can only be achieved with strong support from hospital leaders.¹⁶ Similar support is needed to overcome workflow and scheduling barriers that make it difficult for interprofessional teams to round together at the bedside.¹⁶

EFFICIENCY

Bedside rounding can be time neutral or even more efficient than other rounding models.¹⁷ Regionalization of patients to one geographic ward saves time wasted in transit. Time is also saved by not repeating at the bedside aspects of the history that have already been presented in the hallway or conference room.¹⁶ At our hospital, attendings on teaching and nonteaching services overwhelmingly view bedside rounding as more efficient and accurate than other models. Time is saved because they seldom need to return to the ward after rounds to confirm findings or hear the patient's perspective; these tasks were already accomplished during rounds. The fear that addressing psychosocial issues will make rounds interminable is not supported by evidence; encounters are more efficient when internists and surgeons convey empathy during office appointments.^{18,19} Other time-saving strategies include entering orders before leaving the room and adhering to realistic time limits for presentations (approximately 5 minutes) and total time in the room (approximately 15 minutes). Efficiency is also enhanced when attendings choose to review admission and progress notes before rounds rather than visiting new patients as "unknowns."¹⁶ The attending physician must be mindful to avoid the cognitive biases of premature closure or anchoring on a diagnosis that could occur with this approach. Advance review provides an opportunity for the teaching physician to guide the team in correcting any inaccuracies in documentation after the history and examination findings are probed and confirmed at the bedside. A bedside synopsis rather than a complete presentation leaves more time for teaching the clinical examination and for engaging patients and families in decision making.^{20,21}

EDUCATION

The literature is replete with articles extolling the advantages of bedside teaching. Grounded in the realities of clinical care, the bedside provides a uniquely engaging

venue to demonstrate, observe, and assess communication and physical examination skills, professionalism, and empathic approaches to patient suffering.^{20–24}

JOY IN PRACTICE

Providers and learners frequently report that bedside rounding reconnects them with the joy and satisfaction of practicing medicine. Relationship-centered communication makes the work more enjoyable, fulfilling, and can reduce burnout.²⁵ Reinvigorated providers become ambassadors for culture change and exemplars for how to conduct bedside rounds in busy clinical settings.

PREPARING A TEAM FOR BEDSIDE ROUNDING

Preparation is essential before teams round at the bedside. The rationale, core principles, evidence base, and necessary skills can be conveyed during orientation sessions. Team leaders benefit from more in-depth seminars where they practice communication skills and try out approaches to teach these skills at the bedside.

Getting buy-in from the rounding team is a critical next step. The following questions prompt teams to explore their concerns and develop a vision for what they hope to accomplish during rounds.

“What Are Your Concerns About Bedside Rounding?”

Getting the team’s concerns on the table and listening to them nonjudgmentally builds mutual trust, promotes honesty, and demonstrates respect for diverse opinions.

“What Can Be Learned Best at the Bedside?”

Teams usually list 2 primary educational objectives:

1. Watching senior clinicians demonstrate physical examination maneuvers, and
2. Learning from experienced clinicians about how to approach challenging conversations.²²

“How Can We Conduct Rounds so That Patients Benefit from the Time We Invest at Their Bedside?”

This question prompts teams to consider how to make rounds that are patient centered as well as patient proximate. This is a good time for the team to discuss relationship-centered communication skills that will elicit what “matters to the patient” in addition to “what’s the matter with the patient.”²⁶

STRATEGIES FOR CONDUCTING BEDSIDE ROUNDS

We approach bedside rounds using the 3-stage process described by Faith Fitzgerald (**Box 1**).²⁷

Before the Bedside

In any clinical setting, a key preparatory step is to plan the rounding strategy before embarking. Team leaders assess work volume and decide if the team will see all patients or prioritize those who need urgent attention, new admissions, and potential discharges.

The next step is to set the stage. Patients must be informed ahead of time about what to expect. In a teaching hospital, this is usually done by the learner caring for the patient. On a nonteaching service, the bedside nurse might be the best person to inform the patient.

Specific educational objectives should be reviewed, roles clarified, and expectations established for team function and efficiency. We suggest setting a target of about

Box 1**Bedside rounds choreography***Before the Bedside*

Prepare the team and get buy-in: What can be learned best at the bedside? How can bedside rounds contribute to patient care?

Set expectations: Positions at the bedside; amount of time for the presentation (5 minutes); total time in the room (15 minutes – can vary based on workflow and objectives); assign who will open the computer and enter orders during rounds; each team member should have a task (eg, critique of the presentation; noticing ICE and PEARLS)

Prepare the patient: Request permission ahead of time; explain the purpose of rounds and what to expect in terms of duration, team size, and teaching; ensure confidentiality.

At the Bedside

Begin well: Introduce the team; have patient introduce visitors; explain purpose; check for patient comfort and minimize distractions; sit if possible; invite patient participation.

Communication pitfalls: Limit medical jargon; use language the patient understands; avoid pejorative labels and practice etiquette; talk with the patient, not just about the patient.

Bedside teaching: Limit the number of teaching points (eg, one each from the history, physical examination, and clinical reasoning); less is usually more; engage all learners; “narrate” the examination while teaching.

PEARLS: Look for opportunities to use at least one of the PEARLS during every patient encounter.

ICE: Inquire about the patient’s perspective; also ask, “How has this illness impacted your life?”

Teach Back: Confirm patient understanding: “How will you explain the treatment plan to your family?”

Invite the patient and family to share other concerns, questions, or needs before leaving the room.

After the Bedside:

Check back with the patient: A team member visits the patient later in the day to assess response to rounds and ask about additional concerns or questions.

Debrief and feedback: The team reflects on the interaction, what was learned about the patient, and what skills were demonstrated; patient care tasks are reviewed and assigned.

Abbreviations: ICE, ideas, concerns, expectations; PEARLS, partnership, empathy, apology/appreciation, respect, legitimization, support.

Adapted from Lichstein PR. Returning to the bedside: notes from a clinical educator. *N C Med J* 2015;76:174–9; with permission.

5 minutes for the bedside patient presentation and a total of about 15 minutes spent at the bedside. Time targets must be flexible depending on workflow demands of the day and service structure. Concise presentations require rehearsal, particularly for medical students who are new to bedside presentations. Decisions about which elements of the history and examination are salient to understanding the patient’s clinical presentation and which can be left out are informed by clinical reasoning as well as the time target. Time targets are more easily met as the team gains experience with bedside rounding. It is helpful if the attending physician reviews the chart before bedside rounds so that the encounter is less focused on information transfer and more time is available for patient engagement and teaching.

We suggest that, before entering a patient’s room, the team consider the following questions:

- What should we know about this patient before we enter the room?
- Do you have any concerns about presenting at the bedside? Any topics or issues that we should know about before entering?
- What would you like us to focus on during the interaction?
- What elements of the history and/or physical examination would you like us to clarify?
- Do you have any concerns about the patient's or family's response to bedside presentation?

At the Bedside

Bedside choreography

We define “bedside choreography” as a standard rehearsed way in which the team enters the room and convenes around the bedside.²¹ The purpose is to set the team up for success in accomplishing its goals in education, patient care, and efficiency. Of course, even the best planned choreography will encounter challenges (eg, the patient is about to leave for a procedure, the intravenous infusion pump is beeping, etc). Flexibility is essential while holding true to patient-centered principles.

Choreography implies that each team member is assigned and knows her or his place at the bedside before the team enters the room. For example, the medical student presenting the case may have an assigned place to the left of the patient with a resident standing next to her. The attending physician may have an assigned place to the right of the patient. Another resident may be in charge of the electronic record and another student may be assigned to critique the presentation at the foot of the bed. The remaining team members may be assigned to observe aspects of the interaction, or demonstrate/practice a physical examination maneuver.

Introductions, etiquette, explanation of purpose, and invitation to participate

First impressions are important.^{28,29} Patients and families are particularly attuned to verbal and nonverbal clues when providers enter their room. They can tell within seconds if a provider is in the moment and truly there to care for them. Knock and wait for a response before entering. Warmly greet the patient by name, introduce all members of the team and then ask the patient to introduce all visitors. “Who do you have with you?” and, “Would you like them to stay or would you prefer that they step out until we're done?” Minimize distractions (eg, turn off the TV), attend to patient comfort, and invite the patient to participate. Inform the patient that one clinician will “man the computer” during rounds to access information and enter orders. Whenever possible, sit down. Sitting expands the patient's sense of the duration of the visit. Finding a chair may be challenging in some hospital rooms, but taking a few moments for the presenter and/or attending to sit is worth the effort. Explain the purpose of rounds and what the patient should expect.

Patient presentation and integration of the clinical examination

Presentation at the bedside should follow a standard format with a set time limit. The format will vary based on whether it is a daily update or an initial history and physical. We prefer for presenters to speak directly to their team but also include the patient in the discussion (80% to team; 20% to patient). Some attending physicians prefer to hear a concise 5-minute summary of the patient's entire history and physical examination. Others prefer to pause after presentation of both the history and the physical examination to integrate demonstration of interviewing or physical examination maneuvers before wrapping up with the assessment, plan, and counseling of the patient.

We encourage the presenter to learn something about the patient as a person and begin the bedside presentation by placing the patient in their life context. “Mr Smith is

a retired farmer from a small town about 100 miles from here and today he's missing his family and his dogs." A bit of "small talk before big talk" conveys respect and interest in the patient as a person rather than a stranger.

Clinical examination teaching can be integrated into bedside rounding in several ways. Use of strategies such as the Five-Minute Moment from the Stanford Bedside Medicine group can be seamlessly integrated in the context of bedside rounds.³⁰ In this model, the teaching physician provides historical context on a physical examination maneuver, demonstrates the proper technique and common errors, and discusses the interpretation of the finding. Effective teachers frequently "narrate" the skills they are demonstrating to maintain learner attention and reinforce concepts. The bedside is also an opportunity for direct observation, coaching, and assessment of communication skills and professionalism. The presence of a warm, "covalent bond" between presenter and patient is evidence that attention has been devoted to building a relationship (Jeff Wiese, personal communication, 2017).

Wrapping up the Visit

In keeping with the adage that the first and last 5 minutes of an interaction are best remembered, we suggest investing in the wrap-up before the team exits the room.

- Summarize findings: Statements should be clear, brief, and use language the patient understands. Clarify medical jargon that the patient may not have understood.
- Chunk and check: Information is best delivered and received in manageable "chunks" rather than longer "downloads." Providers should resist the well-intentioned yet ineffective tendency to launch into extensive information "downloads" that patients and families often find overwhelming, especially when cognitive function may be reduced by anxiety, medication, and illness. The key is dialogue rather than monologue. After each chunk of information, check for the patient's understanding, questions, and concerns. Respond to these before proceeding to the next chunk of information. When possible, link information and explanations to the patient's ideas, concerns, and expectations (ie, the "ICE" questions [ideas, concerns, expectations] discussed elsewhere in this article).
- Teach back is an evidence-based approach to assess patient understanding.³¹ It asks patients to teach back their understanding of what has been discussed and the plan for the day. Teach back is preferable to reliance on nonverbal clues (head nodding) or answers to questions like, "Do you understand what I've been telling you?" Teach back questions we find helpful are:

"How will you explain things to your family when they call later today?" or, "Doctors aren't always the best at explaining things and it's important that we're on the same page. So, please tell me your understanding of what we've discussed"

- Conclude by asking patient and family, "What other concerns or questions would you like us to address before we leave?" End by expressing partnership, appreciation, and support. Let the patient know which team member will be back to check on them and when.

OTHER PATIENT-CENTERED COMMUNICATION TIPS FOR TEAMS AT THE BEDSIDE

Each encounter provides opportunities to use relationship-centered communication skills to elicit the patient's perspective and respond to her or his emotions. The ICE questions are a good starting point for learning about the patient's perspective (**Box 2**).³²

Box 2**Patient perspective using ICE questions***Ideas*

"Many patients have ideas about the cause of their illness and I'm interested to hear about yours."

"What was your understanding of why your PCP recommended that you be admitted to the hospital?"

Concerns

"What worries you about your illness?"

"What are your concerns (or fears) about being discharged home tomorrow?"

Expectations

"What do you hope we will accomplish during your hospitalization?"

Abbreviations: ICE, ideas, concerns, expectations; PCP, primary care provider.

PEARLS: Responding to Patient Emotions

Empathy is conveyed both verbally and nonverbally.³³ PEARLS (partnership, empathy, apology/appreciation, respect, legitimization, support) is a mnemonic for relationship-centered verbal responses developed by the Academy on Communication in Healthcare (**Box 3**).³⁴ Empathy can be conveyed through a reflective statement followed by a pause allowing time for the patient to respond. Reflections shift the focus of the interview from data gathering to acknowledging emotion. With advanced preparation, providers learn to notice PEARLS opportunities during every bedside visit. Although it is not feasible, or even necessary, to respond to every empathic opportunity, we suggest using at least one of the PEARLS during every bedside encounter. In general, respond to strong patient emotions when they arise. If not, they tend to keep coming up.³⁵

After the Bedside

Even 1 or 2 minutes of debriefing after a patient encounter can enhance learning and clarify tasks.³⁶ Interactions can be debriefed immediately after leaving the patient's room (perhaps in the hallway) or at the end of the day. The following questions help to guide the debrief. Ask team members with observation tasks to give their reports on the interaction. "What PEARLS opportunities did you notice?" "How do you think the patient/family experienced our interaction?" Draw attention to instructive aspects of the interaction by asking, "What did you notice about how I responded when tears welled up in her eyes?" or "How successfully did we address the patient's concerns?" Similar strategies reinforce physical examination skills.

Inquire about any final concerns about the interaction, what was learned, what questions remain, and what issues need to be investigated further. We suggest that one team member returns to the bedside later in the day for a quick assessment of patient and family reactions to bedside rounds.

RETURN TO VIGNETTE 1: THE TEACHING SERVICE

Dr Wells meets with her team on the first day of the rotation to discuss the rationale for bedside rounding and gains buy-in. They discuss the elements of bedside choreography, assign team member roles, and review the presentation format and patient-centered communication tools. After the first few patients, Dr Wells sets her stopwatch

Box 3
PEARLS

- **Partnership**
"We'll work together on managing your pain."
"Dr Ellis will be back at 2 PM to talk with you about the results of your MRI."
- **Empathy (reflective statement followed by a pause).**
"I can see it's been really difficult not being able to walk for the past several weeks."
"I can only imagine how complex your life has been."
"Help me better understand how it's been for you."
- **Apology and Appreciation**
"I/we apologize for keeping you waiting. We know you've been anxious to hear the results of your tests."
"I/we appreciate your patience. Your time is valuable."
- **Respect**
"Your thoughts and preferences are important to us."
"We respect all that you've done to manage these problems on your own."
- **Legitimization**
"Many patients get angry when they feel they're not getting answers."
"Most patients hate being kept NPO."
"When patients hear different messages from each provider they often wonder if the left hand knows what the right hand is doing."
- **Support**
"I will be with you each step of the way."
"Please let me know what I can do to help you get through this illness."

Abbreviations: NPO, nil per os; PEARLS, partnership, empathy, apology/appreciation, respect, legitimization, support.

and finds that the team is able to round on a patient at bedside in 15 minutes, while incorporating focused physical examination teaching. Multiple patients and their family members during the first week of the new process comment on how impressed they are with the work of the teaching team and their appreciation for their time and care at the bedside. Dr Wells and her team approach the leadership of the residency program to discuss implementing bedside rounding as a broader program initiative.

RETURN TO VIGNETTE 2: THE NONTEACHING SERVICE

Dr Johnson approaches the medical and nursing directors of his hospital to discuss the potential benefits of interprofessional bedside rounding.³⁷ They decide to pilot joint physician and nursing rounds on his primary hospital unit. Within the first week, the nursing staff note that efficiency is improved, important and clinically relevant findings are discussed between Dr Johnson and nurses daily, and patients report that they feel that "everyone is on the same page." After 3 months, patient satisfaction scores increase and hospital leaders are pleased. Dr Johnson is asked by hospital leadership to lead a task force to make joint physician and nursing rounds standard throughout the hospital.

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