Science and art of teaching rounds in dermatology

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Sir William Osler once said, "Medicine is learned by the bedside and not in the classroom. Let not your conceptions of disease come from the words heard in the lecture room or read from the book. See, and then reason and compare and control. But see first."[1] Bedside teaching has been an important component of medical education, at least for the last few centuries. It serves the dual purpose of enhancing the students' learning experience and delivering quality care to the patients.

In a predominantly "visual speciality" like dermatology, teaching rounds have a special position. The residents acquire the ability to describe skin lesions and to make a diagnosis or differential diagnosis. Also, it improves the communication skills of the residents, both with their colleagues and patients. It also bridges the gap between knowledge and practice to a large extent. The skills of the residents in history-taking and clinical examination improve with teaching rounds. Discussing the problems and issues of a given case and finding an appropriate solution (problem-based approach), will help the residents not only to gather new information but also to apply the same in a real-life scenario. Teaching rounds facilitate the assessment of the clinical knowledge of residents and enable the teachers to suggest remedial measures, if needed. In dermatology, there may be a case for seeing the lesions first followed by relevant history taking. This situation would make the history taking more focused and informative. It would also help to emphasize the morphology of lesions, which is vital to arriving at a diagnosis in dermatology.

Teaching rounds essentially follow a patient-centered approach. They incorporate methods like "*reporting back*" and "*role modeling*'." In the former, the residents present the case to the teacher, who asks questions related to the case under discussion and corrects their mistakes tactfully, without humiliating them. In *role modeling*, the resident observes the teacher and imbibes the attributes that are worth adopting.[2]

A learner-centered model for case presentations, known by a mnemonic called SNAPPS consists of six steps:[3] (1) Summarise briefly the history and findings; (2) Narrow the differential to two or three relevant possibilities; (3) Analyse the differentials by comparing and contrasting the possibilities; (4) Probe the preceptor by asking questions about uncertainties, difficulties, or alternative approaches; (5) Plan to manage the patient's medical issues; and (6) Select a case-related issue for self-directed learning. SNAPPS improves the clinical reasoning of the residents. The Sandwich (commend – recommend – commend) model of feedback can also be effectively incorporated during teaching rounds.

Current status

Many think that the practice of bedside teaching is on the decline. The reasons could be varied and due to the following factors related to physicians, students, or patients:

(1) Physician-related factors: With an increasing caseload, physicians may find it hard to balance patient care and teaching during the rounds. Many physicians are overburdened with administrative responsibilities too. If the consultants do not prepare for teaching rounds or are not in the right frame of mind for it, the quality of learning may suffer.

(2) Student-related factors: The quality of bedside learning could decline if the number of residents exceeds the optimum for effective communication in a group. Poorly motivated residents or those who don't prefer extempore communication in a group may render the teaching rounds less effective.

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(3) Patient-related factors: Some patients do not like to discuss their diseases in a group. Discussing sensitive information like sexual history might be especially embarrassing for them. Some prefer to open up only to consultants or senior doctors. Being subjected to a physical examination by a group of people may also dampen their enthusiasm. Such patients may be perceived as non cooperative by the residents.

(4) General factors: Lack of sufficient space and overcrowding in the wards impair the quality of teaching rounds. So does the lack of time management (with disproportionate time allocation to discuss various patients). In the era of the COVID pandemic, increased barriers in communication due to physical distancing and the use of personal protective equipment have decreased the effectiveness of teaching rounds.

Strategies to improve the effectiveness of teaching rounds

There are several methods to improve the effectiveness of teaching rounds. Some of these are summarised as follows:

(1) Set up goals and objectives for teaching rounds and explain clearly to the residents what is expected of them.
(2) Fix a schedule, allocating sufficient time.
(3) Conduct grand rounds at regular intervals in which all the faculty in a unit participate, so that the residents benefit from the inputs of all.
(4) Observe the interaction between the patient and the trainee at the bedside, and evaluate their knowledge, attitude, and problem-solving ability, and plan future rounds accordingly.
(5) Instruct the residents to make notes of the important learning points generated during the rounds.
(6) Try to be impartial and non-judgmental and give enough opportunities to all the residents during the rounds.
(7) Incorporate techniques such as “one minute preceptor” that may add quality to teaching rounds. This model encompasses five microskills that guide the teaching interaction, namely (a) getting a commitment, (b) probing for supporting evidence, (c) teaching the general rules, (d) reinforcing what was done well, and (e) correcting errors.[4]
(8) Assessment methods like direct observation of procedural skills (DOPS) and other workplace-based assessments may be done in the setting of teaching rounds.
(9) Reflection is one of the adult-learning techniques that is a critical component of medical education. The residents may be encouraged to reflect on their experiences, and the consultant may provide feedback in a supportive environment. This helps in self-directed learning and deepen the understanding of complicated concepts.[5] Pendleton *et al*. put forth a set of rules that facilitates the tutors to provide a constructive feedback to the residents, focusing on the positive aspects first.[6]
(10) Periodic evaluation of the process and instituting necessary modifications, as in any other teaching-learning process, would improve the effectiveness of teaching rounds in the long term.

Declaration of patient consent

Patient’s consent not required as there are no patients in this study.

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Conflicts of interest

There are no conflicts of interest.

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