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Heart of the Matter

Brief Encounters: Hospital Teaching Rounds

BY SIDNEY GOLDSTEIN, M.D.

Recently I was told of rounding schedules in several teaching hospitals that urge physicians to shorten their patient and house-staff contact during rounds and, in some cases, to limit the time to 3-5 minutes per patient. That admonition made me look back on an era when teaching rounds were the foundation of medical education.

The presence at the bedside of the rounding physician, medical students, and house staff represented the integration and application of years of preclinical training to the patient lying before us. Our anxious presentations of the patient's history, our physical findings, and our impressions of the situation to the professor were indelible experiences.

The discussion of the patient's history and the demonstration of physical findings were the essence of that experience. All this was followed by an insightful discussion of the patient's pathophysiology and the treatment plan. It was nevertheless the apotheosis of medical teaching.

That, of course, was in a time when our therapeutic options were limited to a few now-discarded drugs. Much has changed in the interim, driven largely by economics and therapeutic advances.

There has also been the unquestionable need to modify the inhuman work hours of house officers now that we better understand that we often functioned inefficiently, out of sheer exhaustion. But then, the exigencies of care were few, and patients stayed in the hospital for weeks, in contrast to today's cost-driven admission and discharge process.

The hospital has become the center of emergent care that drives the never-ending thirst for bed access. And that drive eats up the time and energy of house officers, who struggle just to keep the assembly line moving. Admission and discharge orders are so telescoped that it is difficult to wedge a progress note into a chart. So it is no wonder that the house officers seek easy answers to complex medical questions, most of which are available on their personal digital assistants. There is a guideline for almost every disease, and if there isn't one, it will soon be written. In the end, all that is required is for house officers to take the laboratory data and plug it into the guideline, and out comes the diagnosis and treatment. If the guideline doesn't quite fit the patient, then one makes the patient fit the guideline. So why would you need any more than 3-5 minutes?

Unfortunately, the patient is eaten up in this process. It is no wonder that many seek additional support from holistic healers, who at least spend time dealing with their disease in totality. William Osler, the founder of modern day medicine, said, "The good physician treats the disease; the great physician treats the patient who has the disease."

The issue in contemporary medical education is how to incorporate Osler's message into medical education. We cannot divorce ourselves from the daily realities of the health care pressures that we face in our hospitals and emergency wards. But we need somehow to reserve space and time for medical education to be brought back to a tradition that integrates the patients and their caregivers, and specifically, time during which the experienced teacher can impart some dimension of patient-centered wisdom to young doctors.

It will, however, take more than 3-5 minutes. ■

Dr. Goldstein, medical editor of Cardiology News, is professor of medicine at Wayne State University and division head, emeritus, of cardiovascular medicine at Henry Ford Hospital, Detroit.

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