Ward teaching (dys)connections

Kenneth M. Flegel

Ward rounds these days are short and focus on the many acute problems of the very ill. When teaching takes place it has to be insisted on, over bell boys, portable phones and Palm Pilots. Getting everyone to the bedside in teaching mode can be a major accomplishment. The teaching had best be arresting and brief.

It was not always this way. In the late 1960s and early 1970s, attending staff still bore the manner of the days before medicare. Hospital work had until only very recently been *pro bono*, done in return for a university appointment and admitting privileges. Though the staff could now at last bill medicare for their visits, their behaviour had not yet changed to today's standard, whereby the attending is on the ward daily and for much of the day. The twice-weekly teaching rounds of former days were glorious occasions that went on for hours around the beds and the chart rack. The visit was a mixture of assurance to the patient that the residents were doing the right things, bedside teaching, academic talk and anecdotes. The attending phsyician had to supervise, teach and, above all, impress. Part of that impressing was accomplished through showmanship.

As a medical student just beginning my clinical years, I quickly discerned that those rounds were the place I had to be. As this was not usually tolerated, I had to use guile. After some sleuthing and discreet inquiry, I found myself on the Saturday morning ward round of the chief of service. A supportive resident instructed me to wear my white, embroidered Royal Victoria Hospital jacket, stand at the back of the group and be silent. If I should be addressed by the chief, my informant advised, I was to answer briefly and simply. We had got to the second room, and the second patient after an hour. The patient, a middle-aged man from somewhere in the United Kingdom, had a straightforward complaint that kept him in hospital for observation but without much need for physician intervention. After chatting amiably with the man about his origins, the chief turned to the horseshoe of residents surrounding the foot of the bed. He was a Newfoundlander, a man of immense stature, who towered over us all. His kindly eyes engaged mine; the horseshoe parted, leaving me fully exposed.

"You, Sophocles, who was the only Canadian ever to be Prime Minister of Great Britain?"

I controlled my plunging lower jaw and generated an answer faster than any modern computer: "I don't know, Sir."

"Bonar Law, son."

I was completely at sea.

"Bonar Law," he assured me, most sincerely. I knew that in some way, the answer must be correct but I had no idea what it had to do with becoming a good physician.

A number of years later, as a junior resident, I was with a cardiology ward round visiting a young man with subacute bacterial endocarditis. He was known to have a drug addiction. The attending, this time a diminutive man with a military bearing, had meticulously examined the young man and carefully explained to him the implications of his predicament. The man was not interested and announced his intention to leave the hospital. Despite much effort to dissuade him, he was determined to leave. The attending physician acquiesced. I protested this decision, vehemently insisting that we had to stop him, to find some way to help him. Outside the room, the attending drew up to me, rested his Statham stethoscope on his chest and interrupted my protestations with a steely gaze.

"Flegel," — at least I had got my surname back — "do you know what happened in the Second World War on the first day that the Germans invaded Poland?" (Note, more history.)

"No, Sir, I don't."

"Well, Flegel, 5000 Germans and 20 000 Poles died. That's what happened."

I was silenced. After cooling off, I set to wondering what I was intended to glean from his reply.

A number of years later, I had risen to the rank of chief medical resident. One of my privileges and duties was to accompany a professor of medicine every Wednesday afternoon to a different medical ward as he taught the residents. An older man, he was engaging and at times inspired, always ready for a spirited debate. Canada's lay press had dubbed him "Master Physician" because of the esteem in which he was held by patients, trainees and physicians. Among his favourite teaching ploys was to hear only the lab results, upon which he would provide a credible history of the patient's illness. Sometimes he performed the reverse trick: on the day that I vividly remember, the residents had presented a man in the advanced

stages of alcoholic liver disease. He proceeded to estimate the total bilirubin, the serum sodium and the glucose to within 5 points of the measured values. The residents were suitably wowed, but I was more inclined to engage him in debate.

"Professor," I said, "knowing about this man's state is well and good but don't you think we should discuss what can be done to help him stop his destructive drinking habit?"

In front of all the house staff, he faced me and said, "Dr. Flegel," — ah, at last! — "do you know what the first thing was that Noah did after spending 40 rainy days and nights on that cramped boat with his extended family and all those beasts?" (Old Testament history this time.)

"No, Sir, I don't." (This answer is always useful and is easy to recall.)

"Well, he planted a field of corn, brewed beer and got completely drunk!" I have long since pondered his remark in my heart.

All these years later, after my own struggles to teach on ward rounds, I appreciate what these men were trying to teach me. Their remarks may appear to have been confrontational, but they were actually delivered in a rather sincere way. I did not feel demeaned by any one of them; I felt challenged to open my mind to something a little larger.

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I think they were trying to teach me something about the nature of professional help. Help is genuine only when it is freely offered and voluntarily accepted. When either condition is absent, control and coercion creep in. Our professional help is one-way; in resolving any conflict, the interests and wishes of the competent patient must prevail. Some patients don't need our help, others don't want it, and still others are unable to accept it. Our professional obligation to look out for the best interest of the patient is constrained by this autonomy. We need to develop the humility to recognize when patients will not be receiving our help and to accept that fact gracefully. That is what I was being pushed to learn on those ward rounds.

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