

## A PIECE OF MY MIND

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## The Road Back to the Bedside

**According to that old story**, a local giving directions to a lost traveler says, "If I wanted to get there, I wouldn't start from here." Medicine finds itself far from the bedside,<sup>1,2</sup> seeking a way back, unsure where to begin.

That we have wandered far afield is plain to see. Core bedside skills of history taking and physical examination—still vital to comprehensive assessment, diagnostic accuracy,<sup>3</sup> and truly patient-focused care—are taught and assessed in the first two years of medical school but largely ignored once the student reaches the clinical years.<sup>4</sup> During residency, development of these skills is assumed when in fact they wither further.<sup>5</sup> The physical examination of newly admitted patients is often cursory and, what is worse, perverted by drop-down boxes into an exaggerated and invented form that reads better than the truth.

Technology drives diagnosis, but it often merely substitutes our fears of uncertainty with delusions of certainty. We seem increasingly chained to the computer, providing perfect care to our virtual patient, the iPatient.<sup>2</sup> More has seemed better than less for so long that we now need a national campaign<sup>6</sup> to alert our patients to "Just Say No" and save themselves from the hazards and costs of diagnostic misadventure. While we all agonize over the spiraling costs of a "Hi-Tech, Lo-Think" approach, many stand to gain from its persistence.

But we have to start somewhere. The way physicians are taught is fundamental to the type of health care they deliver. The road back to the bedside will, we believe, start *at* the bedside, in the way that clinical skills are taught and assessed.

We in the United States stand out among other major Western health care professionals in having a summative postgraduate medical certification process that is entirely dependent on the assessment of knowledge. Elsewhere, for example, the United Kingdom, internal medicine trainees must additionally pass a clinical skills assessment in which independent faculty-level examiners directly observe resident-level trainees assessing real patients.<sup>7</sup> In the States, no high-stakes clinical skills assessment for the purpose of certification in internal medicine has survived. The USMLE Step 2 CS is for many trainees the last time that their clinical skills are objectively assessed, and it ensures that a basic level of competence is attained. But given its current content and standard, it cannot equip internal medicine trainees for future practice and appears to mark an end, not a beginning. Meanwhile, high scores on tests of knowledge directly translate into better career prospects. If "assessment does indeed drive learning,"<sup>8</sup> we should not be surprised if our trainees prefer books to the bedside.

In the absence of a high-stakes assessment of postgraduate clinical skills, we have myriad formative workplace-based tools, but we use them infrequently and inconsistently,<sup>9</sup> perhaps because we doubt their veracity or perhaps because it is difficult enough to find faculty willing and confident in their own clinical skills sufficient to teach or assess residents. Escalating constraints of work hour rules, rapid turnover, and the need for documentation add to the problem. Direct observation is the key to the development of competence<sup>10</sup>; in its absence a resident's expertise in interpreting information gathered is taken to mean that he or she has similar expertise in gathering the information. As matters stand, assessment of residents' clinical skills often appears to be based on little more than the general impression of attending physicians, whose own clinical skills were never directly observed.

Can it really be that an internal medicine trainee passes through his or her entire residency without ever assessing a patient under the direct observation of a faculty-level assessor? What would our patients say if they knew? Much the same, we suspect, if they were told that their pilot had never been vetted in the cockpit.

At Stanford, our interest in bedside medicine and the presence of a visitor (A.E.) on sabbatical from a system where high-stakes postgraduate clinical skills assessment remains the norm, led us to four principles to guide our own efforts to enhance residents' bedside skills and begin on the path back:

1. **Involve Real Patients.** As valuable as "simulated patients"—of humankind or mannequin-kind—can be, the term is only 50% correct: "simulated," yes; "patient," no. Teaching and assessing higher-level clinical skills, such as the ability to discriminate between normal and abnormal in the physical examination, require *real* patients with *real* signs. Our first step is the establishment of a database of patients willing and able to help.
2. **Observe Residents' Practice.** Direct observation and appraisal of trainees by trainers must increase both in informal day-to-day working practice or with new or established tools. We are piloting our own bedside skills assessment, with real patients and faculty-level assessors, modeled on the Membership of the Royal College of Physicians (MRCP) PACES examination, which is conducted worldwide (and for which A.E. serves as chair of the examining board).
3. **Demonstrate Clinical Skills.** Direct observation is a two-sided coin—trainees must also observe the clinical method of their trainers.

*In Workshops:* We devote four morning report sessions each month to a Stanford Medicine 25 session: a hands-on demonstration of a physical diagnosis technique.<sup>11</sup>

*At the Bedside:* Our core group of attendings are our hospitalists, who have taken the lead in our bedside medicine efforts; their continued interest and experience as bedside teachers leverage our efforts. Trainees model themselves on those who train them—if they are to develop and use their own clinical skills, their trainers need to demonstrate how they complement and inform diagnostic thinking and contribute to high-quality patient care in day-to-day practice. Failure to demonstrate clinical skills at the bedside endorses an impression of unimportance; in doing so we imbue our trainees with core skills and a legacy they can pass on to those they will train.

4. Critique and Develop the Evidence. History and physical examination do not provide a diagnostic panacea: overreliance on bedside evaluation will fail just as many patients as overreliance on technological tests. The wise clinician balances both approaches to maximize benefit and minimize error. It is a false strategy to pit the accuracy of bedside evaluation against that of technology.

The question is not whether physical examination alone is better than the chest film at diagnosing pneumonia,<sup>12</sup> but whether physicians who combine both approaches deliver better outcomes to their patients than had they used one approach alone.

Within our individual institutions, academic leadership must ensure that faculty have time and funding to develop their own bedside teaching skills, to deliver relevant teaching and assessment and to center rounds on patients, not computer screens.

Nationally, the internal medicine curriculum must accord clinical skills, particularly physical examination, greater emphasis, and the feasibility, acceptability, and impact of the reintroduction of a high-stakes assessment of clinical skills for residents in internal medicine must be seriously explored. In doing so it must be recognized that we cannot wait for the psychometrically perfect assessment of clinical skills to be found—it does not exist. The best, in this regard, is undoubtedly the enemy of the good.

Every journey must begin with a first step. It is time we took ours.

**Conflict of Interest Disclosures:** The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Verghese reported serving on the speakers bureaus of and receiving royalties from Knopf and Random House and from foreign publishers for translations of his work; receiving honoraria from health care institutions, universities, and literary societies for lectures related to his books and related to medicine; and that some of his work is funded by an unrestricted grant to his institution from Pfizer earmarked for continuing medical education tools for physicians. No other disclosures were reported.

**Note:** This article originally appeared in an earlier issue. We are republishing it in a theme issue marking 40 years of the A Piece of My Mind series in *JAMA*.

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