Physical Diagnosis Rounds

Category: Bedside Manner
written by Henry Schneiderman | September 5, 2023

“But I wanted to learn more about amyloidosis.” No: the stated goal of Physical Diagnosis Rounds is for the intern to become more comfortable interacting with *any* patient, better at building bond every time. The instruction sheet explains that we are only secondarily in the market for giant spleens and diastolic murmurs, much as those captivate.

Young physicians hunger for bedside skills. When one says in debriefing, “I liked how you de-escalated this patient’s anger,” I reply, “Tell me specifics, then you are more likely to grow *your* repertoire.” I’m hoping they will recognize and articulate that sitting down, not looming, makes a difference; that inviting the visitor to stay (if patient wishes) helps; that chosen words, omissions and facial expressions matter; that twenty seconds of human conversation before we barge into diagnosis and symptom burden, makes all the difference. The more such insights are voiced by peers rather than by me, the better they stick and become part of the learner’s active vocabulary.

Idealism and compassion abound; they must be cultivated explicitly. We name them and distinguish them from naivete. Modelling, precept and praise all contribute. We warn the patient that we may report differing findings, but will discuss and resolve. Then each learner examines, briefly and with focus. Constructive criticism is indispensable: correction is delivered with tact and alliance, respect and collegiality. We volubly reject humiliation and embarrassment, embracing transparency and acknowledging that all of us are imperfect. When I ask what was heard, learners answer in ascending seniority lest the verdict of their elder push one, intimidated, to misreport. We are quickest to praise the strength needed to say, “No, there is no murmur”.

We can’t solve the problem of time. But we model good bedside manners. We are specific about best projecting interest and joy in the patient; seeing him or her as the same species as ourselves. More than three learners fosters a circus, encourages surreptitious cell phone checks, side conversations and destruction of needed intimacy. Running such rounds offers the retired doctor an opportunity for legacy, via taking the time and effort to be rigorous and personable to patient, family, nurse and housestaff. And by teaching the next teachers: Chief Residents. We target housestaff as learners; if the sessions are for medical students only, the cynical will conclude that it is fluff, not the left ventricle of real practice.

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