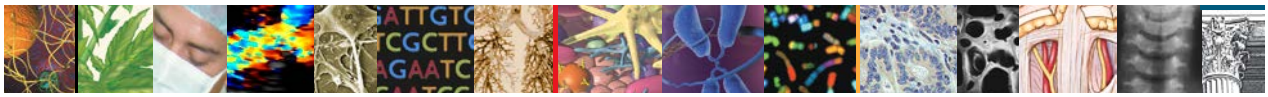

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

JULY 24, 2014

Don't Learn on Me — Are Teaching Hospitals Patient-Centered?

Brendan M. Reilly, M.D.

What she wants seems reasonable enough, a request I've heard from patients before. During my 40 years as a clinician-educator at academic medical centers, I've come to rely on a redoubtable reply: *That's not the way we do things here. This is a teaching hospital. If you don't want residents or students participating in your care, you should go somewhere else.*

This time, though, before I speak, my rote response rings wrong. Mrs. A. didn't choose to come here; an ambulance brought her after she collapsed on the street. Now, as she lies in our emergency department awaiting an inpatient bed, all we know is that she's 82 years old, frail, febrile, and pancytopenic. Telling her to go elsewhere if she doesn't like our rules seems uncaring, even smug. It's also bad medical advice. Whatever Mrs. A.'s diagnosis, I know that I and my team of house staff can help her, not something I can say confidently about "somewhere else."

She needs no convincing on this point. Mrs. A. doesn't want to go somewhere else. She's never been a patient here before, but she respects this hospital's reputation. She just doesn't want "student doctors" taking care of her. She wants "real doctors," not ones who are "still learning."

I don't tell her that I'm still learning myself. Nor do I tell her about the old days when every patient here, even on the white-shoe private service, was considered "teaching material." Back then, of course, the house staff greatly preferred the ward service because there they ran the show, notwithstanding occasional "visits" from teaching faculty. That's one reason why the great public hospitals of yesteryear — Cook County, Charity, Boston City, Bellevue — were so popular among medical students. There, on those teeming open wards (and tubercular fresh-air porches), residents' autonomy was rarely challenged, their professional growth (and confidence as "real doctors") accelerated by peer pressure, personal pride, and undiluted accountability for their patients. Were those patients less safe, less cared for, than patients here and now? It's hard to say.

Today, most teaching hospitals, like mine, staff nonteaching services. These have grown exponentially in recent years as re-

strictions on residents' work hours tighten, caps on teaching census shrink, the number of federally funded positions for graduate medical education remains fixed, and hospital executives (including many trained as physicians) value patient throughput more than medical education. In fact, many academic centers today admit more patients to nonteaching services than to teaching services, despite large government subsidies for their teaching status. These dramatic changes, salutary or not, offer an easy way out when dealing with "demanding" patients like Mrs. A. No longer are the options limited to my way or the highway. *Not a problem, ma'am. I'll arrange your transfer to the nonteaching service.*

And yet, in Mrs. A.'s case, that response doesn't ring right either. Am I really indifferent to these options? Don't I think Mrs. A. will receive better care on the teaching service? Isn't that one reason why I've spent my career in hospitals like this one? I'm a competent clinician — as is every hospitalist who staffs our nonteaching service — but I know I raise my game when I work with residents and students. They make me better — even now, after all these years.

I can't prove it: clinical expertise doesn't lend itself easily to objective measurement, much less controlled trials. (If I could prove it, I would ask patients to give informed consent for admission to the nonteaching service.) But I know it as surely as I remember Mrs. J. in Chicago, whose severe pernicious anemia explained her dyspnea until my intern heard the diastolic rumble I had missed; and Mr. R. in Manhattan, whose raging illness stumped me cold until my resident taught me about familial Mediterranean fever; and Mrs. K. in Rochester, whose near-fatal drug addiction remained undiscovered until my medical student made the effort to bond with her family. Patients' stories are clinicians' lifeblood and conscience; they make us who we are. Shouldn't I tell Mrs. A. who I am? How my student doctors can help her, too?

I'm a competent clinician — as is every hospitalist who staffs our nonteaching service — but I know I raise my game when I work with residents and students. They make me better — even now, after all these years.

But who has the time? I'm busy. So are my residents and students; the last thing they need is a patient who doesn't want them. Besides, even if the evidence of superior quality of care in teaching hospitals was more convincing — and even if we could explain teaching hospitals' lower patient-satisfaction scores[1] — would it matter in Mrs. A.'s case? No less an opinion leader than Donald Berwick has opined that clinicians' best, evidence-based professional judgment "must take a back seat" to patients' wishes.[2] Patient-centeredness, in this view, means that clinicians should give patients what they want even if they don't need it.

The clinical and economic infeasibility of this idea makes me cringe. (Misplaced car keys might become the prevailing indication for brain MRI.) And yet in Mrs. A.'s case, I feel its appeal. Can't doctors both save time and get higher patient-satisfaction marks if we just nod deferentially to "customers" like Mrs. A. and do what they want?

Yes, we can. But as Berwick noted, far from being an easy way out, responsible patient-centeredness presupposes a "mature dialogue" between doctor and patient. Curiosity would seem a minimum requirement. Why does Mrs. A. want what she wants? Why would a patient spurn my residents and students before even meeting them?

Published research has not addressed such questions. It is unknown, for example, how surgeons and procedural specialists in teaching hospitals parry patients' queries about who will wield the scalpel, scope, or catheter in their case. It is also unknown how frequently patients feel reassured by the answers they receive or how faithfully these promises are kept in operating rooms and procedural suites. In teaching hospitals today — some observers wish we called them "learning hospitals" — such issues deserve more attention. Physicians-in-training have expressed well-founded concerns that recent work-hour restrictions might diminish their preparedness for independent practice.[3,4] Might patients' reluctance to serve as "teaching material" pose a similar threat to the quality of our future physician workforce?

But when Mrs. A. answers my question why, she doesn't mention teaching material or guinea pigs. She doesn't dread amateurish invasions of her privacy or the frustration of answering the same questions again and again. She doesn't allude to dark rumors about unsupervised residents run amok. She talks about her late husband's final hospitalization at another academic center. There, she heard often about Mr. A.'s team of doctors, but she never saw them all together. When an intern or student or senior physician popped in, he or she usually came alone and was always in a hurry. Mrs. A. couldn't tell whether they talked to each other because often one didn't know what another one did. And each time her husband needed help at night, a different stranger came.

An audio interview with Dr. Reilly is available at NEJM.org

I transfer Mrs. A. to the nonteaching service, wishing her well. I don't tell her how my team conducts itself here, so differently from what she saw elsewhere. My residents and I will go off service tomorrow, our 4-week rotation over, and I can't promise that the new team will run their show as we run ours. Nor can I promise that the nonteaching service will satisfy her more. After all, her aversion to the teaching service has nothing to do with teaching.

But tomorrow, other patients will ask more pointed questions. Having embraced patient-centeredness with gusto, they'll want to know how clinical teaching benefits them. How should I answer? Will I say that clinical teaching, like its subject matter, is more art than science (and thus lacks gravitas in academic centers today)? Will I admit that this art dances to different drummers (no two teachers teach alike) refereed by recondite rules (no one teacher inarguably better or worse than another)? Will I claim that these are strengths, not weaknesses, and that effective clinical teaching is all about listening (hard to measure), adaptability (hard to judge), and impromptu exploitation of "teachable moments" (hard to plan)?[5] And after we've had our mature dialogue, will these patients buy my assertions? Or will my customers be a hard sell?

Learning hospitals would do well to learn more about these things.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Geisel School of Medicine at Dartmouth, Hanover, NH.

1. Shahian DM, Nordberg P, Meyer GS, et al. Contemporary performance of U.S. teaching and nonteaching hospitals. Acad Med 2012;87:701-8.
2. Berwick DM. What 'patient-centered' should mean: confessions of an extremist. Health Aff (Millwood) 2009;28:w555-w565.
3. Drolet BC, Spalluto LB, Fischer SA. Residents' perspectives on ACGME regulation of supervision and duty hours — a national survey. N Engl J Med 2010;363(23):e34.
4. Drolet BC, Christopher DA, Fischer SA. Residents' response to duty-hour regulations — a follow-up national survey. N Engl J Med 2012;366(24):e35.
5. Reilly BM. Inconvenient truths about effective clinical teaching. Lancet 2007;370:705-11.

DOI: 10.1056/NEJMp1405709

Restoring Trust in VA Health Care

Kenneth W. Kizer, M.D., M.P.H., and Ashish K. Jha, M.D., M.P.H.

It has been nearly 20 years since the Veterans Health Administration (VHA), the subcabinet agency that oversees the Department of Veterans Affairs (VA) health care system, implemented a series of sweeping reforms that markedly improved quality, boosted access, and increased efficiency.[1,2] Recent revelations about long wait times for veterans compounded by systematic coverup by VHA administrators make it clear that reforms are again needed. Apparent manipulation and falsification of wait-time data at more than 40 facilities indicate a serious systemic problem.

To some observers, the VA's problems confirm that government cannot manage health care. To others, they tell a simple story of insufficient funding: the VA needs more money to care for the large number of veterans returning from the wars in Iraq and Afghanistan and for aging Vietnam veterans. Unfortunately, neither narrative adequately captures the challenges facing this organization or provides guidance on how we might address them.

Inadequate numbers of primary care providers, aged facilities, overly complicated scheduling processes, and other difficult challenges have thwarted the VA's efforts to meet soaring demand for services. For years, it has been