Bedside Rounding:
A Perspective from Med-Peds
Amanda Freed

As a Med-Peds resident, I struggled with bedside rounding at first. As an intern I started with three months of medicine, and I got used to rounding outside, then going into the patient’s room to explain the plan and answer questions. It became a habit. Then I switched to pediatrics, where we bedside round on every single patient with only two exceptions—children whose parent or guardian isn’t present and children whose parents decline (usually on heme/onc when they are waiting around for days for the ANC to come up, not wanting to be awoken at 7:30 to hear the same thing day after day). I struggled my first month, when “dyspnea” tumbled out of my mouth out of habit instead of “difficulty breathing”—something parents can understand. I stumbled over my words a lot in the beginning.

The other issue that I see as a source of discomfort with Yale’s new way of rounding is “sensitive topics.” I assure you we have no shortage of those on pediatrics, especially when it comes to teenagers. So, what do we do? I’ve often given the social history outside the room and done the rest inside. Another sensitive topic is when we have a newborn withdrawing from mom’s methadone. Oftentimes grandparents, aunts, uncles, and other family members don’t know about the methadone and can’t understand why this healthy newborn can’t go home.

Bedside rounding is no doubt difficult. We have to find a way to communicate the information that our attending needs to know in a way that our patients understand so that they are also involved. The more difficult part, however, is just breaking the habit. We have to bedside round on every patient every day until it becomes the new normal. Will there be exceptions along the way? Of course. But every time we make an exception, every time we say, “This patient is not a good candidate for bedside rounding,” we make it that much harder to develop our new habit. As the Nike saying goes, “Just Do It.”
**A Reflection on Reflection**
Albert Do

These days I often think about a sick patient for whom I recently cared: Mrs. C was a vibrant, pleasant, elderly lady who died within three hours of arriving in the intensive care unit. I am unable to remember her specific diagnosis, but I do recall that she died. In her case, there was no care mismanagement, no diagnostic mystery, no thrilling acuity, no ingenious heroics. Simply pure, raw emotion: a precipitous decline; a tumultuous family meeting with shouting, wailing, cursing; and ultimately her death. I was left with an unsettling feeling that I missed something. But what it was eluded me, even to this day. Until that event, “What would I have done differently?” was the breadth of my reflective practice, but in Mrs. C’s case, that simply did not suffice. And so, as a defense mechanism, I performed a literature review on the process of reflection.

The practice of critical reflection, defined by Mezirow and summarized by Aronson, is the “process of analyzing, questioning, and reframing an experience in order to make an assessment of it for the purposes of learning (reflective learning) and/or to improve practice (reflective practice).” This process, it turns out, is one of the primary mechanisms of expertise acquisition, engendering professionals whose learning stems from patient care experiences. Intuitively, this makes sense: doing without reviewing is not actually learning. Its five-part composition is outlined in Mamede, referenced below, and appears to suspiciously mirror the scientific method. It has been found to improve professionalism, diagnostic accuracy in complex cases, and better management in complex health care systems. For higher-level residents: You may think this issue is only relevant to students and interns. Wrong. Second-year residents have been found to be more susceptible to availability bias than interns, and this effect corrects with reflective practice.

How to reflect is a tougher question that depends on the individual. The most practical advice is to find something sustainable. Meditating, writing, singing, whatever works. For those interested in teaching reflection, a useful article by Dr. Louise Aronson is referenced below. A useful technique I learned through the pediatrics literature (Butani et al, 2013) involves reflecting upon three domains of patient care: (1) doctor as expert (clinical reasoning and interpretation of clinical/laboratory findings), (2) doctor as scholar (applying scientific data and evidence-based medicine), and (3) doctor as person (exploration of differing perspectives between different stakeholders of patient care: patient, doctor, nurse, and family member).

From Mrs. C, from whom I initially had difficulty reflecting, I ended up learning how to reflect, and also ultimately learned a systematic framework for family meetings (a story for another day), both skills that will remain with me for the rest of my life. I can see no better way to honor her life and the brief time we spent together.

References on Page 4
The Actual Reason for Calling
A Book Review and Discussion of Telephone Medicine: A Guide for the Practicing Physician
Ed. By Anna B Reisman, MD, and David L Stevens, MD
Armand Russo

Dr. Reisman is a Yale General Internal Medicine faculty member and a graduate of the NYU School of Medicine. In addition to her interest in telephone medicine, she directs the Yale Internal Medicine Writer’s Workshop and the standardized patient program at the Yale School of Medicine. She is a talented writer who has published essays in *Slate, The New York Times, JAMA,* Health Affairs, and elsewhere.

**The telephone is the first instrument** in outpatient medicine today. It is, foremost, a tool for triage. We use it to address acute problems and determine whether a patient requires in-person evaluation. The telephone is a patient administrative tool as well. It helps augment issues raised at the office visit, organize home care, discuss chronic treatment, give refills, relay test results, and follow-up patients post discharge.

Getting to the heart of the matter on the telephone is the focus of Dr. Reisman’s book. It covers general features of the telephone interview outlined above as well as more specific issues including chest pain, diarrhea, fever, and headache. When does diarrhea require office evaluation versus emergency evaluation? Is this the actual reason for calling? The book also discusses “difficult patients,” those patients who ramble, become frustrated or angry, and call about seemingly trivial issues. Dr. Reisman discusses some fruitful strategies for being a thoughtful physician to this group of patients. She agreed to offer some insights into her book.

**BB: When did you first become interested in telephone medicine?**

Dr. Reisman: It started with beepers. This was in the mid 1990s, when I was a primary care resident at Bellevue Hospital, before cell phones and E-mail became widely used. We had borrowed beepers that we returned at the end of a rotation. Our clinic patients had no way to contact us. They could leave messages in the clinic but if we were on a rotation where we didn’t have clinic for a month, we’d never get the message. I found this incredibly frustrating. One of my clinic patients was diagnosed with pancreatic cancer when I was on an ICU rotation, but I only learned about it a few weeks later on a night float shift. Another resident was signing out a patient who sounded familiar and I realized, with alarm, that it was him. So I worked with an attending to get permanent beepers for the primary care residents, and – long story short – this triggered my interest in doctor-patient communication – especially the distance-type.

When I was a primary care chief resident, I worked with that same attending to create a telephone medicine curriculum for our residents.

**Why did you embark on writing and editing this book?**

My first job after I finished my primary care chief year was in a community clinic in Baltimore. One of my colleagues had just written a book for the American College of Physicians press, and she knew about my interests in telephone medicine and writing. So one day, she told me that she knew an editor there who wanted a book about telephone medicine. It sounded like a great idea since there were very few books on the subject, none that presented an evidence-based approach to common symptoms over the phone, and quite simply a fantastic opportunity to get a book contract. I emailed the editor, she asked for a proposal and outline, we put together a list of contributors, and, hundreds of drafts and a few years later, we had a book!

**How have you used this book to create a Yale curriculum for telephone medicine? What are the barriers to sustaining this? Did other programs contact you with plans to incorporate telephone medicine into their curricula?**

I’ve taught telephone medicine in a number of settings. At Yale, I’ve taught a combination of hypothetical case discussions plus, depending on time constraints, a role-play, as well as a group discussion of a recording of a resident and a patient on the phone. I’ve also presented versions of this at a number of regional and national meetings as well as to some of the other residency programs in the area. And any resident who has worked with me in clinic knows that I am always eager to talk about telephone etiquette and best practices, especially with tricky issues like breaking bad news over the phone.
Discoveries by Members of Other Specialties:
Sometimes It Takes Balls

Karl Langberg

Sir Percival Pott was a renowned English surgeon who practiced from 1738 until 1787. He was one of the first orthopedic surgeons of all time. His biggest claim to fame, however, was not as a father of orthopedics, nor was it his discovery of tuberculosis in the spine (Pott’s disease). Rather, he was the first physician to attribute an environmental exposure to the development of cancer. In 18th century England there was a common practice of using young boys as chimney sweeps. These poor children were mistreated, malnourished, and notoriously filthy. Dr. Pott noticed that a disproportionate number of these boys and young men developed jagged warts on their scrotums. These lesions, left untreated, would lead to large, painful tumors that were locally destructive and seriously decreased the length and quality of life for these poor young men who had already suffered in the singed chimneys of the aristocracy. Dr. Pott brilliantly noted that these pernicious lesions resulted from "a lodgment of soot in the rugae of the scrotum." We know now that these soot warts were early squamous cell carcinomas caused by polycyclic aromatic hydrocarbons found in coal tar. Pott’s early investigation was used to support legislation earning these boys and young men protection by the law. This discovery was one of the first of many that showed links between health and the changing environment of the Industrial Revolution. Not bad for an orthopedist.

"My chest still hurts but I can finally get an erection!"

In the mid 1990s, Pfizer was looking for their next blockbuster medication. The incredible tide of new cardiovascular drugs in the previous decades seemed to be slowing. The pharmaceutical giant was investigating the utility of phosphodiesterase inhibitors in the treatment of angina. It made sense: block phosphodiesterase, increase the nitric oxide in the circulation, dilate the coronary arteries and, voila, no more angina. Unfortunately the theory did not pan out and the medication was a huge bust—patients continued to have chest pain. However, trial participants did notice a pleasant side effect. Men who had erectile dysfunction began getting their first erections in years. Pfizer took notice and brought the medication to market as Viagra, thus ushering in an era of a sexually active retirement.

References:
http://www.whonamedit.com/doctor.cfm/1103.html
http://news.bbc.co.uk/2/hi/health/8466118.stm

Do References (Page 2):
Amrapali in Sonagachi

Vatsal Patel

“Doctor, can I trust you?”

I glanced at the heavyset, unkempt African American woman in front of me. I was surprised at the question, and glibly responded, “Yes, sure, why not?” The patient burst into tears.

Taken aback, I sat quietly and paid close attention to her story. I learned that the lady sitting in front of me used to trade flesh just a few years ago, lost trust in men, and was currently in a stable relationship with another woman. She had seen many doctors, but had not disclosed the details of her social history for fear of being judged.

Had she ever been heard before? She was isolated by the labels she bore – black, overweight, woman, lesbian, prostitute. I understood why she was reluctant to trust me, and why she feared being stigmatized. I was reminded of Sonagachi, the largest red-light district in Kolkata, India. It is an area pregnant with multi-story brothels, a place where women are slaves and exploited, treated as nobodies. The brothels stand in stark contrast to the much-glorified, nearby Royal Marble Palace.

I consider these women one of the most vulnerable populations in any society. If they cannot trust physicians, whom can they confide in? In Bengali Indian sub-culture, worship of the Goddess Durga requires molding an idol of the goddess out of sand; the ritual is not complete until some of the sand is taken from the doorsteps of women who trade flesh. This is not possible without their formal consent. This recognition, inclusion, and dependence of religious ritual on women at the fringe of society is a celebration of femininity as divine and worthy of respect.

This is hardly new to India – there are stories dating back to 500 B.C. One such tale is of Amrapali, a woman who was declared a state royal courtesan and later exploited by powerful men under the pretext of that title. Later in her life, she was accepted by Buddha and became his disciple. Buddha, a Hindu prince-turned-sage, created a philosophy that revolves around personal spiritual development with the goal of reaching nirvana (an enlightened state free of worldly possessions and limitations). Buddha’s acceptance of Amrapali shows that mobility towards a better life was possible in ancient India. As modern thinkers, we should not withhold care based on occupation, sexual orientation, ethnicity, or any other label. My patient was no longer a flesh trader, but was still living with the fear of being stigmatized because of her past.

With this in mind, I saw my patient from a new perspective – she is a daughter, mother, sister, friend, wife, someone’s beloved. I took her hand and reassured her that she would get all the care she needed, in a judgment-free setting. She left the clinic feeling calmer and more empowered. I rotated off my clinic block, hoping that the next clinician to care for her would establish the same rapport.

My encounter with this patient reminds me of the Hindu credo, “Ganges, no matter how polluted, will always be pristine.” The inner goddess of the river ensures its eternal purity, no matter how dirty the river looks to an outside observer.

Keep Yourselves Well!

The Yale I.M. Wellness Committee promotes personal and community health in our program. The group holds events that focus on stress management, mental health, nutrition, and exercise, through meditation, running, cooking, yoga, tea time, and other fun activities. On Earth Day this year, the committee’s "cookie bomb" lightened the spirits of fellow residents. Keep a lookout for E-mails about their rejuvenating events, and email yale.i.m.wellness@gmail.com with your contributions or questions.
Bombers Dominate!

Our Beeson Bombers have crushed the competition this season, proving that our colleagues are not only impressive differential makers but athletic powerhouses.

6/17: 5-1 LOSS vs. Finance team
6/24: 22-8 WIN vs. the Boneheads of Orthopedics
7/1: 15-9 WIN vs. Transport Services
7/8: 15-3 WIN vs. the Untouchables of Food Service
7/29: 12-5 WIN vs. the Immunizers of Pediatrics – a special victory in honor of Mihir Boddupalli
8/5: 6-5 WIN vs. Finance team
8/12: 20-1 WIN vs. the Immunizers of Pediatrics

This month’s card

Steph McCarty!

BATS: Left
THROWS: Left
HEIGHT: 5’6”
HOMETOWN: Huntington, NY
DOB: 10/24/87

POWER COLOR: Green

COLLEGE: Claremont McKenna College
MED SCHOOL: New York Medical College

Steph played softball from kindergarten through senior year of college, taking some time out for flag football in medical school before rejoining her old sport with the Bombers. When she’s not power hitting, she’s cooking, planning vacations (and occasionally taking them), watching football and hockey, enjoying all things Harry Potter, and reading important news articles on respectable Web sites like perezhilton.com and Buzzfeed. Netflix marathons, her dog Pippin, and outdoorsy pursuits (kayaking, paddleboarding, enjoying bonfires) make her smile. She draws inspiration from Lou Gehrig and hopes to be a traveling wine taster (if that’s a thing).
From the Desk of Paul Beeson, MD

I hold the view that the business of house-staff recruitment is of central importance in the effectiveness of a clinical department. With an able group of interns and residents the patients are properly cared for, and the students see in these young people role models, who demonstrate the progress that can be made within a few months or years of graduation. In addition, the house staff constitutes the best pool from which future faculty members can be drawn.


Book Review: The Evidence

Austin Robinson

This year a group of MGH residents did what all of us have probably thought about at some point: They compiled a list of the most important studies in Internal Medicine and then published it in book form. The final product, called The Evidence, is meant to cover the eighty-six most essential, practice-defining trials that “every medicine resident should know.” The book is organized according to disciplines, from General Medicine to Endocrinology.

Its greatest asset is easy digestibility. Each page is dedicated to a single study, consisting of a structured summary and commentary about its significance for current clinical practice. This allows for quick review of a relatively large amount of material. I found it mostly useful for preparatory reading. It lent itself well to quick study sessions before starting a new rotation. On the eve of my MICU month, for example, it took me all of thirty minutes to review a range of topics, including fluid management in acute lung injury, neuromuscular blockade in ARDS, glucose control in the critically ill, and daily sedation holidays, among others. I was no expert, but I was conversant in the subjects and familiar with the trials that guide our decision-making.

In some ways the book is reminiscent of our very own Yale Internal Medicine educational curriculum. Both include collections of articles and are divided by medical sub-specialty. There are important differences though: Whereas our curriculum tends to include a number of clinical practice and review articles, the focus of The Evidence is more on primary literature. I’ve also found it cumbersome to navigate through the curriculum on Medhub and via the Intranet.

There are also difficulties with the book. Although sized to fit into a white coat pocket, it is ill-suited for point-of-care use. The space allotted to commentary is relatively small and the book is nowhere near as comprehensive as resources like UpToDate or even apps like Journal Club. The lag time involved in publication has left it somewhat dated as well. Newer, frequently quoted studies, such as the comparison of transfusion thresholds for acute upper GI bleed, are noticeably absent. Despite that, none of the trials included seem to have lost relevance for current practice. On the balance, the book is a good starting off point for today’s resident or intern.
Correction
In an embarrassing blunder, we failed to acknowledge the 2014 Primary Care graduates, Med-Peds graduates, and Internal Medicine graduates with last names beginning with “Z” in our last issue. We’re happy to have this opportunity to celebrate their career paths and dispel the impression that we are anti-Z-ites.

Traditional Residency Graduates 2014

Liam Zakko  Geriatrics Fellowship  Yale University School of Medicine
Shali Zhang  Dermatology Residency  Emory University School of Medicine
Wunan Zhou  Cardiology Fellowship  Washington Hospital Center, Georgetown University Hospital

Medicine-Pediatrics Residency Graduates 2014

Annie Cowell  Infectious Disease Fellowship  UC San Diego School of Medicine
Sarah Gottfried  Medicine-Pediatrics Primary Care  Cambridge Health Alliance
Cosby Stone  Allergy and Immunology Fellowship  Vanderbilt University School of Medicine
Jeff Tornheim  Adult Infectious Disease Fellowship  Johns Hopkins Univ School of Medicine

Primary Care Residency Graduates 2014

Valida Bajrović  Hospitalist  Spectrum Healthcare, Grand Rapids, MI
Sadie Barchini  Primary Care Internal Medicine  Coastal Medical Group
Krisda Chaiyachati  Chief Resident  Yale University School of Medicine
Manik Chhabra  Chief Resident  Yale University School of Medicine
Shaun Cole  Urgent Care  New York, NY
Faye Farber  Hospitalist  Duke Regional Hospital
Gretchen Guzek  Occupational and Environmental Medicine  Yale University School of Medicine
Janet Ho  Chief Resident  Yale University School of Medicine
Patrick Kelly  Primary Care Internal Medicine  Cornell Scott Hill Health Center
Jing Luo  General Internal Medicine Fellowship  Brigham and Women’s Hospital
Preeti Manavalan  Primary Care Internal Medicine  VA Connecticut Healthcare System
Leo Moore  RWJ Clinical Scholars Fellowship  UC Los Angeles School of Medicine
Jorge Moreno  Primary Care Internal Medicine  Internal Medicine of Morristown
Nora Osman Segar  Chief Resident  Yale University School of Medicine
Trishul Siddharthan  Chief Resident  Yale University School of Medicine
The Beeson Beat Staff welcomes new members
Amanda Freed
Vatsal Patel

Editor-in-Chief
Beth Heuzey

Editors
Amanda Freed
Sam Gelfand
Anne Mainardi
Austin Robinson
Krishna Sury

Staff Writers
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Karl Langberg
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Layout
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Faculty Advisor
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Think we missed something? 
Like to try your hand at a contribution? 
Thinking about joining the staff?

Send comments suggestions and submissions To

yaleIMnewsletter@gmail.com