Attending Rounds: The HumptyDumptification of Medical Discourse

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"I don't know what you mean by 'glory,'" Alice said.

Humpty Dumpty smiled contemptuously. "Of course you don't—till I tell you. I meant 'there's a nice knock-down argument for you!'"

"But 'glory' doesn't mean 'a nice knock-down argument,'" Alice objected.

"When *I* use a word," Humpty Dumpty said in rather a scornful tone, "it means just what I choose it to mean—neither more nor less."

"The question is," said Alice, "whether you *can* make words mean so many different things."

"The question is," said Humpty Dumpty, "which is to be master—that's all."

—Lewis Carroll, *Through the Looking Glass*[1]

Raphael Rabinowitz and colleagues[2] write in this issue of the *Journal of Graduate Medical Education* about what they learned when they asked residents in medicine and pediatrics to talk about the purposes and functions of "attending rounds." At first blink, their 6 seemingly straightforward questions (eg, "What did you perceive the purpose of rounds to be?") might be expected to produce straightforward responses about an experience that all the respondents held in common. After all, "attending rounds" happen often, if not every day, in all teaching hospitals. However, despite the novel focus of the article on the perceptions of resident physician participants, the received responses merely confirmed already categorized purposes ascribed to attending rounds: patient care, clinical education, and communication with patient and family.[3,4]

Rounds have many purposes, some not always clearly recognized by the participants (including the patient and family), so highly disparate functions are lumped together and assigned shelter under the umbrella of attending rounds. This medley of activities (teaching; learning; devising and supervising treatment; guiding young physicians; communicating with patients, families, and professional colleagues; and generating billable documentation of professional input) emphasizes the need for a clarified definition of what educators and program supervisors imply will happen on "attending rounds." If we want to have all of those sometimes perpendicularly opposed activities accomplished during attending rounds, then all participants (attending physicians, students, residents, even patients and families) need to know what rounds are to be about and why. Or, maybe better, what rounds will be about today, because they may differ tomorrow.

In addition to the present report, a number of prior articles (many cited by Rabinowitz et al[2]) demonstrated that the chiefs of service, hospital finance officials, and even the individual attending physicians who carry out rounds at teaching hospitals attach very different, sometimes contrary meanings to the term "attending rounds." Humpty Dumpty warned us of the treacherous malleability of language when he said, "You see it's like a portmanteau—there are two meanings packed up into one word."[1] The problem, as I see it, is that each of the actors in this educational drama improvise an ad hoc definition based on their different interpretations of what "rounds" mean.

It may help to look at how use of the word "rounds" (in the medical sense) has changed. Early on, the word referred to the practice of physicians walking bed-to-bed, ward-to-ward, even house-to-house to visit patients on their list. Now, the majority of time on rounds is spent not seeing patients, but sitting in conference rooms or lingering in hallways.[5] Eugene Stead told me that in his early days at Boston City Hospital, Soma Weiss would make "grand rounds" once a week, walking bed-to-bed to see every patient on the Harvard medical service there. This activity attracted so many interested observers that it became unwieldy, and the group moved to an auditorium to which (selected) patients were brought and presented for discussion by the assembled physicians. Now we use the same word (grand rounds) to denote exercises largely devoid of the presence of living patients, activities more akin to the bloodless and dry academic exercises that William Osler[6] (whom Rabinowitz et al cite) tried to end when

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he declared, "No teaching without a patient for a text."

Rabinowitz et al cite a number of factors that have brought us to our present state. There is the ceaseless hurry introduced into the learner's day by duty hour restrictions, and by the rapid-fire turnover of very ill hospital patients that the present-day teaching hospital has largely become a glorified intensive care unit. There is the commodification of rounds: insurers are now billed for activities that were, in Osler's day, written off as "charity care" (funded, in part, by the unpaid efforts of residents and students); those bills require daily documentation of input by the attending physician in whose name the bills go out, so part of attending rounds is devoted to generating such documentation. Rounds have been transformed because the physicians leading those rounds are often hospitalists, bred and raised in the hothouse environment of the teaching hospital, and often inexperienced in the ways and mores of physicians on the outside, who help patients who are not in a hospital. Finally, and most importantly, there is the lack of common understanding by senior physicians, interns, and residents (students, too) of what "attending rounds" will mean, and what purpose(s) those rounds will serve—if not universally, then at least while each group is working together. Unless we develop a shared and commonly held sense of purpose, we risk the further HumptyDumptification of our cherished goal of learning and teaching what it means to care for the sick.

References

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