Seeing Wisely: The Pursuit of Clinical Expertise

Ben J. Wilson, MD

About the Author

Ben Wilson is a general internist at the Peter Lougheed Centre in Calgary, Alberta. Correspondence may be directed to Bjwilson@ucalgary.ca.

Clean white hallways. Brightness. Rooms. Rooms with beds. Beds lined up in series, against each wall. People in the beds. *Patients*. A person in a suit, sometimes a white coat, sitting. At the *bedside*. Sometimes thinking. Sometimes feeling or listening. *Always* at the bedside. *Always* with patients.

My earliest thoughts of medicine consist of these powerful, though fragmented, concrete images. At their heart, they embody intimate human connection and healing and the profound fulfillment that inevitably results from this combination. These endeavors – human connection and healing – contribute to my life's purpose and meaning. Inevitably then, these images have become inextricably linked to deep, visceral emotions. These images, and the emotions they invoke, have inspired my insatiable passion for medicine.

Clinical medicine, as derived from the Greek *kline*, for 'bed or that on which one lies'¹ refers to "the practice of medicine based on the direct observation of patients".² More simply, one expert³ has defined it as the day-to-day care of sick patients. When I had first looked this up, likely as a medical student, I remember being puzzled: was this not simply *medicine*? Why was such a qualifier necessary? It seemed redundant.

Over time, during academic training, the qualifier took on new meaning and became increasingly necessary. As residency progressed, medicine was no longer synonymous with the day-to-day care of sick patients. Administrative, research, and educational agendas competed with the importance of clinical care. What I once understood to be the entirety of medicine became but one small part.

While these realizations dawned, candid reports detailing the evolving realities of patient care emerged. Bedside rounds, once the paragon of inpatient care and education, have been largely replaced with verbal rounds in sterile conference rooms. Further, one well-designed prospective study⁴ reported that residents on an inpatient medical service spent just 12% of their time directly with patients. This equated to less than

eight minutes per patient. Interestingly, but not surprisingly, they spent 40% of their time on computers. The screen-side has largely trumped the bedside.

This transition, while surprising and unsettling on a visceral level, is not wholly negative. Indisputably, the electronic medical record, expanding diagnostic technologies, and the ubiquity of computers have advanced the science of patient care. However, if these technologies are to be used to maximally benefit our patients, they should be thought of as adjuncts to the bedside and not as replacements for it.

Indeed, there is no substitute for direct patient care. It remains the chief source of diagnostic information. A correct diagnosis can be made by the history and physical examination alone in the majority of cases. Prior to the widespread availability of contemporary paraclinical diagnostics, the history and physical examination was reported to correctly diagnose approximately 90% of patient problems.⁵ A more recent report,⁶ which more accurately reflects our current access to diagnostic tests, reports a 60% true positive rate.

In addition, time spent with patients is fundamental to the physician-patient relationship. Time is a key driver of patient satisfaction⁷ and education^{7,8} and may be associated with improved outcomes in certain conditions.⁸ Furthermore, it is interesting to note that as we spend less time with our patients, there appears to be an ever greater emphasis on the Patient Safety and Quality Improvement movements.

The time is ripe for a renaissance of clinical medicine. As is the case with many complicated constructs, clinical expertise is easier to recognize than to define. It defies simple metrics. Is it measured in terms of increased patient satisfaction? Or by decreased hospital length of stay, improved diagnostic accuracy, or by more expert therapeutic decisions that translate into decreased morbidity and mortality? In short, yes- a combination of these and more.

Experience seems to be the critical ingredient. With this in mind, at the completion of my general internal medicine training, I intentionally immersed myself in a variety of clinical practices - academia, rural communities, outpatient practice, and intensive care medicine – to gain the experience that seemed so critical to the acquisition of expertise. Although a better physician than when I set out, I am not as strong as I might be, as my single-minded focus on experience came at a cost; in seeing so many patients, I was never able to reflect on any individual patient enough. In failing to routinely reflect, read, and discuss cases with colleagues, I squandered a large part of the learning from each encounter. Diagnosing and managing patients on existing knowledge only curbed my clinical progress. Experience had paradoxically undermined my quest for expertise. Osler's dictum – that “the value of experience is not in seeing much but in seeing wisely” – had never wrung more true.

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