Teaching

Has the Time Come and Gone?

It is 9 o'clock on Monday morning, and we have just finished another faculty meeting. As is often the case at these meetings, we were discussing how to make our clinics run more smoothly—how to decrease patient waiting time, increase patient numbers, etc. We are a regional medical center, not affiliated with a university or medical school, with a small pediatric residency program. We have excellent, dedicated residents, and we often have medical students rotating through the department in the summer months. As I walked away from this meeting, I realized that rarely did our faculty meetings center about how to teach our residents/students. Financial matters, patient numbers and satisfaction, and fitting in with the rest of the hospital seem to take precedence over our roles as teachers. How has this happened?

In these days of managed care and scarce resources, we must justify our existence. My productivity is measured by how many patients I see and, possibly, by how much research I perform; how well I teach does not matter as much. We do not get compensated for teaching, and it does not show up on our curriculum vitae. Teaching does not bring in grant money or generate patient fees. No wonder it is not often a major focus of discussion. However, teaching is our most important job; if future generations of physicians do not learn, then the medical profession does not improve or progress. It is not that we do not want to teach or that we do not teach, but the time allotted to teaching, the time we can justify in educating future doctors, is slipping away. Teaching takes time and energy, which must be be diverted from clinical and research duties if you are to do it right. William Osler, perhaps the most celebrated clinician in history, considered teaching paramount. He stated, almost 100 years ago, “teacher, clinician, consultant, yes gladly; but practitioner—no!”1 Osler had a deep respect for the practitioner, but he knew that if you devote yourself completely to the care of patients then you will not have the time to concentrate on teaching. Is this blasphemy—that you can’t be both a practitioner and a full-time teacher? I don’t think so, but there are many physicians and lay persons who probably disagree with me. Even my own parents and siblings think I must dislike caring for patients (that I cannot be a really good doctor) because I believe strongly that time must be taken away from patient care to devote to teaching. We seem to be forgetting that teaching is an important part of our professional calling—it is becoming an ancillary obligation.

The University Medical Centers are faring no better with respect to teaching. During my pediatric pulmonary fellowship several years ago I noted that most faculty discussions centered on research funds, patient work load, and political matters. Resident education issues were discussed but rarely was teaching the primary focus. Being a good teacher does not get you tenure, and it does not pay your salary.

The problem is not only with the teacher but also with the student. Residents are so busy admitting and caring for patients they rarely have time to stop and listen. We expect them to read and learn, but that important student-teacher relationship appears to be dwindling. How can we stimulate these young physicians to pursue knowledge if we do not have the time to teach them and they do not have the time to respond?

Despite all the obstacles, we are fortunate that our profession still boasts many great teachers. We all have mentors who have influenced our lives and careers, and countless physicians continue to dedicate themselves to their own education as well as to that of residents and medical students. However, until we reassign teaching a high priority, the quality of teaching as a whole within our profession will almost certainly decline.

What can be done? Good teachers must be rewarded, and those interested in teaching must be given the necessary time. Continuing medical education must devote more time to improving our teaching skills. Most importantly, if institutions will not emphasize teaching, then we as individuals must.

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REFERENCE


Pericardial Effusion and Cardiac Tamponade Diagnostic Methods

Where Are We Headed?

The diagnoses of pericardial effusion and cardiac tamponade remain enigmas and diagnostic dilemmas for physical diagnosis-based clinicians. As defined originally by Beck,1 the traditional “triad” of low BP, elevated central venous pressure, and quiet heart sounds occurs so infrequently as to dissuade educators from even teaching it. Other symptoms such as dysp-