EDITORIAL

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If a picture is worth a thousand words, a patient is worth ten thousand

TODAY'S MOST PROMINENT medical journals have a "clinical images" section. High-quality, readily accessible digital photography can transport a patient to the journal's pages, as demonstrated by Grandjean and Huber's "Thinker sign" images in this issue of the *Journal*.[1] Images challenge healthcare practitioners to recall diseases via pattern recognition, or to deduce them by higher-order cognition. Images can reinforce prior learning, change perspective, and challenge preconceived notions.

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I have used clinical images—physical examination findings, skin rashes, blood smears, radiography—for more than 20 years as a medical educator. I have dimmed the lights in conference rooms and lecture halls from Maine to Northern California, challenging students, residents, and faculty to contemplate a snippet of history and describe what they see to arrive at a diagnosis. Images are compelling teaching tools for first-year medical students beginning to make clinical observations, and for seasoned clinicians who have seen thousands of patients.

In my experience, clinical image presentations are consistently engaging. Introducing an audience to 8 to 10 patients in an hour loosely mimics the experience of seeing patients over the course of morning hospital rounds or clinic. The images I use are assembled from a collection of images of patients I have seen during my career in medical education. Showing images of patients I've personally cared for consistently prompts people to engage. "Here is a patient I saw last week on the medicine wards" reignites the sagging eyes and fading attention of the audience. In retelling a patient encounter, I create a human connection between a picture on the screen—my patient—and the listener. My patient becomes a patient of anyone in the room, a patient someone might see tomorrow on hospital rounds or in clinic.

Sometimes, instead of presenting a brief clinical history or select physical findings, I tell a story about the patient in the image. Whether sad or funny, these stories often bring learners together, prompting them to wonder how there could ever be a better job than the one they have. A prominent educator once approached me after a clinical images presentation to opine, "What you did with us today is the cure for physician burnout." Hyperbole, perhaps, but I understood what he meant. Over the course of an hour, the audience had been transported to numerous bedsides and examination rooms, witnessing the interesting and delightfully mundane jewels our patients often bring—true pearls, indeed.

Images portray real patients with stories to tell

However, as educational, fun, and intellectually challenging as clinical images can be, they can never replace the experience of being at the bedside. There is nothing as engaging as the stories the patients themselves tell us. Unfiltered musings come to life, physical findings are indelibly seared into memory.

But unfortunately, even as trainees spend less time than ever before with their patients,[2,3] bedside rounding has dramatically faded, replaced by rounds in conference rooms and hospital hallways.[4] The underlying cause is multifactorial—declining physical examination skills, increasing use of radiography

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and other advanced imaging, the electronic health record, and the overwhelming volume of clinical tasks carried out at a distance from the patient.

But this is not the whole story. I also believe that teachers and leaders fear the "thin ice" of rounding at the patient's bedside. One never knows what will happen there—what will be said, what will be asked, what will be uncovered. What if, while talking to and examining the patient with the Dahl sign shown in Grandjean and Huber,[1] the patient's condition would suddenly deteriorate, urgently requiring nebulized beta-2 agonists and transfer to the medical intensive care unit? What if the patient rambles for 5 minutes about extraneous details not relevant to his or her disease? What if the nurse needs to dispense scheduled medications or hang the next dose of antibiotics? What if the patient asks to use the bedpan at the moment digital clubbing was to be pointed out and discussed?

Of course, the patient may have lots to say, or nothing at all. But in those moments when the ice does not break, when the patient is not suddenly wheeled away to radiology, key clinical findings are seen and remembered, often for an entire career. If the ice does not break, the patient, the story, and the clinical finding—otherwise seen on a large screen in a dark room or on a page in a textbook or journal—come together in that moment, in a way nothing else ever quite can.

In this golden age of technology, we must remember that these images portray real patients with stories to tell, sometimes mundane and sometimes profound, but always worth hearing.

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REFERENCES

1. **Grandjean R, Huber LC**. Thinker's sign. Cleve Clin J Med 2019; 86(7):439. doi:10.3949/ccjm.86a.19036
2. **Chaiyachati KH, Shea JA, Asch DA, et al**. Assessment of inpatient time allocation among first-year internal medicine residents using time-motion observations. JAMA Intern Med 2019. Epub ahead of print. doi:10.1001/jamainternmed.2019.0095
3. **Block L, Habicht R, Wu AW, et al**. In the wake of the 2003 and 2011 duty hours regulations, how do internal medicine interns spend their time? J Gen Intern Med 2013; 28(8):1042–1047. doi:10.1007/s11606-013-2376-6
4. **Crumlish CM, Yialamas MA, McMahon GT**. Quantification of bedside teaching by an academic hospitalist group. J Hosp Med 2009; 4(5):304–307. doi:10.1002/jhm.540

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