BY MELVIN KONNER, M.D.

NEW YORK TIMES MAGAZINE, DEC. 18, 1988

Which Hospital?

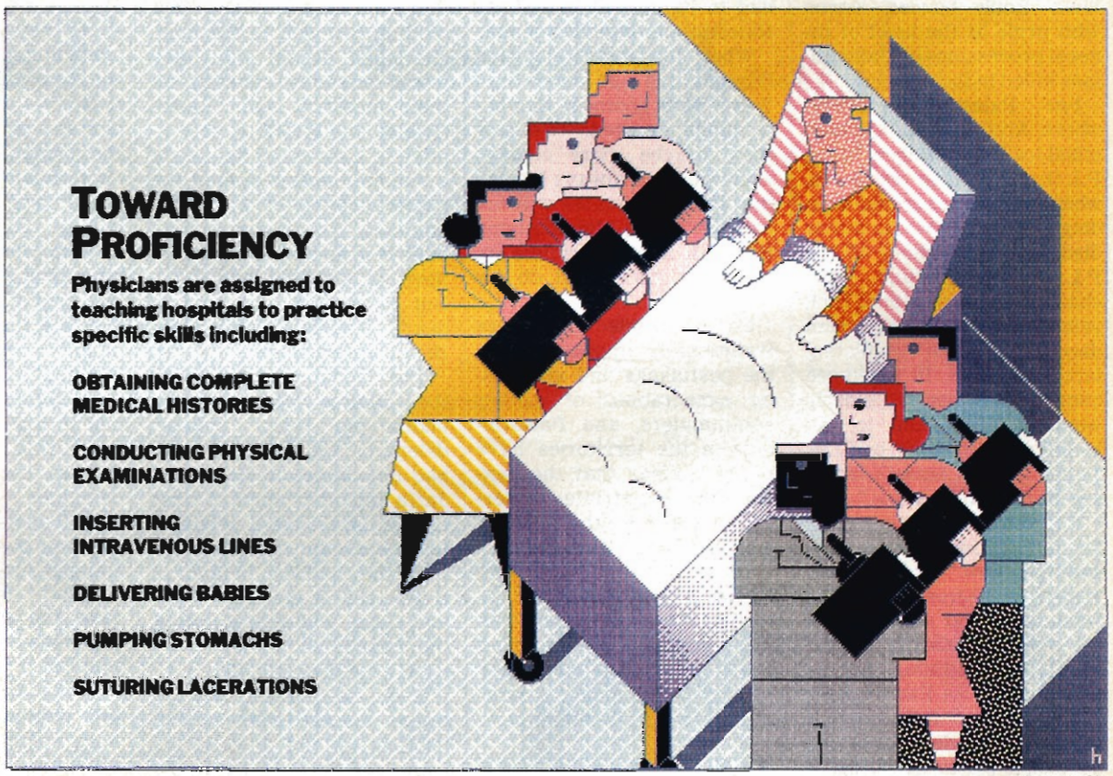
A FRIEND OF MINE WITH AN EARLY case of coronary disease recently had to choose a surgeon and then an internist for follow-up. For both, he went outside the distinguished academic medical center in Atlanta to seek care at private hospitals. Part of his reasoning was that to be subjected to extensive examination by medical students and residents, for the benefit of their education, would invade his privacy and disrupt the mental calm needed for recovery. He found excellent private doctors, and I supported his choice. But the episode led me to rethink some ethical and practical questions. The debate over private hospitals versus teaching hospitals has gotten hotter lately, with some arguing that the care in many private hospitals is actually better than that in the training institutions. My own feelings about these two very different classes of hospitals grow out of the exasperating, unforgettable years I spent in medical school.

Most people are probably not as aware as my friend about what they implicitly agree to when they enter a teaching hospital. They are submitting to conditions under which they will be observed, discussed, interviewed, talked about and tested in a variety of ways that are as much or more for the benefit of the student-doctor than for the direct good of the patient. Although they rarely discuss it openly, some physicians-in-training are disturbed by some of the things they have to do, feeling that they are ordered to carry out procedures that are unnecessary; that they are, in a sense, abusing patients, putting something over on them. Others feel that it is their right to do what they will: after all, the patient is in this hospital in the first place because everybody knows teaching hospitals are the best, right?

During my medical-school days, I frequently witnessed procedures that were of questionable necessity. Indeed, I was sometimes ordered to do them myself when the opportunity for me to practice on a patient seemed the main motive of the physician giving the order. I was once told to stitch a laceration in the hand of a man extremely sensitive to pain. The cut was small and in the web between two fingers, where it is difficult to sew. The man screamed, literally, for a half hour, that he did not want the stitches, and I muttered to my boss that I didn't think they were necessary. Beside the point. I needed the training. "Do it," he growled, believing, I think, that I was trying to get out of work — unlikely, because sewing lacerations is usually fun.

The most common of unnecessary procedures are minor. First, there are those interviews during which someone asks your complete medical history and then someone else does it again. Then the repetitive physicals. In nonemergencies, you may be subjected to at least four encounters that go over much the same ground. One medical student may take two hours to ask about your symptoms, the course of your illness, your habits, your family, as well as conduct a thorough physical. An intern will spend an hour or so doing the same thing. A second-year resident supervising the intern will do it again, possibly in the middle of the night, when time permits. Another history and physical will be taken by an attending physician, and perhaps yet another, by another senior resident.

Certain intrusive questions, such as those about alcohol use and sex, certain indignities, such as the insertion of a finger into the rectum, will occur repeatedly. If you are in pain, the mere touch of a hand can add discomfort or even risk. If you are the source of "interesting findings," you may meet a parade of curious physicians and students eager to ask, look, touch. You can refuse some of these things. You have a right to keep your own body from being assaulted with forever-repeated examinations. But the doctors and students at a teaching hospital have a right to parade in and ask questions. And you are not going to want to alienate them. Eventually, if you are really self-protective, someone may remind you of the information you were given on admission about the medical students and instructional nature of the institution. They may browbeat you a bit, say it is all for your own good. At some point they may well say, "*This is a teaching hospital.*"



JOHN HERSEY

The New England Journal of Medicine recently took up the issue of doctors-in-training who undertake procedures on patients who die in teaching hospitals. Everyone who has worked in one knows it is not unusual for residents to hone their skills in, say, placing a breathing tube in the trachea, or an intravenous needle in the large vein under the collarbone, on a patient just pronounced dead. It is done in the middle of the night, with no one present to be offended. It's efficient and useful training, and those young doctors may one day be using their skills to save the life of someone in your family. Still, relatives and friends might be enraged to know just how the body of someone they loved was being used.

Why, given all these indignities and intrusions, would anyone voluntarily enter such a place? Several good rea-

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sons. Not every patient is offended. People are different. A few are exhibitionists. More like the questions, the touching, the company. Some who are permanent invalids or dying want, believe it or not, to teach. They have been told that they can perform a unique educational function for young doctors, and that is the absolute truth. Some embrace this task, teach well, and find in the process that their lives — and their deaths — take on new meaning.

For those who, fairly enough, cannot share this sense of fulfillment when they are afflicted by illness, there are purely selfish reasons to choose a university hospital. It is often the only way to get certain doctors. In most cities, at least some of the most-sought-after physicians practice only in university hospitals. These doctors are highly ranked by patients and colleagues alike because they are dedicated and they are on the cutting edge. They attend the national and international conferences; they do research; they hear about others' discoveries. They are quick to learn of new drugs and techniques, and yet they are not subject to medical fads. They do not just "keep up"; they create the knowledge and make the judgments that other doctors must keep up with.

And they generally do it for lower salaries than they could earn in nonacademic settings. So if there is a temptation in a university hospital to do a procedure for the purpose of training, there is less temptation to do it for the purpose of presenting the bill; whereas in the nonacademic hospital, the latter temptation is real. Do they cancel each other out? It is unlikely that anyone could measure either. Both temptations should, and probably can, be reduced. But as long as physicians are human, some will be inclined to do things for their own personal gain; speaking as a patient who once served in a small way as an academic curio, I would rather their temptation be intellectual than venal.

WHICH BRINGS UP THE QUESTION OF competence. Aren't these young doctors in teaching hospitals really just half-trained? Approximately, yes; but they are half-trained on the frontier of knowledge and skill. And, more important, they are working under the eye of the master physician. Some patients are unnerved to discover that the surgery they have had was not actually done by the famed senior physician, but by the young surgeon standing on the other side of the table. Yet it is not the hands, in most surgery, but the mind, that matters. And you can frequently get that special mind to focus on your problem only by tolerating a few young pairs of hands.

As for the repeated examinations. Don't be so sure they aren't a good idea. One in seven colon cancers can be detected by a proper rectal examination. And medical students as a rule are patient and thorough; they know less than residents, but they have more time, more open minds. They sometimes find out things that nobody else knows. And as for the levels of doctors, three pairs of eyes, ears and hands may not be three times as good as one, but each adds something. I remember an intern with a keen eye who found a small melanoma — a deadly skin cancer — by peering intently over the whole surface of the skin of a middle-aged man at the intake physical; the others who saw the man missed it. He had come to the hospital for an unrelated reason, and the intern's intrusive, "redundant" gaze probably saved his life. You may find yourself in a roomful of 30 people, from doctors on the verge of retirement to first-day interns, all talking about you, for an hour. Yes, there can be too much, but patients in such situations get a lot of brain power brought to bear. Too much is usually better than too little.

If you shrink from all the examinations, if you fear you would be rattled by the intrusive bustle of a university hospital, you can probably find a nonteaching hospital that is very good or excellent. There are, certainly, excellent doctors outside of academia who function at the highest level of competence. Indeed, you may have special knowledge or special connections that would lead you to them. Then too, private hospitals today must court patients; so you may even find that you get spoken to respectfully. So your choice, clearly, must be guided by many factors. But it is my view that, in general, if you have anything out of the ordinary — that is, not just serious, but serious in an unusual way — you are better off in a teaching hospital. As one senior physician said to me recently, there is no substitute for the stimulus of young minds. ■