VIEWPOINT

What do patients think about appearing in neurology "grand rounds"?

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In a study of 43 patients attending postgraduate neurology grand rounds, patients agreed that their history was described accurately (95%), they were relaxed (91%), the audience was not intimidating (84%), and that they had been well informed (70%); but only 62% found the meeting useful and 18% would have liked to have spoken more. Neurologists' blinded ratings of their patients' perceptions were concordant in 234 (91%) of 258 paired ratings.

"Grand rounds" evolved early in the history of neurology, and patients are still frequently presented in person at neurology clinical meetings. The most celebrated grand rounds were led by Jean-Martin Charcot (1825–93) at the Salpêtrière in Paris, now immortalised in art by André Brouillet (fig 1). In the weekly "Leçons du Mardi", Charcot presented a patient to a large audience including not only hospital staff but also members of the general public. Although never evaluated formally, feelings about Charcot's grand rounds were mixed:

Some considered the Salpêtrière public "exhibitions" of hysterical women patients in a state of partial nudity (and seemingly stripped as well of conventional Victorian inhibitions on comportment and speech) to go beyond the acceptable conventions of clinical demonstrations. In contrast to the silence on this issue on the part of the medical profession, condemnation came from the Church and from defenders of women. Unfortunately, the patients themselves left little direct evidence.¹

Figure 1 Une leçon clinique à la Salpêtrière by André Brouillet, 1887 (above, Jean-Martin Charcot demonstrating a case of hysteria).

These days, clinical meetings are of course confidential, and allow clinicians to present challenging diagnostic and management issues, or educate trainees (and, indeed, other consultants) about clinical neurology.^{2,3} But, despite the passage of more than a century since Charcot's grand rounds, there are no published data on what patients think about neurology clinical meetings. Patients may be troubled by the rehearsal of their history and examination in front of an audience in unfamiliar surroundings. On the other hand, they may benefit from a second opinion in cases of diagnostic doubt, from representing themselves at a re-examination of their problem, and thereby feeling they are "experts" in their condition and facilitators of others' education.⁴ Therefore, we evaluated patients' perceptions of our own department's clinical meetings.

METHODS

The weekly clinical meeting in the Department of Clinical Neurosciences at the Western General Hospital in Edinburgh, UK, takes place in a small seminar room, not entirely dissimilar from Charcot's at the Salpêtrière (fig 1), although medical students and the public do not attend. Prior to the meeting, two patients are identified for the meeting in the ward or in outpatients; they are informed about what will happen and who will be there, and are encouraged to bring a relative or friend with them. Over 30 min, each patient's consultant introduces them, describes the history (usually with a major contribution from the patient), gives the audience the opportunity to ask pertinent questions and examines the patient (with minimal exposure of skin), after which the patient leaves with a plan for further discussion with the responsible consultant. In the

patient's absence, the audience is questioned starting with the most junior members of the neurology staff, and the case is discussed.

This audit involved consecutive, consenting adults attending the clinical meeting at our department between October 2003 and December 2004. Following their attendance at our clinical meeting, patients rated their experience using a paper questionnaire, which they posted back to the department within 24 h. The questionnaire contained equal numbers of positive and negative statements about the patient's feelings, which were rated on a Likert scale (fig 2). Immediately after the meeting, each patient's neurologist also completed a questionnaire, rating their view of the patient's experience, blinded to the patient's response.

RESULTS

Fifty-five patients (55% men, mean age 47 years, age range 17–81 years), of whom 44 (80%) were outpatients and the rest inpatients, attended the clinical meeting. Their diagnoses were mostly neuromuscular (n = 14) and neuropsychiatric (n = 5), but others were movement disorders, cerebrovascular diseases, epilepsy, sleep disorders and headache. Patients were presented for colleagues' education (37%), a second opinion (37%) or both (26%). The median number in the audience was 17 (range 10–23).

In all, 11 of the 55 patients and 1 neurologist did not respond, leaving 43 paired patient and neurologist questionnaires available for analysis. Non-responding patients were similar to responders in age, sex, diagnosis and neurologists' opinions of their perceptions. Overall responses (fig 2) indicated that most patients agreed that their history was described accurately (n = 40, 95%), that they felt relaxed (n = 39, 91%) and that the meeting was useful to them (n = 26, 62%). Most patients disagreed that the audience was intimidating (n = 36, 84%) and that they had not been told enough (n = 30, 70%), although one-fifth (n = 8, 18%) would have liked to have spoken more.

Illustrative quotes from patients

"More plain speaking from doctors to patients so they can understand what to expect in the future" (an 80-year-old man with systemic vasculitis)

"I would like to have been told just a little more about what had been said about my condition after I had left the room" (a 61-year-old woman with a neuropathy)

Figure 2 Overall levels of patient and neurologist agreement with six statements about the clinical meeting. Statements are reproduced verbatim. Patients' statements are in quotation marks.

"In my opinion no improvement could be made on the meeting. Due to the numbers present, I left feeling content, knowing that all avenues had been explored in trying to diagnose my condition" (a 49-year-old woman with a headache disorder)

"I think it's a good idea to show doctors a condition they might never see, and also help them diagnose other patients who may have my condition and give them an idea of how to treat it" (a 40-year-old woman with essential palatal myoclonus)

Overall, neurologists' ratings of patients' perceptions were almost identical to the overall patients' ratings (fig 2). In a

comparison of the 43 patient–neurologist pairs of ratings of each patient's agreement with the six statements (table 1), only 24 (9%) of a total of 258 paired ratings were discordant (patient agreed and neurologist disagreed, or vice versa). Patients and/or their neurologists were most ambivalent about how useful the meeting was for the patient and about whether the patient would have liked to have spoken more (table 1).

DISCUSSION

In our audit of more than one year of postgraduate activity at a regional neuroscience centre, patients' views about neurology clinical meetings were found to be favourable. Neurologists appeared to be in tune with their patients, although they should have given some patients

more time to talk at clinical meetings. Inevitably, certain patients, such as those who are extrovert, are more likely to be chosen to be brought to a clinical meeting, and others may have been asked but declined. Non-response bias might explain the dearth of unfavourable responses. So, no study can be truly representative of how all patients would feel about taking part in a clinical meeting, but it would be worth repeating this study in other contexts to explore the influence of patients' country of origin, meeting venue and style of neurological practice.

The typical neurologist has been controversially stereotyped as "a brilliant, forgetful man with a bulging cranium, a loud bow tie, who reads Cicero in Latin for pleasure, hums Haydn sonatas, talks

Table 1 Concordance between each individual patient's opinions of a neurology clinical meeting paired with their neurologist's ratings of the patient's opinions, for 43 patient–neurologist pairs

	Patient agreed, neurologist agreed	Patient disagreed, neurologist disagreed	Patient agreed, neurologist disagreed	Patient disagreed, neurologist agreed	Patient and/or neurologist opinion was neutral
"My story was told accurately"	40	0	0	1	2
"I felt relaxed during the meeting"	30	0	2	2	9
"The meeting was useful to me"	15	0	0	2	26
"I wish I had been given a chance to speak more"	3	11	3	3	23
"I wish I had been told more about what to expect"	0	25	4	3	11
"The audience was intimidating"	0	29	1	3	10
	(153 concordant pairs)		(24 discordant pairs)		

Agreement and strong agreement are merged, as are disagreement and strong disagreement.

with ease about bits of the brain you had forgotten existed, adores diagnosis and rare syndromes, and—most importantly—never bothers about treatment”.⁵ Neurologists may have evolved, and there are likely to be considerable differences between neurology grand rounds in the 19th century and clinical meetings in the 21st century. We hope our attention to informing and involving patients in our clinical meetings is better than it might have been in “grand rounds” a century ago, but the smaller audience, presence of female neurologists, the dearth of jackets and ties, and the lack of uniformity may explain at least some of our findings.

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ANNOUNCEMENT

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Speakers will include: Professor Marie-Germaine Bousser; Professor Patrick Chinnery; Dr Carl Counsell; Dr Richard Davenport; Professor Geoff Donnan; Dr Ed Dunn; Dr Gavin Giovannoni; Dr Robin Grant; Professor Mike Greaves; Dr Nigel Hyman; Dr John Paul Leach; Dr Colin Mumford; Dr Lina Nashef; Dr Catherine Nelson-Piercy; Dr David Northridge; Dr Mary Reilly; Professor Peter Rothwell; Dr Colin Smith; Professor Charles Warlow; Dr Tom Warner

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