Letters to the Editor

Improving Attendance at Medical Grand Rounds

To the Editor: We read with great interest the Mueller et al[1] article on improving attendance at medical grand rounds (MGR) at an academic medical center and the accompanying editorial by Ende.[2] As the coordinator for Internal Medicine Grand Rounds and the Chairman of Medicine at our institution, we would assert that the declining attendance may be more serious at community hospitals.

Unlike the Mayo Clinic or the University of Pennsylvania Medical Center, our hospital is a medium-sized community teaching hospital with 628 beds, approximately 300 members in the Department of Medicine (of which 125 identify themselves as general internists), and 30 internal medicine and combined medical/pediatric residents. Our Internal Medicine Grand Rounds is presented on Wednesday mornings from 11 AM to noon. One CME credit is offered for attendance at each MGR.

To determine why our audience number has continued to hover around 40 to 50 (of which only about 60% are attending physicians), we issued a survey to 60 randomly selected members of the Department of Medicine attending staff who were not full-time faculty and had not attended MGR in the past 3 months. Our goal was to determine the main reasons for their not regularly attending MGR. Of those surveyed, 35% responded. The most common answers were that it was difficult to get to MGR because it interfered with office hours (67%), that they received their CME through other means (52%), and that they were too busy to come (48%).

When asked how they received CME credit, the respondents listed journals (62%), specialty meetings (eg, American College of Physicians-American Society of Internal Medicine or Infectious Diseases Society of America) (43%), and local courses and workshops (33%) as the most common means. Web-based programs and pharmaceutical company–sponsored events were also popular (28% each).

As Dr Ende noted, departments of medicine exist to provide for their members who supposedly share common values and goals. It is clear from our survey results that the reduced attendance at MGR reflects the concerns and priorities of a considerable portion of our department's constituency. Unlike at university medical centers, where most department members are full-time salaried physicians, community-based private physicians are more restricted in their ability to participate in non–revenue-producing activities, no matter how beneficial this may be to their professional vitality. Physicians whose offices are not adjacent to the hospital providing the MGR also have to account for time (and therefore money) lost in transit. Unfortunately, attending MGR does not cover overhead expenses back at the office.

We congratulate the authors for calling attention to an important topic and for providing some excellent suggestions for improving attendance at MGR. However, in addition to providing more relevant topics, inviting more engaging speakers, and improving the setting of MGR, strategies should also take into account the financial burden that a mere hour away from the office places on physicians.

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1. Mueller PS, Litin SC, Sowden ML, Habermann TM, LaRusso NF. Strategies for improving attendance at medical grand rounds at an academic medical center. *Mayo Clin Proc*. 2003;78:549-553.
2. Ende J. Rounding alone: assessing the value of grand rounds in contemporary departments of medicine. *Mayo Clin Proc*. 2003;78: 547-548.

To the Editor: I would like to offer a couple practical points regarding the topic of a recent article and editorial concerning strategies for improving attendance at MGR.[1,2]

The authors stated that their survey identified lack of food as a barrier to attendance and that the Department of Medicine responded by making food available for purchase nearby. In my experience, free food, including relatively inexpensive items such as coffee, juice, muffins, bagels, and fruit, has achieved better results.

Timing is also important. We all have times that are more or less convenient for fitting in an hour of education, but unfortunately those times often vary by job description. Departments of medicine must decide whom they want to attract to MGR and accommodate their conveniences preferentially. Modern alternative techniques, such as the live teleconferences described in the article, may also expand the audience base. Other techniques include Web-based and CD-ROM technologies.

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1. Mueller PS, Litin SC, Sowden ML, Habermann TM, LaRusso NF. Strategies for improving attendance at medical grand rounds at an academic medical center. *Mayo Clin Proc*. 2003;78:549-553.
2. Ende J. Rounding alone: assessing the value of grand rounds in contemporary departments of medicine. *Mayo Clin Proc*. 2003;78: 547-548.

To the Editor: A further consideration needs to be made regarding the issues raised in the article by Mueller et al[1] regarding attendance at MGR.

Although it is recognized that attendance at MGR by junior staff is beneficial and educational, these meetings often are held either in the early morning, before ward rounds begin, or at lunchtime, when time is often at a premium. Mueller et al mention that at the Mayo Clinic, food is available for purchase outside the auditorium. This situation is the exception and not the rule. I have worked in more than 20 institutions, and in almost every case, food had to be purchased in cafeterias that

were usually distant from the MGR. In the already crowded day of junior staff, additional precious time was taken up going to and from the cafeteria.

In those situations in which food is available, it is extremely morale-depleting for junior staff to arrive at MGR a little late—working it into their busy day—to find only the soggy sandwiches that no one else wanted. Even worse is to find all the food gone. In both situations, there is the dilemma, "Should I stay and learn for my long-term benefit, or should I go find some food so that I can last the rest of the day?" In these situations, the id—the part of our subconscious psychological makeup that demands instant gratification—usually wins.

In my experience, the provision of sufficient quantities of high-quality free food (usually provided by pharmaceutical companies who are only too happy to set up a stand and provide refreshments) is essential to ensure the highest attendance of the busiest staff.

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1. Mueller PS, Litin SC, Sowden ML, Habermann TM, LaRusso NF. Strategies for improving attendance at medical grand rounds at an academic medical center. *Mayo Clin Proc*. 2003;78:549-553.

In reply: Drs Kuo and Klainer describe their experiences with MGR at a medium-sized community teaching hospital. Using a survey, they identified the following barriers to attendance at MGR: the time of MGR (which conflicts with office hours), the financial burden of being away from the practice while attending MGR, the press of clinical practice, and the inconvenience of the MGR location. We agree with Drs Kuo and Klainer that organizers of MGR should consider these potential barriers to attendance. Furthermore, Drs Kuo and Klainer's observations highlight the need for MGR organizers to assess learner needs and the barriers to attendance unique to their respective institutions. In our case, we found that conducting needs assessment surveys was extremely helpful in overcoming a number of barriers to attendance.

We agree with Dr Reinharth that using new technologies (eg, Web-based) may overcome some of the barriers to attending MGR, particularly for clinicians who find the location and/or the time of MGR inconvenient. At our institution, MGR can be viewed by live teleconference at 2 remote locations. Indeed, nearly 50% of our attendees view MGR in this way.

We also agree with both Drs Reinharth and Dhatariya that making food available may improve attendance at MGR. Indeed, at our institution, needs assessment surveys identified lack of food as a barrier to attendance. In response, we made food available for purchase adjacent to the auditorium in which MGR are held. Furthermore, we allow food to be consumed during MGR. We believe this modest intervention positively affected attendance at MGR.

It is also the experience of both Drs Reinharth and Dhatariya that providing *free* food may further improve attendance at MGR. It seems logical that eliminating financial barriers to purchasing food (eg, the cost of food and the need for readily available cash) would diminish the reluctance to attend MGR, especially during the times when many individuals eat (eg, early morning and the noon hour). Indeed, although we did not use this specific strategy, we are considering it for the future. To our knowledge, however, the effect on attendance at MGR when free food is provided has not been systematically studied.

Notably, a major drawback to providing free food for consumption at educational activities is its cost; some departments of medicine may not be able to afford such an expense. Dr Dhatariya suggests that pharmaceutical companies could cover the cost of providing food at MGR. Although a number of institutions undoubtedly use industry support to provide free food at MGR, this approach could raise the ethical concern of inappropriate industry influence over the organizers and the contents of MGR. This concern can be alleviated by adhering to the following general guidelines: (1) the support (eg, money for food) must be unrestricted; (2) all faculty conflicts of interest must be declared; (3) the industry sponsor should have no role in determining the content of MGR; and (4) topics should be presented without bias, especially when products of the industry sponsor are discussed. More detailed guidelines are described elsewhere.[1,2]

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1. Coyle SL, Ethics and Human Rights Committee, American College of Physicians–American Society of Internal Medicine. Physician-industry relations, part 2: organizational issues. *Ann Intern Med*. 2002;136:403-406.
2. American Medical Association Council on Ethical and Judicial Affairs. *Code of Medical Ethics: Current Opinions With Annotations*. Chicago, Ill: American Medical Association Press; 2002.

CORRECTION

Omission: In the article by Drazkowski entitled "Management of the Social Consequences of Seizures," published in the May 2003 issue of *Mayo Clinic Proceedings (Mayo Clin Proc*. 2003;78:641-649), a footnote to Table 5 was inadvertently omitted. The footnote should read, "Adapted with permission from Mesad SM, Devinsky O. Epilepsy and the athlete. In: Jordan BD, Tsairis P, Warren RF, eds. *Sports Neurology*. 2nd ed. Philadelphia, Pa: Lippincott-Raven Publishers; 1998:275-287."