Editorials

What I've Learned From Experience

This old anvil laughs at many broken hammers.
The fireborn are at home in the fire.
Time is a great teacher.
— Carl Sandburg

Experience teaches that experience is not an infallible teacher. Benjamin Rush learned wrongly from his experiences with purging and bloodletting patients to the point of faintness, and his famous cure was criticized by a contemporary as "one of those great discoveries which have contributed to the depopulation of the earth."[1] John Dewey[2] believed that all genuine education comes about through experience, but that "does not mean that all experiences are genuinely or equally educative."

One of the weaknesses of medical language is that the word for experience (empiric and its cognates) has acquired a double meaning. We eschew empiricism, the purely practical, trial-and-error approach to therapeutics, undisciplined by systematic and theoretical analysis; but we applaud empirical when it refers to experience and data derived from proper research. Both experience and empiric, however, share a common root, *pieran*, which means to attempt, to try, with an element of fear.[3]

One of my favorite mentors was fond of saying, "When you say that you have had a lot of experience, that means you have been in a lot of trouble." My experience corroborates this impression as I reflect upon it for the purposes of this essay. I seem to remember the troublesome lessons better.

Run a Little Scared

In medical practice the stakes are high, emotions are fragile, judgment is vulnerable, ambiguity is unavoidable, and fallibility is certain. It makes sense for a family physician to be a bit of a worry wart, out of respect for the uncertainties and intimacies of primary care. Courage does not imply the absence of fear.

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From Birmingham, AL.

Cultivate a Nose for Trouble

Wariness begins in the imagination. It is akin to what the hymn writer, Charles Wesley,[4] described for the pious Christian as:

A sensibility to sin,
A pain to feel it near.

In medicine the sins are missed diagnoses, iatrogenic harm, avoidable complications, arrogance, deception, and not seeking timely help. Family physicians not only need the capacity to smell smoke but also to say, "It's smoke!" Learning only by getting burned is not the most refined form of learning. It is important to recognize early when things are not going well with a particular patient.

Prepare for Performing Invasive Procedures

An orthopedist I met when I was a senior medical student was fond of saying, "Docky" (he called everybody that), "There is no minor surgery — there are only minor surgeons."

My worst fiascos occurred when I underestimated the job to be done. Inadequate anesthesia, poor lighting, lack of exposure, broken sterile technique, and unexpected bleeding turn a "simple" procedure into a nightmare. Here is my checklist for expecting the best and preparing for the worst:

1. Rehearse the procedure mentally before starting
2. Review the relevant anatomy
3. Choose the right setting
4. Arrange for the right assistants
5. Inspect the instruments
6. Test the equipment
7. Locate emergency equipment and supplies
8. Position the patient
9. Prepare and drape a generous field of work

Learn How to Buy Time

There is a legitimate place for appropriate procrastination. Few patients object to returning for more intensive attention or trying a remedy that

might help and won't harm. Time is on the side of all healers because many complaints are self-limited or stable.

Scheduling visits is an art. The depth and intensity of the physician-patient relationship is partly a function of the frequency and regularity of visits. This information has clinical value when used deliberately. There is pressure nowadays to reduce visits in the interests of economics, but there is another side to the coin. Visits may be reduced more in the long run after a time of greater frequency. Feeling understood reduces a patient's anxiety and the need for visits.

Chronically ill or difficult patients do better with regular visits. Diffident or distant scheduling or saying, "Come back when you need to," practically insures one of three outcomes:

1. It is construed as an invitation to leave the practice
2. The patient assumes that you have done all you can
3. Each visit will be a crisis, which takes more time

Learn When to Punt

A freshman quarterback was sent late into a losing game with strict orders to call three running plays and punt. The running plays got him to the opponent's 1-yard line, whereupon, to his coach's dismay, the ball was punted out of the stadium.

Consultation and referral are the medical equivalents to punting. Not to punt at all is disastrous; a quick kick on third down is sometimes advantageous; and rarely, when the score is tied and the field muddy, a punt on first down is good strategy.

Choose your consultants as carefully as you would a partner. Get on a first-name basis with them and learn their skills, habits, and idiosyncrasies. Telephone them early, as soon as the need begins to arise. Never name a consultant until you are sure that consultant is in town and available.

Show continuing interest in patients throughout consultation and referral. Insist on being kept informed, and always be prepared to take the patient back when appropriate.

Do not use consultants to provide informal and unspecified coverage for patients as a matter of your own convenience. Consultants despise you for that.

When you punt, try to make it stick. Don't subvert a consultation or referral by aligning yourself with the patient's resistance. This caveat applies especially to psychiatry. The unsatisfied patient who returns saying, "You are the only doctor who understands me," is using a seductive ploy that exposes the need for the consultation.

The kicking game often makes the difference in a good outcome.

Acknowledge Countertransference

When you find yourself absent-mindedly kicking the wall or impatiently drumming your fingers on the desk while you are talking sweetly to a patient on the telephone, you are experiencing countertransference. The same goes for any surge of emotion you feel when you see a particular patient's name on your schedule for the day.

I read Menninger's[5] common evidences of countertransference at least once a year. It does not always save me from myself, but it reminds me that my emotions sometimes get in the way of my clinical work. Thinking obsessively about a patient between visits, dreaming about a patient, making frequent concessions to see a patient at odd times, and being either too loose or too strict about fees suggest that the physician-patient relationship is out of the ordinary and invite reflection about why.

Pride, anger, guilt, pity, love, eroticism, parentalism, and even the Pygmalion wish to reform a patient are all legitimate emotions that sometimes intrude on the clinical relationship. They are not so much wrong as overloaded on the physician's side — usually from unexamined sources. When one becomes aware of these emotions, the patient's best interests will be served by examining and regularizing them. If this cannot be done, punt.

Seek Modest Therapeutic Goals

Nobody gets angry from better-than-expected results. Don't promise too much too soon. Seek improvement rather than cure, especially with

chronic conditions. Predict what can be reasonably expected from a drug and when that benefit should become apparent. Alert the patient to possible adverse effects, what the chances are for adverse effects, and what will be done if they occur, including alternative treatment. My favorite reminder at the termination of a visit is, "If you are not satisfied with how you are feeling by _____ (e.g., Thursday), be sure to let me know. There are other things that can be done."

When surgery is the treatment, don't let the patient believe, for instance, that an indicated cholecystectomy will cure an irritable bowel. Old symptoms, unrelated to the surgery, are bound to return after the placebo effect has run its course. There is a fine line between persuading a patient that a particular treatment is indicated on its own merits and being realistic about its limits and risks.

Report Laboratory Results Personally

It is unforgiveable to miss seeing laboratory results with your own eyes. Develop a foolproof method to see that such an oversight does not happen in your office.

With few exceptions, any laboratory test worth ordering is worth your reporting to the patient directly. Patients are legitimately disappointed and angry when after a diagnostic workup all they hear is a telephone call from an office assistant saying that "everything is OK." Moreover, an opportunity is missed to answer the inevitable questions and to repeat your understanding of the meaning of the tests in relationship to the symptoms. Surely it's worth a visit to show patients their radiographs, electrocardiograms, chemistry profiles, and other reports and offer them copies of whatever they want.

In justifying recommended tests, it is often useful to predict what they will show. Because most test results are normal, physicians must become adept at handling negative information. A "clean bill of health" is not always received as good news by patients having functional or mysterious complaints. I wish to avoid the embarrassing dilemma of having the patient say (at the end of an expensive workup), "If my tests are so good, why do I feel so bad?" This time is not the best to introduce the concept of a psychosomatic illness. Seeds can be sown much earlier to prepare for negative results.

When laboratory tests do not agree with your expectations or when they contain ambiguous statements and data, telephone the interpreter. A great deal is to be gained by talking with radiologists, pathologists, and other "ologists" and "icians" who interpret data for you. Treat them as consultants, and you will improve the quality of your clinical information.

Insofar as possible, look at the original data, radiographs, and images that generated a report. This is not so easy nowadays, when many tests are easily available at diagnostic centers. Ask for copies and learn to look at them.

I question whether physicians should order tests that they cannot interpret with a degree of proficiency. Perhaps it would be better to refer patients needing such tests.

Become acquainted with the technicians who do your laboratory tests. Go to the laboratory and radiology department, when convenient, and explain what you want. They will go out of their way to give you special service.

Get in Over Your Head with a Few Patients

This lesson does not contradict running scared, wariness, and punting, because courage and willingness to go the second or third mile with a patient are also good characteristics of a physician. There are strategies for learning what to do when you don't know what to do. This experience can enlarge your capacity, lead to surprising discoveries about yourself, and serve the interests of particular patients.

The multiproblemed patient who has made the rounds with many physicians and had all the tests might do better with one physician who tries his or her best to see that patient whole and simplify impossibly complex management strategies. We might not be the best experts for each problem, but we could be the best for their collectivity. What is required is less genius than intelligent compassion, tolerance, and a willingness to be dependable. No one has an inexhaustible supply of these qualities, but we need to exercise them on occasion so that we do not lose them altogether.

Postscript

The lessons I've learned from experience
Added nothing to medical science;
Yet, their price has been dear
— I learned mostly through fear —
And some left a scar on my conscience.

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Illiteracy And Health Status: Can We Read The Meanings?

A relation between literacy and health status, especially maternal literacy and child health, has been convincingly demonstrated in developing countries.[1] Weiss and colleagues[2] have performed a pioneering study, reported in this issue of the *Journal*, indicating that a similar correlation between illiteracy and poor health may exist in the United States. The Sickness Impact Profile (SIP), a well-validated questionnaire used to measure physical and psychosocial health, was administered to 193 subjects with low literacy skills who were enrolled in a publicly funded adult education program. The authors found perceived physical health status of the illiterate subjects (defined as reading level less than the 4th grade) was poor and significantly worse than that of subjects with higher reading levels. Psychosocial health, as measured by the SIP, was more dramatically impaired. Psychosocial dysfunction was common in study subjects of all reading levels.

This study serves to remind us that many factors outside the traditional biomedical model are powerful determinants of health. Socioeconomic factors clearly confound the relation between literacy and perceived health status. The poor are overwhelmingly represented in any study of people with low literacy skills. They also experience the greatest barriers to the use of health care services and have the poorest perceptions of their own health. The authors chose to study only persons of low socioeconomic circumstances to minimize the range of socioeconomic variables. Multivariate statistical techniques were used to control for confounding socioeconomic variables. Other potential confounders were not addressed. Particularly concerning was the impact of only 4 individuals at the lowest reading levels (reading grade levels 0 and 1) who had poor health as demonstrated by very high SIP scores. Poor reading skills may have been the result of a health problem, rather than its cause. Data analysis excluding these extreme subjects was not included. In addition, while a correlation is demonstrated, the mechanism linking illiteracy and poor health is not explained.

Like all good studies, this report raises more questions than it answers. What is the relation between poor perceptions of health status and more objective assessments of actual health and function? Does illiteracy contribute to poor self-perceptions of health? Is poor health a barrier to literacy? How does a family physician best recognize the problem? Does illiteracy limit the effectiveness of our medical interventions? Are there effective, office-based strategies to identify illiteracy that we should learn? Doesn't this study support the contention that many important determinants of health require substantial investment in social programs other than direct health care?

It will come as no surprise to family physicians that a relation exists between literacy and the health status of their patients. Despite their poverty, the study group saw physicians frequently

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