Editorial

When the Part Becomes More than the Whole: What I Learned from Earlobes

One of my regular patients, at the conclusion of a visit for hypertension, showed me her left earlobe, split from many years' wearing of pierced earrings, and asked me in a simple, hopeful way if I could repair it so that she could wear earrings again. Sure enough, her left earlobe was neatly split from its center to the most dependent edge in an inverted V-shape. The edges were smooth, covered with skin and a bit thickened with scar. Not only that, her right earlobe was in almost the same condition; only a thin bridge of skin held the edges of the slit together.

Had she asked in a less ingenuous manner, or even phrased her question differently, I would have followed my usual inclination and referred her to a plastic surgeon; but her trusting attitude and my feelings of confidence on that day conjoined in a special way, and I agreed to "fix" her earlobes, even though I had never done it before. Explaining it to myself as much to her, I drew a sketch showing how the repair could be done; explained about local anesthesia, stitches, and aftercare; and we set a date. It seemed to me a small thing, like doing a favor for a friend, not freighted with unusual significance.

The repair went well, healed with a barely visible scar, and within 6 weeks she was wearing her favorite earrings again. Both of us were pleased, she with her appearance and I with my surgical skills. What I had not counted on, however, was that she had friends and acquaintances who also had split earlobes, and upon her recommendation, I began to get calls for earlobe repairs from strangers. Not only that, some of the employees in my office had earlobe problems, were impressed with my patient's results, and wanted theirs fixed too. To my surprise, I was becoming an earlobe specialist. Gratified by my success, I repaired another half-dozen, all of which turned out well; and I began to fantasize about what "earloboplasties" could mean to my practice.

I discovered a relevant procedural code number that allowed me to charge $100 per lobe, much less, one of my patients told me, than a plastic surgeon quoted her. Virtue was thus added to avarice and pride in my rationalizations for adding this procedure to my therapeutic "armamentarium." After all, competition is the name of the game nowadays, and I felt myself on the verge of having invented a better mousetrap. The procedure was ideally suited to my setting; it was quick and easy, the patients were grateful, and I did not have to apply to anyone for "privileges."

The idea of becoming an expert was especially appealing. Perhaps I could get a research project out of it. The procedure lent itself marvelously to direct measurement and photography. There must be a connection between the size, shape, and consistency of earlobes, the weight and construction of earrings, and wearing time. If I could show these relationships statistically, I might have a great influence on the fashion industry, much like the effects of Retin-A™ on wrinkles. I could envision an article classifying earlobes and earrings in *JAMA*, the public announcement of my findings, and being interviewed on the *TODAY* show. It even crossed my mind that earring counseling could be taught to costume jewelry salespersons and that I could develop a video package to show at health fairs in shopping malls.

On the other hand, in my soberer moments, I knew that I was not an "earlobologist." I could also fantasize infections, dehiscences, keloids, and other untoward consequences. It was one thing to accept these risks with a patient I knew well, who asked in a beguiling way, and for whom I seemed to be doing a favor. It was quite another to accept them with patients who came to me only for that, and who assumed that I must be an expert. Without having established my competence as a general physician, and without the support of good, basic doctor-patient relations with these strangers, I concluded that the risks outweighed the benefits, and I quit doing earloboplasties. The expert's hat did not rest easily on my head.

In retrospect, I think I made the right decision for the wrong reasons. I quit out of fear of failure, but my work as a family physician probably was more in danger from my success. With appropriate modesty, I did a good job on earlobes, and I had enough surgical experience to stay out of trouble or to have handled complications; but I was at risk for elevating a bit of technical expert-

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ise, a hobby, into a place of undue prominence in my practice. That I could do it did not mean that I ought to do it or that I could do it without changing the nature of my role with this subset of patients. My fundamental role with patients is communicative in nature; I listen, talk, advise, counsel, persuade, explain, admonish, and reassure. I deal in information, fantasies, superstitions, mysteries, and meaning. Of course, I also touch, examine, order tests, prescribe, and do procedures, but I do these within a context of personal understanding, limited though that may be. To evade these communicative processes by substituting procedural expertise is a subtle and seductive sellout of my hard-won professional soul.

This is not any easy issue to resolve. Modern medicine is procedurally oriented, and it seems incorrigibly bent towards more fragmentation of care. No one ought to deny the benefits that have accrued through specialization, but one also cannot help wondering what price physicians pay for identifying themselves with a single procedure or a single disease, such as endoscopy, abortion, mitral valve prolapse, headaches, anxiety, eating disorders, sleep disorders, and substance abuse, to name but a few. Undoubtedly, they get good at whatever they do, but what effect is had, for instance, on a physician's values and perspectives when performing 15 to 20 gastrointestinal endoscopies a day or a dozen abortions? What can they possibly know about the patients who pass through their hands?

Then, there are the marginal activities, the fat clinics, vanity vein injection clinics, face-peeling operations, clinical ecology, megavitamin therapy, and the like. The public buys all of them, and many are promoted to family physicians as fast moneymakers without the tedious bother and messiness of a broadly based practice.

My experience with earlobes convinces me that substituting a part for the whole is risky business. We need to keep our commitment to the whole patient, no matter what inducements attract us to diminish our traditional role. Surely, we must learn to do appropriate procedures competently, and these can vary among physicians depending upon interest, aptitude, and opportunity to learn, but we must keep these in perspective with our main work. There are many jobs in medicine that do not yet constitute careers. Let us not mistake one for the other.

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