stood out like a solitary dandelion on a country club lawn, and I hope you'll forgive me for challenging it:

> Few human relationships, expert or otherwise, can tolerate that much honesty. . . . We do not tell patients when we find them tedious or boring; how trivial we find many of their complaints; how we dread their headaches, backaches, fatigue states, and nerves; how repulsed we are by their "refractory" obesity; how inane we think it is to worry about cholesterol when one has not lost weight, exercised, and given up smoking cigarettes; how we hate it when they do not comply with our recommendations; how we resent their denials, misrepresentations, and withholding of information. I find it hard to confess here that I have such feelings, and I have no intention of sharing them with my patients.

It seems to me that recognizing and adapting to human imperfection is part of being a family physician. Dr. Stephens is correct in saying that we neither do nor should express hostile feelings toward patients, but one reason for having "behaviorists" around our residency programs is to help our young colleagues learn to face their feelings openly and not get "uptight" when human beings act like human beings. The alternatives, both unsatisfactory, are burnout and cynicism.

Ian McWhinney helped me with this issue a long time ago when he suggested that "problem patients" cease to be "problems" when we look at the person behind the behavior, become intellectually interested in them, and seek to understand the internal dynamics of their behavior. This approach has worked for me in terms of helping patients and also relieving my internal stress.

My one small contribution to the medical literature in this area appears in *J Fam Pract* 1986; 23:431. In working with residents I'm more inclined to fall back on aphorisms as conversation starters. Here are a few that might have relevance:

> One of the greatest honors we can confer on other people is to see them as they are; to recognize not only that they exist but that they exist in specific ways and have specific realities.
>
> – Shiva Naipaul

> We yearn for the precision of science but sit amongst the mess and fuzz of humanity.
>
> – D. G. Wilson (*J Roy Soc Med* 1988;81:3)

> The physician needs a clear head and a kind heart; his work is arduous and complex, requiring the exercise of the very highest faculties of the mind while constantly appealing to the emotions and inner feelings.
>
> – Sir William Osler

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Editor's Comment

Dr. Gillette is not the first to take umbrage at my "dandelion," although his remonstrance is gentle and consistent with his counsel and the flavor of his aphorisms. Another person accused me of betraying myself and my other writings through this confession of negative feelings about patients. It was as if I have created an expectation of total understanding and benevolence in physician-patient relationships that I cannot violate now.

The truth is, I have always been a reactive person with hard edges that sometimes become exposed. I deny cynicism, however, and I've never burned out in patient care; but I do become confrontational at times.

The paragraph in question was not intended to be mainly about me as an individual, but to express what I believe to be generic feelings among physicians. I used myself in the last sentence as a rhetorical device in order to identify with readers to show that I am a fellow-traveler and not merely a critic.

Dr. Gillette is quite correct about our need to teach and practice tolerance, patience, and forbearance towards our patients. It was Carl Rogers who first used "unconditional positive regard" as the proper clinical attitudes, which seem to be close to the Biblical notion of grace. I remember a long conversation with a medical corpsman when I was a 25-year-old first lieutenant in the medical corps about whether "acceptance" is a higher and better virtue than "forgiveness." (I haven't thought about that in a long time; perhaps, he was right.)

On the other hand, I believe that family physicians, more than most physicians, deal with intimacy; by that very fact, they also have more to do with the dark side of human emotions – their own as well as those of their patients. Merely to hide this, or gloss it over with professional style, (which I know Dr. Gillette has not said) can be demeaning to patients and probably ultimately corrupting to physicians. Then, I become upset when another person does not take my anger seriously, like telephone operators used to do. I resent being the object of programmed responses intended to blunt my feelings. Patients must feel the same when physicians reassure vacuously, or give them platitudes.

I have digressed, but let me add one more thought to show that I am accepting the reproach. Leston Havens, in his newest book about psychotherapy, *Making Contact*, deals with the language of therapy and has a section on "performative statements." These are statements of the type that create states of being. "I pronounce you husband and wife," or "I christen thee the *SS America*," creates the state of marriage and being named. Havens sometimes uses "I admire this or that about you," which creates in the patient the state of being admired. He finds this useful in some circumstances.

Thanks for writing. It was an act of charity.

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References

1. Havens L. Making contact: uses of language in psychotherapy. Cambridge, MA: Harvard University Press 1986: 141-159.

NSAIDs

To the Editor: The article on nonsteroidal drugs (JABFP 1989; 4:257-71) was a good outline. However, I did want

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to correct one item that seems to me important in patient care about the effect of these drugs on bleeding time. Certainly, this complication has been a major concern in preparing patients for surgery. As the article is now written, one might interpret it to be that 7–12 days will be required before the bleeding time returns to normal after ingestion of aspirin. This view is held by many as incorrect. It is an old observation made in 1972[1] on a group of medical students that indicated that bleeding times returned to normal within 48 hours after the last dose of aspirin. Hence, I have emphasized to the anesthesiologist that aspirin bleeding defects were of no concern for surgical procedures after the drug had been discontinued for 48 hours. Even in our own hospital, patients in past years have had extra days awaiting this time to pass for aspirin to be eliminated. Second, the binding of the nonsteroidal is not irreversible. Hence, the platelet life span is considered to be 10 days for average measurements. It would appear from the data in 1972 that one needs only 20 percent of normal platelets to initiate proper control of bleeding. That would mean that 2 days need pass and we would have platelets that had not seen aspirin binding to the membrane and be available for normal hemostasis. I do not have any information about the use of DDAVP on nonsteroidal response, but there have been reports that this vasopressor will allow the bleeding time to return to normal shortly after the ingestion of aspirin. Thus, one has several ways to have the patient available for surgery if intervention is necessary.

Aside from these observations of the bleeding time, I have always wondered why over the years I saw little or no bleeding in the use of aspirin in the treatment of rheumatoid arthritis. Certainly, I was in contact with large clinics in Boston and Philadelphia where aspirin was used in ranges of 4–6 gms daily. It always impressed me that there was little or no significant gastrointestinal bleeding from gastric ulcerations in this group of patients using the drug for months or years. In almost every instance when I inquired of patients about the use of aspirin, they seemed to know that the drug should be taken with meals to protect them from bleeding. I make a major effort to explain to all patients using aspirin the need to ingest the drug during a meal for this added protection. Most of the patients that I interview with bleeding problems have not had any instructions on using aspirin when I quiz them in an interview. There are variable reports on the nonsteroidal drug response to the bleeding time. Aside from Feldene™, I have followed the same 48-hour role to prepare patients for surgery. The half life of Feldene™ is longer, and I have had no experience with it. Certainly, the bleeding time is the simple way to be certain that intervention is safe.

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References

1. Stuart MJ, Murphy S, Oski FA, Evans AE, Donaldson MH, Gardner FH. Platelet function in recipients of platelets from donors ingesting aspirin. N Engl J Med 1972; 287: 1105-9.