Editorial

A Family Doctor's Rules For Clinical Conversations

Clifton Meador's *A Little Book of Doctors' Rules*[1] excites my admiration and provokes my envy. He condensed what he learned in 30 years of medical practice into 425 rules, which are pithy statements of opinions and attitudes, that passed three tests. A rule is "good" if it makes intuitive sense, "valid" if based on personal observations of workability, and "sound" if it can be affirmed or refuted by others. The first three rules are representative of the style.

1. Sit down when you talk with patients.
2. Always examine the part that hurts. Put your hand on the area.
3. Touch the patient, even if you only shake hands or feel the pulse, especially with old people. But not with paranoids.

This is not the sort of writing found in medical textbooks and journal articles; it belongs to a more venerable literary genre, like the *Regimen Salernum*, containing aphorisms, axioms, "pearls," and secrets from practice, which originated in medicine's oral tradition. Such writing is subject to obsolescence and error and is not likely to be tested by research. Its authority is mild and persuasive more than commanding, and while "pearls" have special appeal to the callow learner, its value can be judged best by clinicians who have their own experience to compare. I have two fat pocket notebooks from my student days containing mostly worthless pearls and forgettable facts from my favorite teachers. Many facts have been superceded, and I lacked the experience to discern wisdom from mere opinion.

Meador's rules vary in complexity, some are repetitious and a few are paternalistic and sexist, but mostly they are modest, unpretentious, and practical. Forty-six rules are about drugs and prescribing; they would comprise a lively topic for a teaching conference. Consider the provocativeness of Rule 173:

There are no controlled studies of patients taking more than four drugs, and very few of patients taking three. Any patient on more than four drugs is beyond medical science.

The character and competence of Dr. Meador are what make this book interesting. He is well known in the South, especially Alabama and Tennessee, as a clinician, teacher, humanist, medical school administrator, and friend and mentor to family physicians. I recommend his *Little Book* . . . to all primary care physicians and was pleased to observe, recently, its gratuitous distribution to a class of graduating family practice residents by their faculty.

I am stimulated by Meador's book to indulge my long-standing interest in clinical interviewing, the case history, and the physician-patient relationship to offer some of my rules for clinical conversations. These have been collected from more sources that I can credit, and I do not claim originality. (Goethe was reported to have said that everything has been thought of before, but the difficulty is to think of it again.) In that spirit of rethinking, and remembering the conditions under which family physicians have always worked — heavy case loads and short visits — I follow Meador's literary example, remembering also his "bewares": "There is no rule without an exception," and "Most rules can be broken."

Attitudes and Presumptions

1. Never hire an employee or adopt an office strategy to save yourself from talking with patients.
2. Do not accept the insidious cliché that physicians are too busy to attend to the essential intimacies of their work. It is not a compliment to your professional self-understanding, your priorities, or your management skills.
3. All case histories are invented as well as discovered. Case histories cannot be "taken" but must be constructed by both patient and physician.
4. Read Samuel Novey's *The Second Look*.[2]

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5. Facts rarely speak for themselves; they must be interpreted by a disciplined clinical imagination.
6. Begin each interview by assuming that the patient intends to tell the truth and wants to be understood. This might not always be true, as in cases of drug-seeking or compensation-seeking, but it is the best basis for building clinical relationships.
7. Pervasive suspiciousness about patients' motivations and intentions is pathological.
8. Better to be "conned" occasionally than strive for a perfect defense against appearing foolish. My old Huntsville friend, Dr. Silas Grant, used to say: "First time, shame on you; second time, shame on me."
9. Clinical interviewing is not the same as:
   a. a game of 20 questions,
   b. cross-examination by an attorney,
   c. personal opinion polling and surveying.
10. The difference between patients describing their illnesses to their barbers or hairdressers and their physicians is the difference between a newspaper story and a chapter in a history book. A good story is not history.
11. Read Michael Balint's *The Doctor, His Patient, and The Illness*.[3]
12. Data collection is not the same as clinical conversation.
13. All clinical questionnaires and forms completed by patients are worthless unless they are read and interpreted by a physician, *then* confirmed with the patient.

At the Beginning

14. Before meeting a patient, cleanse your mind of prejudice that might have originated in comments from persons who do not share your clinical responsibility for the patient. This exercise applies especially in episodic and emergency care.
15. To medical students and residents: It's a sterner test of your skills to interview new patients before reading their medical records.
16. There is a golden opportunity at the very beginning of each visit when the patient's priorities and uncoached words are full of possibilities for disclosing their illness. The moment you ask a leading question, the possibilities diminish.
17. Think of the first 5 minutes of an interview as a funnel into which patients can put anything that comes to mind. You can sort it out later for diagnostic and therapeutic importance.
18. "How are you feeling?" is a better beginning than "How can I help you?" "What seems to be the trouble?" or "What brings you to the office (clinic, hospital) today?"
19. Eye contact escalates the importance of the interview and enhances intimacy; its absence is insulting to a patient. Lack of eye contact from a patient is a clinical sign to be interpreted.
20. Read Anatole Broyard's chapter, "The Patient Examines the Doctor" in his remarkable book, *Intoxicated by My Illness*.[4]

In the Middle

21. If you only ask questions that can be answered "yes" or "no," you will not discover the deeper reasons for the visit.
22. You have permission to bring up again any topic, event, or person first mentioned by the patient.
23. Cultivate the capacity not to seem surprised by what patients tell you. They feel less odd or weird when they believe you have heard such tales before.
24. Read Berger and Mohr's *A Fortunate Man*, about the British general practitioner, John Sassall.[5]
25. When the story seems hazy and confusing, pause to summarize your understanding so far, and ask the patient to confirm or correct it.
26. When you feel unexplainedly bored during an interview, think about compulsive personality traits — yours and the patients. Boredom can be a clue to unwanted restraint and is a first cousin to anger.
27. Read MacKinnon and Michel's *The Psychiatric Interview* to see how personality types are revealed in clinical interviews.[6]
28. Recognizing the differences among loquaciousness, circumstantiality, looseness of associations, and flights of ideas puts a wordy interview into proper perspective.

When Death Is the Topic

29. Always notice and pause to express sympathy when a patient mentions the recent death of a family member, friend, or fellow

employee. Spontaneously mentioned deaths, even remote ones, often have clinical meaning.

30. When you discover that a patient is grieving a death, find the time to let them tell you *all* about it, at least once.
31. When a grieving patient's spouse died more than 6 months ago, find out, gently, where the patient is living and sleeping, and what disposition, if any, was made of the spouse's clothes. Any of these items can help pick up on excessive grief.
32. When a patient acknowledges thoughts about suicide, inquire directly about *intent*, a *plan*, and *means* to do it.
33. Never "invite" suicide by word or attitude; either by admitting your powerlessness to prevent it or by appearing dispassionate about death-welcoming behavior.
34. Express your strong, personal wish that patients will not harm themselves and, if possible, extract a promise to that effect.

At the Conclusion

35. Give patients a gift for being so helpful and allowing you to hear their story — a smile, thanks, a pertinent compliment.
36. Your best gift is a preliminary interpretation of the case history, even though it might have to be amended and corrected later.
37. Nurture what is normal in the patient.
38. Recommend a clear plan for action, seek patients' informed consent, and negotiate about differences between their priorities and your own.
39. Persuade without intimidation, concede without umbrage, care about whatever the patient chooses.
40. Say something hopeful.

Concluding Unscientific Postscript

A good many of these rules remind me that I do not always live by them. When I fail to do as well as I know with patients and am forced by one circumstance or another to recognize my failing, the problem is likely to be my violation of one or more of the bundle of meanings intended by a traditional Southern mother when she admonishes her child — leaving for a party or a week at summer camp — "Don't you be ugly." She is less concerned about appearance than bad manners, inconsiderateness, quarrelsomeness, and selfishness; and she knows that proper socialization is a hard-won and fragile achievement, needing constant reinforcement and practice.

On the other hand, because rules for medical practice are distillations from experience with common errors and traps, they are rarely learned once and for all. They, too, need repeated reinforcement, disciplined practice, and even revision to fit new circumstances. It might be illusory to imagine that we can learn from the mistakes of others, but the alternative is to make them all ourselves.

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References

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