

Why Should Doctors Read Medical Books?

Many of us were raised on the multiple-choice approach to knowledge. This method is frequently used for tests in medical school and on Board examinations. Too often, it is the fashion of teaching at the bedside as well: "Name three other things that present like. . ." or "List five etiologic factors in. . ." One might object to calling this an approach to knowledge, saying that it does not produce literate, erudite, scholarly, intellectual, or polished physicians—words usually associated with the idea of knowledge. In fact, knowledge is not the word most often used to describe what is necessary to answer examinations, bedside quizzes, or even the questions of patients. What is wanted is information, and information is just what we get. Information is available everywhere you look or listen, it pours out at us from every crack and cranny. Make no mistake, I believe that this endless flow of information is marvelous, but there are problems.

Access to even the most technical information is inherently democratic; it is there for everyone. In fact, well-informed patients are no longer the exception. The effects of widespread dissemination of and easy access to information about medical science must give us pause. If the facts about medical science do the work in medicine, information about these facts should, like the Colt revolver of old, be the great equalizer, leveling distinctions between physicians and nurse practitioners, physician assistants, and even educated consumers. This implies that the physician is secondary in the care of patients: same science, different physician, same care. This ideological belief dies hard—witness the implications of the rise of practice guidelines and the call for evidence-based medicine.

The idea of an almost autonomous medical science is linked to the concept that physicians treat diseases, an understanding that held medicine in its thrall from the 19th century until it started to wane only a few decades ago. We know now—in fact, clinicians have always known—that physicians treat patients, some of whom have diseases and some of whom do not. In the past few decades, the patient has increasingly assumed center stage, and it can be said that this has been the century of both medical science and the centrality of the patient. The increasing importance of the patient is seen in the patient-centered care movement, contemporary consumerism, the rise of bioethics, debates about the right to refuse treatment, and the assisted suicide

controversy. It is also known that the nature of the person in whom a pathophysiologic process is taking place modifies its onset, diagnosis, treatment, course, and outcome. This is true for acute diseases and is a central fact of the chronic illnesses with which physicians are increasingly concerned.

All of these developments mean that to treat patients most effectively, the physician must understand persons both sick and well, which requires much more than just information about medical science. It demands knowledge of illness, judgment, decision-making skills, and the ability to command technology and apply the advanced therapeutics of today's medicine. Many of these skills used to be called the art of medicine, but this romantic notion is no match for the environment of science and technology in which we practice. Many components of what might be called the clinical method—the skills and understanding that physicians need to best apply medical science to their patients—are just coming into their own, such as clinical epidemiology or communication. Others, such as the place of narrative in medicine, are only now being written about.

For clinicians, an adequate understanding of the psychology of illness and behavioral medicine remains barely visible. At the same time, aspects of molecular medicine new enough to be a mystery to many physicians are on the rise. The knowledge needed to apply modern therapeutics is well beyond that possessed by second-year pharmacology students, just as the understanding required to make the best use of diagnostic technology cannot be acquired by standing around a view box (important as this activity may be). To remain a good clinician, much new material must be learned.

With new kinds of knowledge making their debut in medicine, the problem is no longer merely absorbing an ocean of facts but rather figuring out how the new knowledge fits with the old. Real learning requires personal change. If that does not happen, the new knowledge has not become part of a person's basic understanding. A good example is the common experience that physicians do not pay attention to patients' desires not to be resuscitated. A recent study documented this fact, to the consternation of the public (1). Did this happen because these physicians do not care about the wishes of patients or because they do not know that patients have the right to refuse treatment? I think not. It

