Introduction to Volume 1

This book is based on four premises about clinical medicine: doctors treat patients, not diseases; the body has the last word; all medical care flows through the relationship between physician and patient; and the spoken language is the most important tool in medicine. Because not every physician would agree with these beliefs (although most would accept the primacy of the body), a little history is necessary to situate this book and the ideas in it.

During the 1930s my grandmother saw a specialist about a melanoma on her face. During the course of the visit when she asked him a question, he slapped her face, saying, "I ask the questions here. I'll do the talking!" Can you imagine such an event occurring today? Melanomas may not have changed much in the last fifty years, but the profession of medicine has. I believe medicine is in the midst of fundamental and exciting changes; it is evolving toward a profession in which the primary concern of physicians is with sick (or well) persons rather than merely their diseases. Indeed, this is probably the most profound shift in medicine since the concept of disease, as we know it, came into being in the 1830s.

Medicine has always been a profession of action: doctors do things to their patients. When the primary focus of medicine is on diseases, the important acts of physicians are, generally speaking, acts of discovery. In his book *Doctor and Patient*, Dr. Lain-Entralgo tells the story of the brilliant clinician Skoda making rounds. Skoda held forth at the bedside of a patient, displaying his usual diagnostic skill. At the end one of his assistants asked what should be done for the patient. Skoda impatiently brushed the question aside as irrelevant! Because of the lack of effective therapies in his day, one might understand Skoda's posture. However, only a few years ago the same attitude was expressed by a resident who told his students that only three things were important in medicine: "The diagnosis, the diagnosis, and the

diagnosis." In view of the importance of diagnosis and research, it is no wonder that the heroes of the disease era were heroes of discovery—primarily research scientists.

In the last few decades, with the advent of modern therapeutic effectiveness, we have changed from a profession of discovery to one in which intervention is primary; now the acts of physicians are acts of intervention. It should be no surprise that the heroes of an interventionist medicine are often surgeons, and the status of research scientists has faded (a state of affairs that could compromise progress in medicine). While one would think that the behavioral guidelines and the basic concepts and skills that doctors acquire during their training would be truly different in an era of intervention, compared with those aquired in the era of discovery, this does not yet seem to be the case. In emphasis and curricula, with a few notable exceptions (particularly among the new medical schools), medical education today is monotonously similar to my own education thirty years ago. Lack of change in the educational agenda is one of the reasons that our exciting and successful interventionist technology continues to have many problems in its application.

Although physicians can often do marvelous things for a liver or a cardiopulmonary system, what is good for the liver, the heart, or the lungs is not always good for the patient! Symptomatic of our difficulties is a patient with end-stage ventilatory failure, whom all know is as good as dead, still hanging from a respirator which no one has the nerve to turn off. Everybody is uncomfortable about such a situation: students talk about not wishing to play God; the hospital administrator fears a law suit; the house staff wonders how many more times they will be called on to resuscitate the patient; the attending physician avoids talking frankly to the patient or the family; and the family guiltily wonders how much longer all this will go on. When I was a student, my professor of surgery described an exploratory laparotomy on a patient with bowel obstruction in the days before long tubes. He said, "As I watched them trying to stuff all that distended bowel back in the belly, while it kept popping back out, I thought, 'This just can't be the way things are meant to be.'" Thinking about patients like the one just cited I feel the same way. Difficulty in judging how best to use the new knowledge causes trouble for patients and their families and creates emotional and professional strains for physicians as well. Not only does conventional training fail to prepare physicians to mediate these strains, the orientation of training is itself responsible, at least in part, for the undiscriminating use of medical technology. The attitude taken by some physicians is, "If it *can* be done, it *should* be done."

Classical science taught that to understand the whole, whether it be a human or a laboratory mouse, one should break it down into observable parts, isolating (in a controlled fashion) the aspect to be studied. The results of such research, when they are put back together, are believed to give an understanding of the whole organism. The science that underlies the brilliant accomplishments of modern medicine, and that all physicians are taught, is based on such reductionist beliefs. It is obvious to most, however, that despite past achievements the complexity of human existence with its creativity, desires, hopes, aspirations, as well as oppression, war, poverty, and misery has not yielded to the methods of science. Rather than either pretending that reductionism is working when it is not, or eschewing science for some mystical approach, concerned scientists have searched for alternate scientific methods. A whole new way of thinking about the complex wholes that physicians deal with—persons, families, and communities—a theory of "general systems," has come into being. The emphasis in this book derives from systems thinking: physicians dealing with sick patients must always try to find out how the pathophysiology that bears on the illness is expressing itself at the whole human level, as well as at the organ and cellular levels.

During this period, when doctors are beginning to confront the dilemmas of technical versus humane medicine, the general public has also changed its attitude toward medicine and its practitioners. Increasingly dissatisfied with reductionistic principles, people are seeking what is popularly referred to as "holistic" medicine. Although most people are not sure what holism is, they are quite clear about what it rejects: the treatment of patients by physicians as though they were merely objects, diseases, or malfunctioning body parts. As practiced now, however, holism frequently seems to embrace chiropracty, "megavitamin therapy," and other alternative therapies that do not seem to many of us either holistic or even particularly useful. These deficiencies should not keep one from recognizing the unmet needs and the social force for change represented by holism.

If the sick person is to be the focus of medicine, then new concepts, skills, and guidelines for behavior are needed. In medicine we do not simply describe the procedure for an appendectomy and then leave students to their own devices. We define appendicitis, base the definition on anatomy and pathology, demonstrate how it manifests itself, how the diagnosis is made, and how to treat it. Similarly it is not sufficient to tell a student or physician to treat sick persons and not

just their diseases. Without the necessary definitions, tools, and skills all that has been created is a moral injunction, like the story of the Good Samaritan—"Go and do thou likewise." When a person fails to fulfill a moral injunction, that person generally ends up taking the blame and feeling badly. Then, despite good intentions, patients are not better off, and doctors feel like failures. This is frequently what happens today when physicians start their internships. They are supposed to care about their patients as "persons," use their "feelings," and be "open" and communicative. Given the fact that they have no specific training in this aspect of patient care, however, that they are overwhelmed by work, and that they are usually rewarded for technological rather than interpersonal skills, the young physicians' sense of inadequacy may defeat their good intentions.

From time immemorial there have been physicians who were extraordinarily adept at working with patients—taking histories, establishing rapport, achieving compliance with even the most unpleasant regimens, being sensitive to unspoken needs, providing empathetic support, communicating effectively, and even getting paid after the illness. This expertise, usually called "the art of medicine," is acquired by most through years of experience. Some doctors, nevertheless, are more skilled with patients than others; because of this it is frequently said that the art of medicine is a matter of "intuition" and is unteachable: "You either have it or you don't."

I am convinced that the art of medicine can be studied and taught in a systematic and disciplined manner. Critics often act as though the words "systematic and disciplined" are applicable only to science and are incompatible with "art." Ludwig van Beethoven, judging from his notebooks, was extremely systematic and disciplined, as were Michelangelo, Pablo Picasso, and probably every other fine artist. With regard to teaching an art, although talent and intuition may be essential, even child prodigies have teachers and work constantly to refine their skills. In the absence of disciplined effort prodigies would surely not realize their promise.

The art of medicine is composed of abilities in four different but interrelated areas. The first is the ability to acquire and integrate both subjective and objective information to make decisions in the best interests of the patient. The second is the ability to utilize the relationship between doctor and patient for therapeutic ends. The third is knowing how sick persons (and doctors) behave. Finally, the central skill on which all the others depend is effective communication, the subject of this book.

This book is about the spoken language in medicine, about con-

versation between patients and doctors. The chapters that follow go into considerable detail about how the spoken language actually *works* in medicine—how it does its job. We would never dream of teaching physical diagnosis to students lacking a background in anatomy and pathology. It is important to know not only what hepatomegaly due to metastatic cancer feels like but *why* it feels the way it does. Similarly it is a great help, when listening to heart sounds, to be able to visualize the heart in action. Although physicians in training will have a chance to feel the nodular liver of malignancy and to hear the murmur of mitral stenosis, the next liver and the next murmur will not present themselves in the same way or in the same setting. One must not only have experienced fingers and ears but the knowledge to interpret sensory information when it varies from that encountered on previous occasions.

Because the way a person speaks is an intimate and integral part of that person, the spoken language differs from other tools and skills in medicine. Digitalis glycosides work the same way whether the doctor prescribing them is shy or bold, sensitive or overbearing; the drug's action is separate from the doctor. If a doctor is teaching the use of a sigmoidoscope and says, "Never push the 'scope forward unless you see a hole," it does not matter what kind of a person you are for the strategem to work. Suppose, however, that the interviewing instructor tells you, "Walk straight in and say, 'My name is Doctor Osler and I'd like you to tell me the story of your illness.'" Perhaps you can do that, but if you are uncomfortable, the words may sound wooden and artificial. For you it may be necessary, for example, that the patient give some sign of approval before you can feel at ease asking questions. "Hi, Mrs. Friendly, may I sit down? Thank you. My name is Bill Osler. Could you tell me the story of your illness, please?" Speech is part of the presentation of self, and a speaking style that is foreign to you will not work. When, however, you understand the function of the utterance—what you want it to do—then the phrases can be successfully adapted to your personal style.

One would think that the spoken language would have been subject to intense scrutiny, given its importance. Yet the scientific study of natural conversation is a relatively new discipline. The basic difficulty with such study derives from the fact that language is fundamentally and irreconcilably different from other objects of scientific inquiry. Science has been successful because of the ability of scientists to study in controlled isolation, simple, linear, cause-and-effect parts of more complex wholes. This produces "dyadic" statements of the type with which we are all familiar: "If A, then B."

Starling's law of the heart is of that type, as is the All or None rule of nerve conduction. Explanatory principles are easily constructed when phenomena can be characterized in terms of dyads, or sets of dyads.

Language, however, is totally different; it is irreducibly triadic. Words do not merely stand for things, as in "Apple is a word that stands for the firm, fleshy, edible fruit of the tree, *Pyrus malus*." How about "She's the apple of my eye," or "One bad apple spoils the whole barrel," or even "Adam's apple." If words merely represented things in the same manner that a thermometer reading represents a certain temperature, then the study of language would proceed in a nice orderly manner. But whereas the thermometer functions independently of persons who might take an interest in its reading, words do not; they represent not only something "out there" but the person using them as well. With exceptions that will be discussed in the text, words always stand for something *to someone*. The irreducible triangle consists of a word, the thing it stands for, and the person for whom it has that meaning. Complications arise because there are almost always variations between the meanings of the same words for different people. Since one cannot verify in objective terms what is going on inside the mind of another, the problem of personal meaning has thus far proved impenetrable.

Fortunately all the features that make the spoken language opaque to science provide opportunities for clinicians. Human illness is, in fact, triadic in the same manner as language. Diseases, when isolated and confined to their afflicted cells, organs, or enzyme systems, may be quite constant in the manner in which they express themselves, and we have instruments that measure their activity, just as a thermometer measures the kinetic behavior of molecules. However, each *illness* caused by a given disease is unique and differs from every other illness episode because of the *person* in whom it occurs. Even when a disease recurs in the same individual, the illness is changed by the fact that it *is* a recurrence; it now carries the associations and the history of the previous episode. Though it is obvious that genetic makeup or changes in immune response can alter the reaction to disease, as can diet, personal habits, and level of physical conditioning, the presentation, course, and outcome of a disease can also be affected by whether the patient likes or fears physicians, "believes" in medication or abuses drugs, is brave or cowardly, "self-destructive" or vain, has unconscious conflicts into which the illness does or does not fit, and so on. These features are part of the illness, for illness is not only a physical event but a "meaning event" as well. Throughout the book

the reader will see examples of patients attaching meaning to symptoms and illnesses. Indeed, there is no event that befalls humans to which meaning is not attached. It is the triadic nature of human illness that makes the art of medicine so vital; if every patient were the same, then merely to know the disease would be to know the illness.

The material in this book is drawn from hundreds of hours of natural conversations between doctors and patients in offices, hospital rooms, clinics, and emergency rooms. These hours were distilled in turn from well over one thousand hours of recordings involving many physicians and more than eight hundred consenting patients taped in 1974 and 1975. (In contrast to most previous studies of doctor-patient communication, only a small minority of these recordings involved clinic patients or doctors in training.) My staff and I attempted to apply the existing knowledge in linguistics to the specific problem of doctor-patient communication. However, every idea and concept had to meet two simple tests: was it relevant to conversation as it actually occurrred, day to day? and was it relevant to better patient care? (Tape recorders are like cameras; they merely record what is, whether flattering or not. Listening to a conversation in which you have tried a new way of talking can indicate success or failure in short order. I strongly recommend that you tape your own conversations with patients. Nothing will enlarge understanding more rapidly—this has been my own experience and that of my students.)

The object of the analysis of these recorded conversations was an increased understanding of medicine, not of linguistics per se. Nonphysicians and students of language who may read this should be aware that, although much of what is presented here clearly has wider theoretical implications for the study of the spoken language or applicability to other fields such as law or education, this is a book about medicine, by a physician, for physicians and students of medicine. (Similarly I have ignored some of the issues that have exercised linguists interested in doctor-patient communication because I do not believe that they have utility in the care of patients.)

The examples, besides illustrating issues in communication, also involve actual cases and approaches to the care of patients. The reader will become closely acquainted with how I practice medicine, what I believe the nature of the relationship between patient and physician should and should not be, and even how I treat certain illnesses. In addition the personal approaches of other physicians are exemplified.

When I first started listening to recordings of other physicians in

their offices, I was pleased to hear that the same things, some of them quite strange, happened in their offices as in my own. Doctors who have listened to me with my patients have expressed the same sentiment. The practice of medicine is a very private matter. The most intimate aspects of a patient's life are revealed in physicians' offices, ranging from what kind of underwear is worn (or not) to what the person secretly thinks about other family members, as well as the overtly sexual matters that are usually associated with the word "intimate." At times the doctor is as much exposed as the patient; for this reason I admire the doctors who put aside their reservations to wear my microphone. Consequently readers should understand that they are privy to information shared by few in the past. For the same reason and because it has a single author, this book will be unavoidably idiosyncratic. Despite the drawbacks of this personal quality I hope the reader will find learning about how another doctor works as interesting as I do. Because this approach is neither quantified nor treated statistically, it may cause discomfort to physicians who have been raised on numerical data and taught to avoid the anecdotal. I believe that there is *no* other equally effective or realistic manner, however, to approach the study and teaching of communication between doctor and patient in the clinical setting. Indeed, the recitation of cases—telling stories—has been a way to teach medicine that has survived through the ages because nothing else does the job as well. In fact recently scholars have begun to direct attention to the stories about patients used in teaching because they convey a kind of information that can be transmitted in no other way. Because the information presented here is personal, subjective, or anecdotal does not mean that it cannot be studied in a systematic manner that will allow generalization beyond the particular instance. Examining the music of a particular composer, for example, will reveal aspects that are unique to the composer's style. Studying the same music, one can demonstrate the rules of form and composition that apply to music generally. So it is in this book: examples drawn from the interaction between two people reveals things about these two people as individuals and also about interactions and communication in general.

It takes time to become adept at using the spoken language as an effective medical tool; readers should be patient with themselves, but persistent. It may require many months before you begin to hear people shift to impersonal pronouns when they describe their illnesses or unpleasant events, as described in chapter 2. But once you become aware, you will hear the phenomenon everywhere. The secret of mastering the spoken language in medicine is simple—just keep at it.

Remember, you cannot avoid using the language; the question is whether you will use it to its best advantage. Let me recommend again that you tape your own conversations with patients. Modern tape recorders are so small and unobtrusive that it is generally a simple thing to do. Remember to ask the patient's permission. Patients generally do not mind as long as they know that their privacy will be maintained. (The appendix describes the techniques for recording in greater detail.)

When I was a medical student I bought a copy of Bailey's *Physical Signs in Clinical Surgery*. It was full of wonderful pearls of wisdom about physical diagnosis. It sat by my bedside for years, and I would often pick it up and read wherever it happened to open. On many occasions what I learned from Bailey has worked for me. I began to buy copies and give them away as gifts for my students, so that they too should come to love the lore of clinical medicine. (You'd do better to buy the earliest editions you can find; the later editions are weaker.) It is my hope that students and physicians will find that the more medicine they know, the more this book has to offer, and that it too will be worth revisiting.

References

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