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

reflects the fact that physicians do not know how, in terms of their medical actions, to make the patients' desires, needs, concerns, or wishes central. All of our long training has concentrated on the centrality of disease and medical science, learned decision making, automatic behaviors, rules of thumb, and algorithms. Too many of us have not yet incorporated the basic concepts of contemporary medicine into the matrix of ideas and actions that determine our treatment of patients rather than their pathophysiology.

How will physicians learn to change the focus of their actions and acquire the new knowledge and clinical skills needed to place the patient rather than the disease in the center of their thoughts? I do not believe that this will happen by scooping up information, even by the bucketful and from no matter what source. It is necessary to read books.

To prepare this essay, I went to the bookstore and looked at many textbooks of medicine. They reminded me of the Irish elk of evolutionary fame whose antlers, it is said, became ever larger in the course of its evolution until it could no longer get through the forests and perished from the earth. Aside from the immense size of medical textbooks (which requires that some of them have smaller books to tell you what is in the larger book), I believe that I can generally get what is in them from my computer at a similar speed. It is natural that they should have evolved in this fashion because their task has been to describe human disease in depth and give the associated details of pathophysiologic mechanism. These days, that takes up a lot of space. Clearly, these are not the books from which one can learn to reformulate one's actions.

The form and content of medical books, naturally enough, reflect the dominant theory of medicine of the era in which they are written. Typical of its era is *Typhoid Fever and Typhus Fever* (2) by H. Curschmann, translated from the German and edited by William Osler and published by Saunders and Company in 1901. This book contains precise, in-depth descriptions of typhoid fever and typhus fever and discusses their cause, pathology, diagnosis, prophylaxis, and treatment. Osler's textbook (3) was cast in the same mold. At that time, medical attention focused on diseases; the theory of medicine that arose early in the 19th century held that sick persons had a disease and that disease could be discovered by finding the structural (later, biochemical) abnormalities that characterized it. The idea of pathophysiology and the importance of mechanisms of disease began to take hold early in the 20th century and became entrenched by the 1950s. Books changed to reflect the new emphasis. When Homer Smith (4) wrote *The Kidney* in 1951, he did not merely describe various renal diseases. Instead, he illustrated the physiology of the kidney in mathematical terms, according to the growing ideal that biology should approximate physics. Physician–readers of such books struggled with the formulas (such as that for creatinine clearance) while they absorbed the new perspective on medicine. The same ideas ultimately became the basis for the current textbooks of medicine, and the streams of information that reinforce these same theories continue to dominate our thinking.

Now that knowledge is again changing, newer books focus increasingly on the centrality of the patient. The opening chapters of modern textbooks of medicine often offer excellent discussions about patients, medicine, and the experience of being a physician, subjects absent from Osler's textbook of medicine. (I am surprised that nobody has collected these often wonderful essays into the book of their own that they deserve.) More important, however, are the books about medicine that have appeared in the past decade or so that focus on the patient; these provide a perspective on and a way of understanding medicine found nowhere else. *The Meaning of Illness* (5), by S. Kay Toombs, is an excellent example. A philosopher with a highly readable writing style, Toombs has multiple sclerosis. Her book is an introduction to what illness means to the patient on many levels. Because of Toombs's training, keen intellect, and wit, the reader learns about the life world of the patient and how it contrasts with the technical world of physicians (toward whom she is sympathetic and about whom she is very knowledgeable). Just as the early pathologists taught clinicians how to look at diseases, books such as Toombs's teach us how to look at ill persons. Unlike the profusion of biographies of patients with illness, *The Meaning of Illness* is about illness and medicine, not its author. Although Toombs uses her experience with multiple sclerosis as the lens, she herself is barely visible. I cannot recommend this book too highly.

Much can also be learned from biographies of patients with illnesses, but there are so many that it is difficult to know where to start. Fortunately, Anne Hunsicker Hawkins (6), in *Reconstructing Illness*, provides an analysis of the genre that makes the task of deciding which books to read much easier. Howard Brody's *Stories of Sickness* (7) is a slim but substantive book that examines the meaning of illness from a philosophical and a medical perspective. Brody, a philosopher and a practicing family physician, shows how these disciplines enrich each other. In his book, one discovers many of the underpinnings of the current emphasis on narrative in medicine as he examines sickness from the point of view of the patient and of a person in a social world. Arthur Kleinman's *The Illness Narratives* (8) is another important work. Kleinman is a psychiatrist and an anthropologist; because of this dual

background, he is keenly aware of the importance to patients of the meaning of their illness. Everyone, including physicians, reacts to objects, events, and relationships on the basis of what they mean personally, rather than on the basis of some objective standard for external reality. To act effectively for patients, clinicians must understand these meanings. One cannot finish Kleinman's readable book without comprehending what meaning-centered medicine is and the challenges it presents to our profession.

Physicians illustrate the meaning of events for each other by telling stories; in fact, medicine is awash with stories. We have heard of the dangers of anecdotal medicine, actions based on a series of one case, but I think an equivalent problem is that we do not know how to construct a good anecdote. Katherine Hunter's *Doctor's Stories: The Narrative Structure of Medical Knowledge* (9) confronts that problem head on. From a background in English literature, Hunter writes engagingly about what medical narratives are, their uses in day-to-day medicine, and their importance for understanding the work of physicians. She shows convincingly how much more could be done with narrative to understand patients, physicians, and the work of the medical profession.

All of the aforementioned books are well-written, highly readable accounts of a new trend in medicine. In this view, what happens to the patient in the course of the illness is an unfolding story into which physicians, medical science, and other caregivers enter and become participants. Successful outcomes are not cures, but a life of personal and social function continued to the degree permitted by the disease. The narrative of the illness after treatment should be free of suffering and unnecessary symptoms and coherent with the patient, even in terminal illness. Because of this trend, do not be surprised to see the narrative history and physical examination ultimately replace the current, disappointing problem-oriented record.

The centrality of the patient has become part of books devoted to technical medicine. For example, in Russell K. Portenoy and Ronald M. Kanner's *Pain Management: Theory and Practice* (10) and Alexander Waller and Nancy L. Caroline's *Handbook of Palliative Care in Cancer* (11), the underlying assumption is the central importance of the patient. In Ira Byock's *Dying Well* (12), the narrative and the technical aspects of medicine come together. Byock has written a series of engaging case reports about palliative medicine from which one can learn a great deal about caring for the dying in ways that enhance rather than diminish them.

Returning to the patient is also the compelling and unspoken theme of a unique book that demands special notice. Joseph D. Sapira's *The Art and Science of Bedside Diagnosis* (13) may be the most readable, aesthetically pleasing, and fact-filled physical diagnosis book ever written. By mentioning this book, I mean to make it clear that the centrality of the patient does not mean just the patient's narrative or the patient's psychology; it means all of the patient, body and soul, from the mitochondria to the community and every part in between.

One more thing: Evidence-based medicine, clinical guidelines, critical pathways, and the like are intended to ensure that physicians do the right (evidence-supported) thing for their patients. These systems for organizing modes of treatment, for all the good they may do, have a baleful effect. They are like computerized interpretations of electrocardiograms that ultimately reduce the ability of physicians to read them. They shrivel up the most important tool that physicians bring to patient care: the exercise of rational judgment. The silent theft of the ability to craft sound clinical judgments is best fought by reading medical books. A wonderful antidote to the diminishment of clinical judgment is *Advanced Dermatologic Diagnosis* by Walter B. Shelley and E. Dorinda Shelley (14). Reading the opening chapters on observation and diagnosis and seeing how the authors use the literature is a joy. The Shelleys open their acknowledgment section by stating that, "Thought doesn't grow on trees. It grows in the library."

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