Letters to the Editor

The Journal welcomes letters to the editor. If found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with Journal style. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, Department of Family Medicine, Medical College of Georgia, Augusta, GA 30912, or Fax (706) 855-1107.

TOBACCO AND PHARMACIES

To the Editor:

I have included a copy of my prescription form, which provides a message to pharmacies that continue to sell tobacco products to customers. It is my belief that cigarette smokers use more prescription products than nonsmokers. The provision of tobacco products at the pharmacy may send a message to smokers that this pharmacy supports the desire to smoke. The cigarettes are often displayed just below the pharmacy window. This is excellent marketing, but horrible health care. The pharmacists in my area hate this practice and openly state their disgust. But their complaints to their managers usually fall on deaf ears. It seems that pharmacy chains are more concerned about money than health.

I am asking that you consider publishing a copy of my prescription form and encourage other doctors to put my slogan on theirs: *Please consider using a pharmacy that does NOT sell TOBACCO products.* Maybe it will send a message back to the marketing departments of these large drugstore chains if they see this is being done throughout the country. A pharmacy that makes tobacco products available to its customers is not a welcome partner on my health care team.

Wm. Jackson Epperson, MD
Murrells Inlet, South Carolina

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DEA # AE3171662
(803) 651-4111 or (803) 237-8481

Date: _____ Patient Name: _____

Address: _____

Rx		Refills
1		
2		
3		
4		
5		

_____ M.D. _____ M.D.
Dispense as Written Substitution Permitted

Please consider using a pharmacy that does NOT sell TOBACCO products.

INFORMED CONSENT

To the Editor:

The recent editorials by Hartlaub et al[1] and Stein[2] raise many questions about what constitutes informed consent. These questions transcend the specific case presented: that of a man with a 40-year history of "prostate problems" who was advised by his physicians to have a needle biopsy of the prostate based on "irregularity of the prostate and . . . elevated prostate-specific antigen level." In his commentary on this case, Stein concludes that "a good physician-patient relationship is the only reliable foundation upon which 'informed consent' can take place."

There appear to have been several omissions on the part of the physicians portrayed by Hartlaub et al[1] in the provision of informed consent prior to needle biopsy to confirm prostate cancer in this particular case. We are told that these physicians perceived "a new problem that possibly was cancer, for which treatment, although not proven to be effective, could be considered." How thoroughly did they discuss with the patient the current controversies concerning the efficacy of their recommendation? Were they aware of the evidence that finding palpable prostate nodules[3] or aggressively treating symptomatic prostate cancer[4,5] might not be in the best interests of their patient? Did they understand that finding cancer does not necessarily confer a benefit? Our questions, as well as those raised by Dr Stein,[2] highlight our need as physicians to appreciate our often limited understanding of the risks and benefits of the interventions we propose.

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References

1. Hartlaub PP, Wolkenstein AS, Laufenburg HF. Obtaining informed consent: it is not simply asking "do you understand?" J Fam Pract 1993; 36:383–4.
2. Stein HF. Informed consent: who's informed? who's consenting? and other questions. J Fam Pract 1993; 36:385–6.
3. Mold JW, Holtgrave DR, Bisonni RS, et al. The evaluation and treatment of men with asymptomatic prostate nodules in primary care: a decision analysis. J Fam Pract 1992; 34:561–8.
4. Stamey TA. Cancer of the prostate: an analysis of some important contributions and dilemmas. Monogr Urol 1983; 4:68–92.
5. Johansson JE, Adami HO, Andersson SO, et al. High 10-year survival rate in patients with early, untreated prostatic cancer. JAMA 1992; 267:2191–6.

The preceding letter was referred to Drs Hartlaub, Wolkenstein, and Laufenburg, and to Dr Stein. They respond as follows:

An editorial we recently published in *The Journal of Family Practice*[1] has re-

cently been challenged in an interesting way. In the editorial, a case was described in which a patient with an irregular prostate and an elevated prostate-specific antigen level was told by the authors that he had a new problem that possibly was cancer, for which treatment, although not proven to be effective, could be considered. In a recent response letter, this approach has been challenged with the implication that the authors should have further discussed the current controversy regarding the efficacy of screening and treatment of prostate cancer with this patient. A reference to three[2–4] of the numerous studies that contribute to this continuing controversy was made. Although this issue was the primary focus of our editorial (ie, that the physicians in this case did not adequately ascertain whether the patient indeed understood what he had been informed of), the letter from Drs Hahn and Roberts raises another interesting issue: How much detail should we relay to patients?

The word *doctor* in Latin means "teacher,"[5] and as the word implies, our duty as physicians is to educate patients. But to what extent? How many of the side effects listed in the *Physicians' Desk Reference* do we relay to the patient for whom we prescribe a specific drug? In working up a complaint of "fatigue," do we explain every possible test that could be performed, or just the ones that we believe would be appropriate? When doing routine medical cultures during a prenatal pelvic examination, do we explain the potential marital ramifications of all possible culture results, or just explain that we would like to do some routine cultures for infections that might be bad for the baby? Medical judgments such as these are individualized and make up what we refer to as "the art of medicine." Because the individual needs and capabilities of patients vary, there are no universally "correct" approaches.

Did the physicians in this case provide enough information to the patient? We believe the amount of information given to the patient was appropriate to his level of understanding, and in accord with the standard of practice in the community. The providers were aware of the paucity of evidence regarding the efficacy of prostate cancer screening and treatment, as clearly and thoroughly described by the US Preventive Services Task Force.[6] The providers also believed that the potential value of available treatment options was important enough that the options, although not yet adequately studied, "could be considered." The uncertainty regarding the potential benefit of treatment was communicated to the patient by stating that treatment was "not proven to be effective." The clinical and ethical judgment of the providers in this case was that giving the patient more details about the prostate-screening and treatment controversy was not indicated because it would not have enhanced the patient's understanding and freedom of choice. In fact, it would have risked poorer understanding by virtue of confusion.

How much detail should providers relate to patients in general? It depends. It depends on the needs and capabilities of the individual patient. It depends on the clinical and ethical judgment of the physician. It is the essence of what we respect and admire in "the art of medicine."

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References

1. Hartlaub PP, Wolkenstein AS, Laufenburg HF. Obtaining informed consent: it is not simply asking "do you understand?" J Fam Pract 1993; 36:383–4.
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4. Johansson JE, Adami HO, Andersson SO, et al. High 10-year survival rate in patients with early, untreated prostatic cancer. JAMA 1992; 267:2191–6.
5. Stedman's Medical Dictionary. 22nd edition. Baltimore, Md: Williams & Wilkins, 1972:373.
6. Fisher M, Eckhart C. Guide to clinical preventive services. An assessment of the effectiveness of 169 interventions. Report of the US Preventive Services Task Force. Baltimore, Md: Williams & Wilkins, 1990: 64–5.

In their letter, Drs Hahn and Roberts's interest in the case of informed consent reported by Hartlaub et al, which involved a patient with prostate cancer, reminds us that, in biomedicine, a truly "good" or interesting case need not always be the exceptional or diagnostically exciting one (*Hartlaub PP, Wolkenstein AS, Laufenburg HF. Obtaining informed consent: it is not simply asking "do you understand?" J Fam Pract 1993; 336: 383–4*). Instead, it is sometimes the *exemplar* of a potentially large class of similar cases or clinical situations.

Drs Hahn and Roberts remind us that in obtaining informed consent it is important to ask good questions, ones that explore all participants' viewpoints, values, expectations, feelings, hopes, and assumptions. But questions can also be noise we cast into the void where a true patient-physician relationship should exist. If it is true that questions make opportunities, they can also lose them. Questions can interrupt feelings and thoughts, which then remain unexpressed.

Sometimes asking questions can actually be a way of not listening, of not having to listen, of forcing our own story line on patients, because we do not wish to hear theirs, or because we are unable to bear the story we might hear. In obtaining informed consent, do we remove ourselves emotionally from the situation, secretly abandoning the patient, or do we convey the message, "I shall be with you no matter what"?

Perhaps a widely shared but unstated fantasy among health care providers is that informed consent could be assured if only we knew the right questions to ask—either the perfect definitive question or at least a computerized protocol of questions statistically proven to achieve "informed consent." The essence of informed consent, however, is not found in the art of questioning or in the questions themselves. Rather, informed consent is a matter of process. It involves the ebb and flow of a doctor-patient relationship, in which questions arise, are posed, feel safe, and are answered—but this context cannot be dissolved into the questions themselves!

In talking with patients, I have often found that by giving them the opportunity to tell their story, they will answer questions I need not ask. Every question embodies a kind of answer. I do not hold that we should not ask questions, but that we understand ourselves and our patients well enough to know why we are asking what we are asking.

I sometimes despair that "informed consent" is little more than a culturally supersaturated cliché that may turn out in the long run to render more risk than benefit. We had good intentions when

continued on page 328

continued from page 326

we conceptualized it, but it has become a monument to our depersonalized, paper-trail world, an artifice of our mistrust, a clumsy way we strive to make amends in a society built largely on latch-key relationships.

Good questions can help us to tolerate not knowing and sometimes overcome it. So can compassionate listening and shared silence.

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"BACK MOUSE"

To the Reader:

My old mentor, Peter Curtis, MD, has always been a bit of an iconoclast. I was therefore not surprised when I received his manuscript on the back mouse (*Curtis P. In search of the "back mouse." J Fam Pract 1993; 36:657–9*). Readers may recall that this is a frequently ignored fibrous nodule that occurs in the low back of patients with back pain. Many of these patients have had multiple musculoskeletal diagnoses in the past (ie, disc disease). Having never heard of a back mouse, I assumed that if it did occur, it must be rare.

Today, I saw a 70-year-old man with several previous episodes of back pain. "Lumbar disc" and "back strain" had been the former diagnoses. Each episode had been precipitated by bending, and each slowly resolved over a matter of weeks. The current episode had lasted 2 days.

Because of Peter's paper, I checked this man for a back mouse. Sure enough, in the left lumbar region was a 5-cm fibrocystic, subcutaneous mass. I realized that I had palpated mice many times before and assumed they were muscles in spasm. Having discovered this back mouse, I followed Dr Curtis's advice, injecting it with lidocaine and sticking it numerous times with a needle. The patient had instantaneous relief and in amazement (exceeded only by my own) he jumped off the table pain-free.

Thank you, Dr Curtis.

Paul M. Fischer, MD
Editor
The Journal of Family Practice
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To the Editor:

I was pleased to see the article about the back mouse in your June 1993 issue (*Curtis P. In search of the "back mouse." J Fam Pract 1993; 36:657–9*). I have found that these nodules are a relatively frequent cause of low back pain over my 38 years as a family physician, but have seen only one article during this time. Many times the patient has been seen for chronic low back pain over many months or years by other physicians, including orthopedists, without resolution of the problem. Thus, I have become the "hero" in many cases.

My technique has varied from injecting lidocaine alone to injecting lidocaine with a corticosteroid directly into the nodule by multiple needle punctures. Nearly 100% of tender nodules so treated become nontender immediately and the patients become symptom-free by the next day. The few who have been relieved by injections temporarily but pain has recurred have been permanently cured by excision of the nodule.

I would try the multiple needle puncture technique without lidocaine, but the lidocaine gives immedate relief of the tenderness, verifying that I have punctured the correct nodule. Also, the patient knows immediately that the procedure has been successful and walks out of the office with a smile on his or her face instead of having to wait until the next day.

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CORRECTION

In the August 1993 issue of the Journal (page 117), the references given for the letter of reply from Peter Curtis, MD, and Geoffrey Bove, DC, were incorrect. The following references correspond with the five citations in the letter.

References

1. Chiropractic in New Zealand. Report of the Commission of Inquiry. Wellington, New Zealand: PD Hasselberg, Government Printer, 1979.
2. Livingston M. Spinal manipulation causing injury: a three-year study. Clin Orthop 1971;81: 82–6.
3. Bourdillion J. Spinal manipulation. 5th ed. London: Butterworth-Heinemann, 1982.
4. Cyriax J. Textbook of orthopedic medicine. 11th ed. London: Bailliere-Tindall, 1984, vol 2.
5. Maigne R. Orthopedic medicine. Springfield, Ill: Charles C. Thomas, 1978.

The Journal regrets this error.