Evidentiary Medicine Lacks Humility

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Five years ago as editor of *The Journal of Family Practice*, I had the pleasure of working with Mark Ebell to start the "JFP Journal Club" feature, now called POEMs. I am pleased to say it continues to provide an appropriately conservative view of the world's medical literature, with a bias that is clearly grounded in the real world practice of patient care. Reading this feature is one of the most efficient ways to stay current with the important changes in medical science.

I now spend most of my professional time in the private practice of medicine; however, I still use an academic approach to patient care. I regularly read 4 medical journals. I enjoy my daily repartee with drug representatives ("Gee, you mean your new drug is just as effective a platelet inhibitor as aspirin and costs only $70 per month?"). I even admit to momentary feelings of guilt when I prescribe an antibiotic for what is likely to be a viral sinusitis ("You certainly are tender over that left maxillary sinus.").

You might, therefore, expect me to be supportive of the recent national infatuation with evidentiary medicine. Its supporters seek to distill the truth from medical science and then standardize health care by providing physicians with various consensus panels, clinical guidelines, expert opinions, and clinical report cards. This proposed industrialization of health care assumes that the world would be a better place if we treated our patients uniformly by a single set of rules, such as all patients with diabetes must have eye examinations once a year.

If I do not systematically follow such scientifically supported pronouncements, there are threats of specialized programs that claim to efficiently and reliably accomplish the obligatory work. I recently discussed one of my patients with the regional chief medical officer of a national managed care organization who was enamored with single-disease–focused programs:

Me: There is no way that some patients will ever get their Hb A_{1c} level below 8. I am happy when Brenda's value is below 9.

Him: You should enroll her in our diabetic module. We have the data that it really works.

Me: But she also has depression and believes that chocolate is a better antidepressant than Prozac. She cannot exercise because of her stroke and heart failure. Her husband hates her. She has no money, and her son is in jail for kidnapping.

Him: Then you should also enroll her in our congestive heart failure and depression modules. We have the data that they are very effective.

I worry about attempts to standardize health care, because a good physician is an expert at *individualizing* care. I also worry about those who come away from reading the medical literature with total confidence and dogmatic pronouncements about appropriate care. I come away from that same literature with incredible humility about how little medical science knows.

There is a great deal that one must know to be a good physician, but evidentiary medicine does not get you very far. It is a necessary beginning, but it is an alarmingly insufficient tool for the practice of good medicine. Here is my list of alternative tools that a good physician accumulates during the long days and nights of caring for the sick, the sad, the worried, the well, and their families:

Understanding the Power of the Therapeutic Relationship. A dose of the good physician can be the very best medicine. Good physicians understand the power of their role as healer. This power makes their diagnoses believable, their treatments effective, and their presence comforting. This power is nurtured by the physician's choice of words, the attentiveness of his listening, and the reassurance of his touch. Much of what I accomplish with the physical examination comes from its role in promoting this trust. It is the reason why I often listen for carotid bruits. The therapeutic relationship is your most effective tool, and it cannot be studied with double-blind placebo-controlled clinical trials.

Using Empiric Trials. I spend much of my day designing empiric trials for individual patients. Some of my favorites include Metamucil for abdominal pain (irritable bowel syndrome), Prilosec for chest pain (gastroesophageal reflux disease), Paxil for what looks like Alzheimer's disease (pseudo dementia), and Immetrex for head pain (migraine). In a properly selected patient, a response to an empiric trial proves the diagnosis, convinces the patient that the diagnosis is correct, and treats the problem. It provides all of these benefits while minimizing endoscopies, computed tomography scans, and thallium stress tests.

Predicting the Course of Disease, the Response to Treatment, and the Timing of Death. Few things make you a better physician in the eyes of your patients

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then being able to correctly predict their future. With attention to the natural history of common illnesses and a boldness of spirit, you can tell a patient with flu, "You will have fever for 2 more days, then the fever will go away. You will feel tired and miserable for 2 more days, then you will get better." Or you can tell the patient with a steroid injection for lateral epicondylitis, "It will hurt more for 2 days, but by this time next week, you will feel great." Clinical prediction is especially important in caring for the family of a dying patient, and it can only be learned by sitting at the bedside at the ends of life. Those experiences can be drawn upon to tell family members, "Your father is in no pain. He will become less alert, then stop eating. His blood pressure will slowly drop, and then he will quietly pass away within the next few days."

Knowing How to Prioritize Clinical Interventions. As family physicians, we are asked to screen patients for everything from sexual dysfunction to hemochromatosis. Although much of this is theoretically worthwhile, only a limited number of things can be realistically accomplished. Hordes of experts promote their favorite interventions, yet not one has the honesty to admit that their favorite may be less important than the next. (I long for the day when someone at a National Institutes of Health Consensus Conference will say, "Prostate-specific antigen testing may be useful, but it is a lot less important than helping your patients quit smoking.") We become the final negotiators with the patient in deciding which interventions are provided.

Understanding How to Make a History. I was disappointed as a medical student to realize how pathetically inefficient the formal medical history was as a tool for collecting information ("I know you are passing a kidney stone, but I must ask you these 60 things in the review of systems. Now— have you ever had a problem with ringing in your ears?") Good physicians learn that you do not take a history, you make a history. You may ask the 45-year-old obese man with unexplained heart failure, "Do you snore?" and diagnose sleep apnea. Sometimes, you will have no clue where to go next. For those situations, my lifesavers include: "What do you think is wrong?"; "What does your spouse think is wrong?"; and "Has anyone in your family ever had anything like this?"

Learning to Teach. Teaching patients involves much more than providing information. That is why traditional patient education pamphlets do not work well. The majority of teaching has to do with persuasion, negotiation, reassurance, and understanding the patient's view of his or her life and illness. Each physician uses tools to teach. I use humor (eg, to the man grimacing about his rectal examination, "You know, this is not especially my favorite time of the day either!"); I use drawings that patients take home and post on their refrigerator door (eg, "Let me draw you a picture of the low back."); and I use self-disclosure (eg, to the new parents, "I know how exhausted you must feel. My daughter woke us up 5 times a night for the first 2 years after she was born. At one point it almost drove us to divorce.")

Being Comfortable with Uncertainty. Diagnosis is often impossible. Good clinicians must, therefore, learn to live with uncertainty and know how to reassure their patients even when there is no clear evidence to permit reassurance. This requires that you go out on a limb, and it means that you will sometimes be wrong. (Clinical medicine is not a job for those who are weak of heart!) I will tell some patients with undiagnosed abdominal pain, "I don't know what you have, but I am very sure that it is not something bad. Let's wait a week and see what happens." A patient's willingness to be comforted in the face of uncertainty depends on uncovering their fears (eg, "I can live with this headache as long as I know that it is not a brain tumor. You remember that my aunt died with a brain tumor last year.").

Knowing the Person Who Is the Patient. I begin each visit with a new patient by asking, "Can you tell me a little about yourself?" This catches some people off guard, and they will say, "You mean my cough?" I respond, "No, we'll get to your cough, but tell me a little about you." My charts are then filled with memory aids to help me to personalize my care (eg, Pt's mother is in nursing home with Alzh; husb died 6/98 with lung ca; passes out with veinipuncture). Some managed care companies assign quality factors to calculate their capitation rates. Sadly, I have yet to see one that gives you quality points for knowing your patients.

There has always been a balanced tension between the science and the art of medicine. We currently threaten that balance by failing to understand the limitations of the science and the power of the art. To those physicians who write clinical guidelines, quote consensus panels, or produce clinician report cards, I recommend spending a little more time in the rich yet humble world of patient care. You cannot be a good physician if you ignore science, but you also cannot be a good physician if you believe in it too much.