The Social History Matters!

To the Editor: “The patient does not smoke and drinks occasionally.” This, sadly, is the patient’s social history as recorded in too many of our medical records.

The social history has fallen into disrepair. Physicians can and must do better. In the drive for efficiency and reliance on technology, the connection between patient and doctor need not be lost. We should aim to at least equal good hairstylists, who keep track of personal details on cards or in memory so they can make connections with their clients. “How is your son doing in college?” “Did you plant a garden again this year?”

Along with the chance to connect with the patient as a person, the social history can provide vital early clues to the presence of disease, guide physical exam and test-ordering strategies, and facilitate the provision of cost-effective, evidence-based care. For example, the golfer who no longer golfs due to dyspnea on exertion is developing the first signs of heart failure, lung disease, or anemia; if the doctor doesn’t know about this change and must wait for other clues, valuable months are lost.

For one patient with COPD who came to the emergency department, the social history, with a simple question about pets, revealed crucial data. “My dog becomes visibly agitated and starts barking after smelling my breath when I’m getting sick,” she offered quickly when asked. Literally, her dog caused her to seek care.

How can we physicians change the culture of our institutions to promote the taking of a proper social history? We must role-model how to take a social history for our trainees and peers. An illustrative poem or short work of literature can be incorporated into morning report or teaching rounds. In these and other ways, we must encourage trainees and peers to spend dedicated time with patients, sitting down and getting to know them as people. With careful listening, the focus of the physician can be directed to what is most important to the patient. By knowing patients better—and taking better social histories—we will provide better care and will be more fulfilled and energized in our work as physicians.

Ruric (Andy) Anderson, MD, MBA
Assistant dean for medical education, NorthShore University HealthSystem, and clinical associate professor of medicine, University of Chicago Pritzker School of Medicine, Evanston, Illinois; aanderson@northshore.org.

David Schiedermayer, MD
ThedaCare Palliative Medicine Service, Theda Clark Medical Center, Neenah, Wisconsin.

References

Business-Success Literature and the Health Care Enterprise: The Need to Test “Insights”

To the Editor: Health care delivery is a complex and competitive business. To help meet its challenges, management commonly espouses principles from best-selling business-success literature. However, if viewed through the lens with which we view our medical literature, are the “insights” from business-success literature always reliable predictors of success? Or are they sometimes overstated, unvalidated claims or, even if valid in certain contexts, not valid in health care? Before health care leaders parrot the catchphrases or apply the principles of these best sellers to the business of health care, perhaps they should closely examine these insights.

An example of this genre, Built to Last by Collins and Porras, in continuous publication since 1994, is a “must read” for CEOs and is listed as one of the best business books. The authors claim to determine the characteristics associated with business longevity using a case-control, retrospective study comparing 18 “successful, visionary” corporations with 18 “unsuccessful” corporations. Their findings rest on a large set of data, yet my investigations convince me that much of the data are biased, dependent on performance, and not prospectively validated. So, with their Big Hairy Audacious Goal (BHAG), would a health care enterprise be guaranteed success? In scientific literature, claims to the importance of the BHAG would constitute confusion of correlation with causation. Yet, the BHAG is commonly bantered about as a buzzword connoting success.

In contrast, other business-success models have been more rigorously analyzed and have been helpful when applied to health care. An example is the performance-based compensation (PBC) model. The goal of PBC is to ensure that employees are compensated for their efforts. A portion of the salary is put at risk, allowing total compensation to fluctuate depending on revenues generated by the individual, either through clinical practice or through research funding. A number of academic medical centers that have implemented this plan report improved faculty work satisfaction. In addition, the plan has resulted in increased clinical and research revenues for the departments and higher median faculty salaries.

In summary, the business-success gurus are frequently accused of biased evidence, circular reasoning, and statistical errors. This should alert leaders in the health care industry to be equally critical when a business-success principle becomes fashionable, and to use a scientific approach to determine value.

Paul C. Kuo, MD, MBA
Chief of general surgery and vice-chair for research, Department of Surgery, Duke University Medical Center, Durham, North Carolina; kuo.paul@duke.edu.

References
2 Tarquinio GT, Dittus RS, Byrne DW, Kaiser A, Neilson EG. Effects of performance-based...
Should Medical Students Major in a Specialty?

To the Editor: Why do we still spend the first four years giving every medical student the same training?

This approach made sense when there was less medical knowledge; one could study it and feel some sense of mastery of all of medicine. Learning in this way led most physicians-in-training to think that they were doctors first and specialists or generalists second. But today, physicians do not learn their trade until they are residents, are focused on their specialty by necessity, and identify themselves more by that specialty than by being a doctor. So, why do we still waste four expensive years training everyone to be “a doctor”?

Medical education might become more effective and efficient if we gave up on the idea of training all medical students identically for the first four years and instead allowed them to differentiate from one another from the beginning, as they do in most other fields of study. This could be done by having students “major” in a specialty. This approach would still expose students to the major areas of medicine, but just how many courses a student took in an area would depend on his or her major: Surgeons would take more anatomy, and psychiatrists would take more human behavior, for example. They could spend time with practitioners of their chosen specialty early on, to see if they fit in. Students would be able to change their majors as they discovered what they liked and disliked about the practice of medicine in given areas.

More focused medical training would be faster and thus more cost-effective and efficient. It probably would be more effective, too, as a student’s training could be specifically tailored for any given specialty. We have already moved to a system of providing care by specialists. Perhaps it is time that the medical education system acknowledged this by changing and catching up.

Thomas A.M. Kramer, MD
Associate professor of psychiatry and director, Student Counseling and Resource Service, University of Chicago, Chicago, Illinois; tkramer@uchicago.edu.

Most Reports Should Be Brief Reports

Lo bueno, si breve, dos veces bueno.
(What’s good, if it is brief, is twice as good.)
—Baltasar Gracian

To the Editor: Verbosity in scientific publications is destructive. Much of the tedious noise in original scientific articles could and should be avoided. Conciseness is relevant for scientific, economic, and ethical reasons.

If concision (from the Latin concisus, “to cut up”) is not a traditional Aristotelian virtue, verbosity can be thought of as a vice in some respects. In a recent survey, authors affirmed they would be very likely to stop submitting papers to BMJ if the print version was to contain abridged versions of their manuscripts. Could vanity be a motive for some of those authors? (Incidentally, vanity is the vice defined by Aristotle as an excess of pride that manifests when one “thinks himself worthy of great things, being unworthy of them.”) Another possible motive would come into play if the author’s goal was not to convey truth or sincerity but—using the term favored by the American philosopher Harry Frankfurt—bull...t. In such cases, verbosity not only results in filler, but also in misdirection and confusion.

On a more practical note, wordiness can often create misunderstanding and lead to misquotation. Also, scientific and scholarly journals are expensive. When governments use taxpayers’ money to make relevant articles available, the typical long-winded articles tax us twice. Finally, longer articles take up space, which means that some interesting and important reports will not get published.

Verbosity should be more harshly evaluated; we authors should be forced to become better at tightening our texts. Of course, for reports of truly complex work, extended elaboration is useful and should be stimulated when needed. But this should not be confused with verbosity. The length and scope typically expected of a manuscript in a “brief reports” section should be the standard paradigm for the publication of original articles.

Pedro Vieira da Silva Magalhães, MD, MSc
Laboratório de Psiquiatria Molecular, Hospital de Clínicas de Porto Alegre, Porto Alegre, RS, Brazil; pedromaga2@gmail.com.

References