WHAT PHYSICIANS SHOULD READ

A canon shot from an addicted reader

BY CHARLES R. MEYER, MD

In a seldom-used room in my childhood home was a shelf full of black, dusty, hardbound books entitled *The Harvard Classics*, which were used even less than the room in which they resided. Occasionally in one of my fits of wanting to fill the holes in my education, I would attempt to crack one of the tomes, only to sheepishly place it back in its lonely resting place after a meager attempt.

The brainchild of Harvard president Charles Eliot and first published in 1909, the *Classics* were intended to supply a “liberal education” in one shelf. Like Mortimer Adler’s and Charles Hutchin’s *Great Books* series, it was one of many attempts to define a canon of books that the elite educated class would have mastered en route to desirable, but vaguely envisioned, goals of erudition and perhaps being a “better person.”

Similar attempts have been made for physicians. Most of these compilations have shunned “classic” medical texts like Gray’s *Anatomy* or *Harrison’s Principles of Internal Medicine*, assuming that all physicians would have tackled their scientific canon in medical school and residency. Instead they have focused on works that speak to the human condition as a physician presumably will encounter it in their professional life.

A recent collection of essays edited by Michael Lacombe, MD, *Osler’s Bedside Library: Great Writers Who Inspired a Great Physician*, explored Sir William Osler’s choices of necessary reading for physicians. Sir William’s imposing lineup included Plutarch, Shakespeare, Sir Thomas Browne, Montaigne, Marcus Aurelius, Epictetus, Don Quixote, Emerson, Oliver Wendell Holmes and the Old and New Testaments with which he hoped practicing physicians would pursue a serious dalliance intended to nurture a complete person who also happens to be a physician.

My approach to a canon for physicians is a bit more pragmatic. I looked for books that address issues common to every doctor’s journey—dealing with end of life, conquering the art of communication and listening, wrestling with insecurity, understanding the limits of medicine and experiencing what it’s like being a patient. This list might not be everybody’s top five and certainly the list could be longer but I think it touches on the essence of what it means to be a practicing physician.

In his 2014 book *Being Mortal: Medicine and What Matters in Life*, surgeon and *New Yorker* writer Atul Gawande, MD, MPH, analyzes modern medicine’s grappling with mortality in a society that increasingly expects fixes for all ailments. Confronted with a burgeoning population of nonagenarians and centenarians, 21st century doctors flail against the dire threat for physicians, patients whose aging bodies present problems doctors cannot solve.

Dramatizing his points with his father’s and grandfather’s end-of-life stories, Gawande pens a sage conclusion for physicians: “Being mortal is about the struggle to cope with the constraints of our biology, with the limits set by genes and cells and flesh and bone. Medical science has given us remarkable power to push against these limits, and the potential value of this power was a central reason I became a doctor. But again and again, I have seen the damage we in medicine do when we fail to acknowledge that such power is finite and always will be.”

My search for a single volume that focused on the art of communication in the practice of medicine came up dry. Instead I found selected short pieces or parts of books that addressed different aspects of the doctor-patient interaction. In *On Being a Doctor 3*, a collection of perspectives edited by Michael Lacombe, MD, various selections spotlight the chemistry that is the doctor-patient relationship.

Yet nowhere did I find a concise tutorial of what is a healthy interaction between physician and patient. If left to me, my lesson would emphasize paying attention to jargon usage and eye contact, becoming an actor who is attentive to word choice and facial expression because what is heard is more than words; understanding that a 15-minute conversation may be the most important event in a patient’s week; and, in the spirit of good acting and good medi-
cine, analyzing each day to see if you can improve how you relate to patients.

Perhaps the ideal tutorial has yet to be written and it will be tough to teach that most difficult lesson—attitude, the open mind and unbiased judgment that are crucial for perceptive doctors. If the patient is a “crock until proven otherwise,” the physician won’t recognize significant chest pain. If doctors think they know the diagnosis from the patient’s first sentence, they’ll miss half the history and physical. If MDs let their personal dislike or disapproval of patients color their interactions, communications will be distorted in both directions. And the key lesson is listening.

Many of the stories in collections like Lacombe’s and What Doctors Feel: How Emotions Affect the Practice of Medicine by internist Danielle Ofri, MD, PhD, feature the uncertainty and insecurity that walks with any physician during their career.

What to do about that insecurity is part of the message in the 2007 book by Harvard oncologist Jerome Groopman, MD, How Doctors Think. Deluged with symptoms, signs and historical information, all laden with uncertainty, doctors resort to shortcuts to pare away the irrelevant and the unhelpful to reach firmer footing. Although shortcuts help deal with the vagaries of clinical practice, they can be fraught with errors.

Groopman identifies errors endemic in physician thinking and opines that recognizing those errors is half the secret to avoiding them. The doctor-thinking promoted by Groopman is really physician confidence-promoting, self-questioning—a look inward, a constant vigilance about where your mind is taking you and repeatedly asking whether it’s leading you astray.

Whether confronting mortality or just ordering an MRI, physicians must realize that their medical science has, or should have, limits. Hastings Center bioethicist Daniel Callahan, PhD, has been one of the boldest proponents of what medicine should and should not do. His 2009 book Taming the Beloved Beast: How Medical Costs are Destroying our Health Care System advocates that we move from the present infinity model of “unlimited medical progress and technological innovation” to what he calls a “finite model” of health care “that understands the necessity to shape health care goals that are affordable, accessible and sustainable.” It should be required reading for any physician that signs an order.

And any physician who treats a patient and will one day be a patient themselves should read the wrenching memoir When Breath Becomes Air by Paul Kalanithi, MD, published in 2016. In a lyrical meditation on life and death, Kalanithi describes his journey from discovering he had metastatic lung cancer at the end of his neurosurgery residency to literally taking his last breath. During that journey he moved from the analytic physician trying to manage his own illness and control his fate to an accepting father who pens a moving letter to his 8-month-old infant on his death bed.

My canon has omitted the literary stars in Osler’s list, which certainly would round out even the most deficient liberal education. In your spare time, for sure pick up Plutarch—but not until you’ve sampled these authors who speak directly to what it means to be a physician.

Charles R. Meyer, MD, is the former executive editor of Minnesota Medicine.

Charles R. Meyer, MD, will host the first MMA Book Club on June 18, 7–8:30pm at the Edina Barnes & Noble. Barron H. Lerner, MD, will talk about his book, The Good Doctor: A Father, a Son and the Evolution of Medical Ethics. Future Book Club events will be held in July and October.