Reflections for February

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AN ECONOMY OF WORDS

Last year the World Bank announced that the global economy lost the equivalent of $50 trillion USD in 2008. This unimaginable sum underscores the worst economic recession in decades.

The economy, broadly defined, is the production, exchange, and consumption of goods and services. As economists and historians pursue the gory dissection of the recent crisis, those of us in medicine may take an opportunity to learn from the many parallels between the recent economic unwind and the challenges in our own daily practice.

The quantum of medical care can be defined as the simple patient–physician interaction. In economic terms, the patient produces the problem at hand, exchanges it with the physician, who then produces solutions for the patient's consumption. While the global economy is transacted in the form of currency, trade between the patient and the physician is transacted largely in the form of words.

Complexity

One of the causes of the recent financial cataclysm has been the use of increasingly complex financial instruments. Derivatives such as credit default swaps (CDSs) and asset-backed securities such as collateralized debt obligations (CDOs) were frequently used yet poorly understood, to disastrous effect. When the underlying assets of these instruments lost value, the contagion of panic in the capital markets led to pandemic fear.

The complexity of knowledge and technical skill required for effective clinical practice is also unquestionable. However, this complexity damages our medical economy of words when we allow arcane terminology to enter our conversations with our patients. SAHs, CIDPs, and DRPLAs are as confusing to our patients as the acronyms in the prior paragraph. Communication with our patients in mutually understood terms is critical to maintain the health of this patient–physician exchange of information.

Liquidity

As financial institutions tried to sell complex assets into increasingly frozen markets, they came to the frightening realization that these companies may not have the ability to meet their obligations. This fear led to the collapse of a number of banks and stock prices, and reduced the liquidity of the affected markets in a vicious downward cycle.

In the patient–physician relationship, a lack of liquidity translates to a lack of communication. If verbal exchange becomes "frozen," catastrophe may follow ("I'm too embarrassed to tell the doctor about the incontinence," or "If I ask this patient how her headaches are doing, I'll be stuck in this room 'til Thursday"). Aggravating this problem is the ever-shrinking amount of time patients and physicians spend with each other; there's only so much that can be shared in a 15-minute clinic visit.

Inflation

We are all familiar with the concept of inflation: the rise in prices of goods and services over time, often paired with a corresponding decline in the real value of money.

If words are the currency of our interactions with patients, inflation manifests as long-winded narratives comprised of near-worthless verbiage. One need look no further than our own medical documentation to find examples. Our notes labor under the boilerplate of multiple patient identifiers, long-winded system reviews, and the medicolegal need to document that the next aspirin the patient takes may be lethal. Somehow, in all of this, our important thoughts (if we have them) are easily lost. An economy of words in our economy of words would be . . . nice.

Credit

Credit is based entirely on the level of trust held between the granting body and the receiver. If a bank cannot trust that a business will survive to repay a loan, it likely will not extend the loan in the first place. Recently, lending institutions that were consumed by the fear gripping the markets became increasingly reluctant to extend credit. As the credit markets froze in late 2008, many otherwise sound institutions faced the possibility of fail-

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ing to meet such basic obligations as making payroll.

In our medical practice, a lack of trust on either side of the patient–physician relationship results in failure. The composition and delivery of our words is important in establishing credit between patient and physician. Effective communication of things we may not like talking about, such as potential complications of a procedure, or that a patient is dying, are critical in the development of trust in the patient–physician microeconomy. Violation or neglect of that trust affects the relationship much as a bounced check affects one's FICO score.

The ultimate product of effective clinical communication is effective patient care, an increasingly important outcome for patients, physicians, and policymakers. The global financial system will eventually recover, and the recent recession will eventually give way to a return of economic growth. One hopes that as this happens in the coming months and years, we take the opportunity to tend to our own garden. Our patients will gladly share in the wealth.