The Primary Care Science of the Ordinary: Little Stuff as Big Stuff

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The history of science is full of instances in which the familiar has become foreign. We have learned much from this uncomfortable estrangement from our own beliefs and expectations. Suddenly the unnoticed becomes noticeable—becomes what in medicine we call "interesting" (as in "an interesting [clinical] case"). We bother to ask questions about what we thought we knew, about our answers, and about our assumptions behind the answers. The article in this issue of the *Journal* on "Gowning: Effects on Patient Satisfaction" by Meit, Williams, Mencken, and Yasek (pages 397-401) is a seminal and inspiring work in this neglected genre of breeding doubt and uncertainty for the sake of deeper knowledge. The authors make into a problem an artifact and a ritual we have long made assumptions about—gowning vs nongowning with respect to modesty and satisfaction.

But their study is *doubly* seminal, for it exemplifies what I propose to call a primary care science of the ordinary. In the language of the equestrian metaphor, the authors notice, and study closely, the life of the mundane, familiar "quarter horse" rather than that of the rare, exotic "zebra." (I realize that in some locales, zebras are the rule and quarter horses the exception, but in this essay I stay within the bounds of North American biomedical discourse. "Exotic" is not an intrinsic property but is relative to where you are.) Studying the relationship of patient gowning to patient satisfaction, the authors pioneer methodologically and substantively. They elevate the "small stuff" of medical practice to high science—or what at least deserves to be high science. They show how meticulous, modest research can be good medical social science as well as good medical research.

In offering an analysis of the article, I am most interested in widening the net of their approach. The authors blur boundaries—for instance, between (1) the "real medicine" of internal organ systems and high-tech methods, and (2) the "doctor-patient relationship" and "bedside manner." In so doing, they show some of our taxonomies to be prison bars, our own. Suddenly, the marginal becomes the core. We are bound to be uncomfortable with their reordering of things.

Theirs is a paradigm shift with respect to the *status* of what is worth studying. The paper by Meit and colleagues is a quiet, subtle revolution that deserves our diligent study. It shows that what we had regarded as "little stuff" is in fact quite "big stuff," that what we had thought to be mere "background stuff" is real and vital knowledge—with real medical consequences. To put it in terms of the biopsychosocial model: The authors demonstrate that physicians (or any clinical researchers) cannot (except with unconscious patients, or with cadavers) attain the coveted "bio" part of supposedly "real [organic] medicine" if they fail to pass through the "psychosocial" relational part of the physician-patient relationship, whether that be in the realm of gowning or anything else. The study is thus a self-critical essay about viewpoints. The authors remind us that what you see is how you see where you see from, a vantage point that includes your social role if not your very identity. It requires a certain relinquishing of status and power (humility) for physicians, social scientists, and other researchers to regard the world from another point of view—especially the view of people who are usually the subject (or "object") of research.

Even knowledge in "medical science" is cultural knowledge. That is, it is subject to ranking and ridicule, not only rationality. Meanings and values that undergird professional cultures render certain knowledge worth more, and other knowledge worth less (for instance, the human genome vs rural spider bites). Despite doctrinal pronouncements that the doctor-patient relationship is the foundation of the art and science of medicine, its study is not regarded as high medical science. Meit and colleagues show us how silly our distinctions can be.

To gown or not to gown is an important question, for reasons interior to the study and beyond it. What could be more symbolic an issue than barrier-and-access issues to a patient and to a practitioner, both of whom possess physical bodies? Boundary issues

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are at the core of human identity, and often at the core of bloodied misunderstandings over how far to go and where to stop. Who has access to whom, and what kind, are universal concerns. "Whose privacy is it?" is a question about "Whose body, whose boundary, physical and symbolic, is it?" Further, "What assumptions are we making about your/my privacy?" Even privacy does not have the same dimensions everywhere, or even the same language. I thus take gown and gowning not only to be a medical artifact to the physician, and a temporary piece of clothing to the patient, but also a *metaphor* for virtually every facet of the doctor-patient relationship. Gowning serves as a point of departure for exploring the symbolic foundation of clinical work.

I wish to extend the authors' theoretical framework. Whatever else gowns and gowning are about, they are about an intermediate, transitional, potential space between people, a way of thinking I draw from pediatrician and psychoanalyst Donald W. Winnicott.[1,2] As a garment, a gown is neither strictly theirs (the patients') nor ours (the health care professionals'). Although a gown is worn by a patient and dispensed to the patient by a health care staff member, it is part of a middle terrain of barrier and entry, of privacy and access, of modesty and exposure, of revealing and concealing. It is both and neither. What we do with it, and mean by what we do, defines what "it" is. It is negotiated. So, for that matter, are a patient's street or work dress, and a clinician's lab coat, dress, sweater, shirt or T-shirt, trousers, or khakis. The study by Meit and coauthors explores the intermediate space of feeling and meaning, of trust and intimacy, inhabited by both. The study also offers the unexpected possibility that clothing worn by the patient can serve at least some of the same purposes as the gown, even though clothing is the property of the patient and the gown worn by the patient is the property of the physician's office. In either case, gowning and not-gowning are about the experience of intrusion or respect, of violation or safety, of persecutory anxiety or of security.

The study reminds us that we often assume we share culturally more (or for that matter, less) with the patient than we do—about privacy, about trust, about time and efficiency. We "treat" our own anxieties through countertransference,[3] so it is not surprising to consider that we might treat our own concerns about privacy, modesty, and shame by projecting them onto patients, and then treating it as if it were a patient issue rather than, at least initially, a physician issue. Meit and colleagues implicitly coax us to ask, "Precisely whose issue, agenda, problem, protection, or satisfaction, is it (gowning and beyond)?" They reply that we need to study the question, not assume the answer. Yet, people make assumptions, often for defensive reasons, and do not realize that they are assuming rather than taking in raw perceptions (say, about patients' supposed preference for gowns). Much cultural knowledge is projective knowledge. What we first project onto "them" becomes perceptually a part of "them." We may further provoke in "them" that very behavior by our own, thereby "confirming" what we wish to see..

It is easy to talk about "them" (and think we are) when in fact we are talking about "us." There is need for ruthless honesty and self-scrutiny about our motivations, including financial incentives, on the medical side of the tracks. Renewed clinical interest in "gowning" and its meanings could be little more than a matter of physician convenience by way of the human equivalent of Boyle's law, phrased in such euphemisms as "patient volume" and "patient flow." This appears mercifully not to be the case in the essay by Meit and coauthors. Co-option by others is another matter.

The questions behind the study originated from physicians in collaboration with behavioral scientists. This introduces the issue of *what questions get asked* and *what questions* (including *whose* questions, which is a question about authority, power, leadership, politics, and economics, not only about science) *get studied.* I would have like to have known the circumstances and timing in the authors' practice and working relationship in which questions about barriers, trust, satisfaction, time efficiency, and gowning were raised and heeded. Why? Because this tells us as much about faculty-researcher-practitioners as it does about patients. From the other side, I wonder what kinds of questions *patients* are asking about themselves and their relation to physicians. The next stage in relationship-centered care is to build studies around *patients'* questions—collaborative studies, perhaps. In adopting a patient-centered, as contrasted with an exclusively physician-centered, approach to gowning, the authors in fact take a *relationship*-centered viewpoint. The authors inquire about that relationship by means of posing the question of gowning and patient satisfaction.

Physicians (all practitioners) need the ability to

switch perspectives, to encompass many participants' understandings, verbal and nonverbal. Intimacy between an "I" and a "Thou" (ie, as a whole person to whom one is present rather than as a thing),[4] even in the era of corporate managed care, presupposes an interest in how one's counterpart in the healing relationship experiences the world. Physicians' interest in patients' barriers and boundaries is at the core of the intimacy of the clinical relationship. What could be a more personal, symbolic, act—though shrouded in rituals and symbols of professionalism—than negotiating closeness and distance, entry to and exit from, approach and retreat from another person's body? "Gowning" is a specific garment and medium through which boundaries are symbolized and ritualized. "Physician access to the patient's body" by means of the gown becomes a point of departure for thinking about physicians' and patients' access to many facets of each other in the process of care and healing.

Implicitly, Meit and his coauthors challenge us to wonder what else we take for granted—and mistake for the patient's own good. They modestly prod us to reexamine our clinical sacred cows, and to adopt multiple viewpoints, much as a surveying team does, to recalibrate comfortably familiar points. Their study hints at how much more we might be *missing* clinically from a one-sided vantage point. For instance, if gowning is a profoundly cultural issue, what do we regard (or overlook) as "cultural" in the first place? How about rural/urban, or regional, or religious ways of life, as well as ethnic or national—and not as homogeneous blocs but culture-as-we-find-it used in people's lives?

Meit and coauthors have added to primary care practice a vast new dimension of the ordinary "big stuff" that we might have overlooked. They have studied far more than gowning. They have set a new standard for thinking about and conducting primary care research. They deserve our gratitude—and emulation. "Little stuff"? Not at all.

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