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In Clinical Practice, Patients Have Names

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FROM THE EDITOR:

In Clinical Practice, Patients Have Names

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Social scientists understand Social Determinants of Health (SDH). As SDH become an ever-increasing focus for doctors, we need to educate ourselves about medical social science. As a social scientist-physician, I know social scientists criticize doctors for turning patients into objects and treating people as diseased organs. Cheryl Mattingly summarized the sentiment, "We [anthropologists] have criticized the culture of biomedicine for being insufficiently mindful of personal, familial, institutional and cultural factors that influence how a disabling condition is experienced and handled by the person who is ill."[1] Many others have reiterated this criticism.[2-7] This cognitive process started simultaneously with the origins of Western medicine during the Enlightenment, when the Catholic Church lost power as an organizing social framework and science and empiricism were ascendant.[8] A prominent example of this cognitive process is the case report, which is actually a report of a rare or previously unrecognized disease. This cognitive process is a vital component of the work of the doctor.

However, I also know doctors engage in deeply personal and meaningful relationships with their patients.[9] This complementary relationship work of the doctor is often unrecognized by social scientists.

The scholarly focus of this journal is clinical practice. Instead of case reports of rare diseases, we examine and describe case reports of clinical interactions, which includes both biomedicine and "personal, familial, institutional and cultural factors" that affect clinical decision making.

In order to better reflect this robust description of clinical practice, we have initiated the use of pseudonyms for patients in our publications. This is what social scientists do in their scholarly reports. It is intended to better describe the lived experience of a human.

We make this change with appreciation of both the potential benefits and potential harms of such a practice. Foremost, we want to avoid a homogenized "John Smith" style that misrepresents the diversity of the patients we see. We also need to approach this practice with humility, recognizing that a name (pseudonym) has cultural meaning to our patients. Doctors are expected to be culturally competent when interacting with patients and we expect the same as we attempt to describe clinical practice.

We made this change to better report the scholarship of describing clinical practice and the scholarship of clinical decision making.

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