by *Donald A. Redelmeier,*†‡** MD; Miriam Shuchman,¶** MD; Steven L. Shumak,*†** MD*

HOW TO READ CLINICAL JOURNALS: IX.

SOUNDING LIKE YOU'VE READ THE LITERATURE WHEN YOU HAVEN'T READ A THING

Many clinicians do not regularly read journals, can't remember the details or confound the data with misinformation. Consider the following situations:

(a) You're in clinic, prescribing a lipid-lowering medication for a patient, and your medical student inquires about research suggesting the drug is associated with violent injury. How do you respond?

(b) You're on rounds when a colleague asks about a study linking computers to cancer. Some house staff are listening. How do you respond?

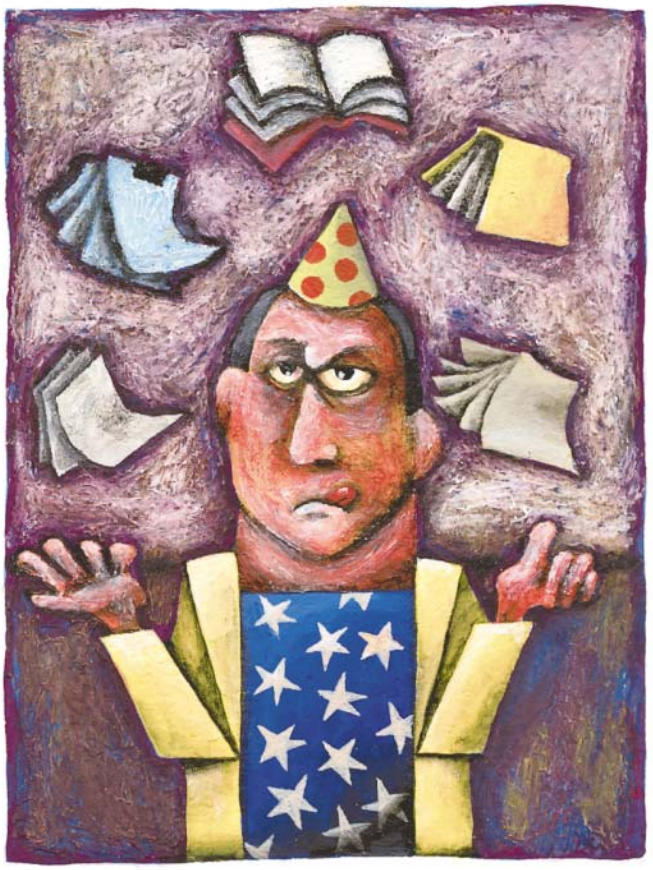
In this article we outline methods for handling these types of situations. Our goal is to present effective strategies for practitioners to use when they need to pretend they've been keeping up with the medical journals. As with previous articles in this series, the guidelines we offer constitute "applied common sense" and are relevant to diverse clinical settings.

The intent is to help you to masquerade as someone who regularly reads the literature.

1. Distract the questioner

Canny physicians learn to cultivate a frantic atmosphere so that lesser issues can be side-stepped. For example, when asked "Did you see the latest report in *CMAJ* on bypass surgery?", try answering with "Oops, I left my laptop computer in the library after downloading a search!" This eliminates the risk of saying the wrong thing while simultaneously conveying a scholarly image. If sufficiently clever, this type of distraction gets stronger with repetition. Consider, for example, the rejoinder "That's the third time today I've left it behind!" Seems more convincing, doesn't it?

Diverting the questioner is fun and easy. Sometimes we favour a pompous approach, such as "I'll answer that in a moment, but first let me talk about a recent triumph of mine." The secret here is to be long-winded rather than exciting. Alternatively, sometimes we adopt a more emotional approach by stealing lines from Marcus Welby. A favourite is: "This is not an easy topic for me. I remember an earlier patient ...." Let your imagination run wild, and even a swift questioner can't catch you.



Andrew Young

2. Redirect the conversation

What if you don't want to kill the conversation? Have no fear, because less evasive strategies can also convey a scholarly image when you're clueless. Consider the following 2 lines: "I remember serving as a reviewer for that article a year ago for *CMAJ*. I recommended acceptance but can't remember the details right now." Notice the brilliance. You assert your scientific authority. You justify any lapses of memory. Moreover, you can't be faulted no matter where it was published.

Redirection can follow any orientation of the compass. Try being grandiose, such as: "I know of other work by a high-profile colleague that will entirely change the field; however, I'm not allowed to talk about it yet." Try being self-deprecating, as in "I'd love to answer that but my colleague Dr. X would get offended because she considers herself the authority." Try being obsequious, as in "I

think Dr. X said it best the other day; perhaps I can find her for you." Any of these will work fine.

3. Hog the high road

Only the mediocre are always at their best and always polite. Thus, the occasional combative response is fine. Self-righteousness works well. Try "That's exactly the type of terrible science that wastes public dollars and should never have been supported when other, more important issues deserve attention." Notice how bruising this will be to the earnest questioner. In addition, it allows you to exploit any other current tragedy for your own personal gain.

Styles of intimidation vary by personality and generally work better in Canada than the US. Some prefer methodologic rebuffs such as "That study was seriously flawed by a small sample that does not apply to my patient." Others prefer a clandestine style, as in "There's stuff you don't know that I can't tell you." Still others prefer an ad-hominem approach, as in "Those scientists are only interested in advancing their careers and not in improving the health of my patient." All these lines contain no information, cannot be falsified and fully terminate discussion.

4. Waffle like a pro

Doctors frequently take a dim view of politicians and thereby miss opportunities to learn from masters of rhetoric. Watch a member of parliament demonstrate lines such as "Well, the answer to that question really depends on your perspective. Sure, there are going to be some people who will be better off. But there are also going to be some who aren't. There may be other complications as well. It's difficult to predict. And there are other priorities too." Admire how such comments are so lengthy and so vacuous.

Indeed, physicians receive more professional training than politicians and thereby should be capable of even more elaborate rhetoric. Try the orthodox line, "The results are quite intriguing; still, I'd like to see these findings confirmed by other groups before I commit myself." Or the cosmic line, "It's a big issue that we don't have time for now. It's so big and important that I want to avoid giving you a fast response." Or the elitist line, "I used to believe I knew the answer to that question, but now I'm not so sure."

Summary

Keeping up with the literature is essential for being a leader in medicine. Yet who has the time? We suggest, therefore, that good pretending is an essential clinical skill that should be taught in medical school, practised during patient care and honed at CME courses. Ironically, faking your way through the literature may also be a near-optimal use of time given that research is rarely definitive. Most studies won't stand the test of time, and realizing this encourages rational clinicians to ignore them all.

Our article has offered 4 guidelines for bluffing when asked factual questions about the medical literature. We know that the articles are difficult to read and easy to forget. So, we encourage you to use our guidelines when commenting on them. To consolidate your understanding, try also to write a letter to the editor about an article you've not seen. In addition, recognize that ongoing research is needed because standards for bluffing may change as the field of evidence-based medicine evolves.

David Sackett, Gordon Guyatt, Deborah Cook and David Naylor provided helpful points on early drafts, but we didn't listen.

No granting agency made the mistake of funding this work. We bluffed our way past the editors by claiming no financial conflict of interest.

From *the Department of Medicine, University of Toronto, Toronto, Ont.; †the Clinical Epidemiology and Health Care Research Unit of the Sunnybrook and Women's College Health Sciences Centre, Toronto, Ont.; ‡the Department of Health Administration, University of Toronto, Toronto, Ont.; ¶the Department of Psychiatry, State University of New York at Buffalo, Buffalo, NY; and **the Department for Excessive Affiliations, Everywhere, Canada