

MEditorial June 2010

“Timidity in the Practice of Medicine”

Recently reading a book about the “calm decisiveness” and quick thinking of the admirable US Airways pilot Chesley Sullenberger (landing jet on the Hudson River) made me think of my own profession how “boldly” it handles difficult situations.

Like aviation (the Airbus 320 in the “Hudson” event is said to be semi-robotic and can actually “relieve” the pilot of his need to make certain technical decisions in an urgent situation), medicine and surgery have had great technology, to a certain extent over-glamorized as an “equalizer” among health providers that reduces the individual need (or perhaps desire) to be decisive. Unfortunately, many quite costly technologies have been developed without studies showing they work better than existing less engineering-buffed procedures or that there is anyone out there willing to pay the asking price. In a sense, doctors and nurses have ceded personal involvement in diagnosing and treating conditions to machines that can never take over the human function of assessing the interpersonal variance and complexity of disease. Likewise, insurance companies, hospitals and medical school training programs have introduced concepts such as clinical algorithms and “evidence-based medicine” to create rote care templates (sometimes mutable by the healthcare provider only at a personal cost to that individual!), which allege to be better and safer for the patient. In my opinion, these never come close to the full utility of a well trained and astute doctor/ nurse (especially in a more idealized environment, not currently existing in the US, lacking worry as to “post-facto second guessing”).

Now--if you wish to read on--here are a few examples of what I observe. Primary care doctors, pressed for time and dizzied by an aging overmedicated population with too many problems on their “list”, tend not to want to render a definitive diagnosis or treatment for anything complex--but to defer that to a specialist. Such timidity raises the cost of healthcare, inconveniences patients, in some cases reduces the patient’s respect for his physician, and often

accomplishes nothing. Unless serious illness or death is imminent, a good history and physical, basic relevant lab tests and an educated guess (after considering the “horses” and not the zebras”) as to the diagnosis will either be correct or at least “do not harm”. If the problem seems puzzling but not dangerous, how about the "boldness" of just a follow-up visit?

Hospital admission history and physicals for urgent illnesses nicely outline the problem list and symptoms, but it is rare to see a discharge summary which in retrospect captures the exact real reason why the individual became ill; and what could be done to prevent readmission for the same. There always seems to be a list of multiple irresolvable possibilities.

Timidity is also seen where I myself graze, in the land of surgical and medical specialties. Unfortunately, some specialists tend to offer the patient testing only within the realm of what they know best. They figure once they have done everything to rule out disease in their part of the body, let someone else determine what, if any, real disease exists. An example would be a patient with midline upper abdominal pain, who is sent to the urologist when the CT scan suggests a previously unknown low grade right or left kidney blockage (likely congenital and of no clinical import/clearly not causing the person’s pain). That individual then has ordered further CT with contrast, nuclear renogram and possibly endoscopic surgery including a ureteroscopic inspection of the upper ureter, all of which turn out normal and not worthy of further treatment. In the meantime, this patient had acid reflux disease, easily diagnosable perhaps by a primary care physician and most certainly by a gastroenterologist, even without the benefit of extensive testing. Another example would be the gastroenterologist feeling the compulsion to endoscope the upper and lower GI tracts (and perhaps biopsy innocent-appearing tissue abnormalities) for anyone sent him/her with obviously “benign” GI symptoms. “That is what gastroenterologists do”; [they are paid to suspect serious versus minimal disease]. Then, there is the surgeon who is referred a man with a groin hernia present--without symptoms--for months to years. The doctor, thereupon, in a sense, timidly, convinces the patient a hernia repair is best done soon.

Nurses, perhaps by training, personality traits, or deference to the "expertise" of physicians, tend to be timid about saying clearly what they think about a clinical situation. Even those quite experienced may not be able/willing to "go out on a limb" and "boldly" state whether what they are observing in a hospitalized patient seems serious or routine; the decision is placed on the shoulders of the doctor who knows the patient (often at home after hours) or a hospital-based physician, who--albeit he/she is clinically quite competent, does not have familiarity with the patient or treatment of the condition up until that point. In this case, a proper review of the chart and selected exam and some questioning by the nurse of the patient/family, and conferring with the charge nurse, could lead to a more reassuring phone call, the essence of which might be.." your patient has some blood in the urine [postoperatively], but in my experience, this is not unusual after the procedure you performed--and I think it is reasonable you assess this when you make rounds in the morning".

Out of timidity, many of us in medicine have turned everything into an emergency; emergency room doctors have a low (lower than ever) threshold for advising admission to the hospital, whereas further observation as an outpatient may suffice. Patients cannot seem to leave the emergency room without a prescription, e.g., for antibiotics, even when deep inside the treating physician doubts an infection; and waiting a few days for the laboratory result to come back would not be detrimental. ER discharge notes implying the patient must be seen by a specialist within a day or two are often mere hyperbole, meant to protect the interests of the referring M.D./hospital and not necessarily to lead to better care.

With strength of conviction, and a hands-off approach from lawyers, government, insurance companies, hospitals and the like, I am hopeful we, as healthcare providers, can regain our decisiveness--and in doing so, restore the trust patient should have in our extensive expertise and judgment.

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