

“Common Sense Is Not So Common” (What We All Need to Remember) – Part Two

Voltaire (Francois Marie Arouet, 1694-1778)
Dictionnaire Philosophique, 1764

This essay is the second of 2 dealing with clinical aphorisms that I have derived during many years of clinical experience. The first part contained 8 items and was published in the August issue of *The American Journal of Medicine*.

Rule # 9: Physician, heal thyself. The physician should be a model of good health habits for 2 reasons.¹ First, patients are unlikely to follow the advice of someone who they believe is hypocritical. A doctor who smokes cigarettes will hardly be believed when informing patients that they have to stop smoking. Secondly, physicians with poor health habits eventually become patients themselves; it is difficult to be an effective health care provider when one's own health is impaired.

Rule # 10: Respect your fellow health care workers; they are your most important clinical asset. Just as no man is an island, no physician works in isolation. The health care team consists of nurses, physician assistants, technicians, laboratory staff, administrators, and many other individuals who make the health care system run smoothly. It is essential that the physician, as the leader of the clinical team, establish smooth working relationships with the many individuals in that unit. Friction, irritation, and bad humor in the environment lead to poor performance and, in the end, harm the patient. When I was a medical student, Judah Folkman informed my classmates and me that if we had a negative relationship with the nurses in the hospital during our clinical rotations then we would be better off selecting a profession other than medicine (personal communication, Judah Folkman, 1967).

Rule # 11: Admission to an intensive care unit in a tertiary care hospital can be a harrowing experience for the patient. Proof of this aphorism can be obtained easily if one takes an objective and uninvolved look at patients in an intensive care unit setting. Many of these individuals are tied to the bed and connected to a variety of tubes that emerge from nearly every natural orifice as well as many iatrogenic orifices. Patients are often unable to communicate with caregivers because of tracheal intubation. Usually they are given periodic doses of mind-altering substances and often are left by themselves for periods of time even in

the intensive care environment. Therefore, it is imperative that we periodically take a step back from the bedside and decide what our goals are for these patients. Is there a reasonable chance that all that is being done to them will result in meaningful survival? If the answer to this last question is “no” or “probably not,” then the time has come to start discussing plans with the patient's family for discontinuing life support.

An important corollary to this aphorism is that many patients in the United States undergo excessive testing in the name of defensive medicine. One example is the excessive numbers of brain computed tomography scans that are performed on patients with minimal head trauma or vague histories of headache. In a similar vein, many patients with atypical chest pain are admitted to coronary care units. Much of this excessive utilization of diagnostic services could be eliminated if physicians took the care to obtain a comprehensive history from the patient and spent a few minutes explaining to the patient why certain tests are being performed and why others are not indicated. Many malpractice lawsuits arise as a result of poor communication between the doctor and the patient and not because of medical errors. Establishing rapport with the patient by taking a careful history—the “careful listening” referred to by William Carlos Williams (1883-1963)²—is the physician's best defense against liability risk.

Rule # 12: True, true, and unrelated. This phrase refers to a commonly used form of question on medical knowledge examinations. A series of possibly related entities are presented, and the examinee is asked to pair them and state whether they are related or not with respect to causation. Situations often arise in clinical medicine in which one event or one physical finding occurs in close proximity to a second event or finding. However, these 2 events may be related to each other, or they may have occurred spontaneously without any relationship.³

An example of the true, true, and unrelated phenomenon in clinical medicine happens on a daily basis in the emergency department, involving patients with chest discomfort. Frequently, such patients are given a sublingual nitroglycerin tablet. Within minutes, the patient informs the staff in the emergency department that the pain has attenuated or disappeared. This result is then interpreted as proof that the

patient's discomfort was the result of myocardial ischemia. Unfortunately, in 9/10 patients who present to emergency departments with chest discomfort, this symptom is not the result of myocardial ischemia but stems instead from an episode of esophageal spasm or musculoskeletal inflammation or irritation. Nitrates can relieve the pain of esophageal spasm, and musculoskeletal discomfort may disappear as a result of a placebo response.

Thus, for many patients seen in the emergency department with chest discomfort, the situation can be described as true, true, and unrelated: true that the patient had chest discomfort; true that the pain was relieved by nitroglycerin therapy; but the disappearance of the discomfort was not related to relief of myocardial ischemia. Temporally related clinical events should be examined and considered with a skeptical attitude.

Rule # 13: **The enemy of good is perfect.** Physicians should always strive to achieve the best possible outcomes for their patients. But this does not necessarily mean that a so-called perfect result is in the patient's best interest. For example, I have seen patients with peripheral edema secondary to congestive heart failure who were managed with large doses of intravenous diuretics, resulting in complete resolution of the edema. Unfortunately, complete clearing of the edema fluid was accompanied by volume depletion, prerenal azotemia, and arterial hypotension. In these instances, the patient's condition was actually worsened by the attempt for perfect elimination of any evidence of interstitial edema.

Rule # 14: **Physician error is often the result of overconfidence.** This observation has been documented in a number of studies focusing on root causes of physician error.⁵ I remember a number of times when I personally made an erroneous diagnosis or initiated an incorrect management strategy because of overconfidence in my first impression of a particular patient's problem. Fortunately, in each of these instances, subsequent observations showed me the error in my original formulations and allowed appropriate corrective action to be taken. A recent supplement of *The American Journal of Medicine* dealt with prevention of medical error.⁴ This monograph, sponsored by the Paul Mongerson Foundation through the Raymond James Charitable Endowment Fund, stressed that physician overconfidence was one of the commonest causes of medical error.⁵ Therefore, an open mind and willingness to admit one's fallibility are important qualities for clinicians.

Rule # 15: **It is a privilege to practice medicine.** Patients share their most intimate feelings and life events with us, even things they fail to tell their closest family and friends. We are part of a profession capable of doing great good or great harm. Physicians need to recognize their limitations and strive constantly to improve clinical skills and medical knowledge. Of course, it is also important to remind ourselves that when patients tell us intimate details of their lives, these confidences must be kept confidential.

CONCLUSIONS

The 7 aphorisms or rules listed here, along with 8 others in Part 1 published last month in *The American Journal of Medicine*, contain advice for students, house officers, fellows, and junior faculty early in their careers. I would like to repeat the conclusion from Part 1 of this commentary: the principles on which this series of recommendations rests mostly have come my way from experienced, empathetic, and skilled clinical teachers. Their guidance has stood me in good stead through many years of practicing and teaching clinical medicine, and I offer these aphorisms as aids to becoming an effective clinician regardless of the environment in which one practices medicine.

As always, I'd be interested in hearing your comments on this important topic. Feel free to post a comment on our blog, <http://amjmed.blogspot.com>.

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References

1. Alpert JS. 12 guides to health, happiness, and longevity (with apologies to P.J. O'Rourke). *Am J Med.* 2008;121:551-552.
2. Williams CW. The practice. In: Williams CW, author; Coles R, compiler. *The Doctor Stories*. New York: New Directions Publishing Corporation; 1984:119-126.
3. Alpert JS, Goldberg RJ. Dear patient: association is not synonymous with causality. *Am J Med.* 2007;120:649-650.
4. Graber ML, Berner ES; Paul Mongerson Foundation through the Raymond James Charitable Endowment Fund. Diagnostic error: is overconfidence the problem? *Am J Med.* 2008;121(5 Suppl):S1-S46.