Something had to be done

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Sometimes good medicine means doing nothing at all. It can also be the most difficult thing to do.

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Perhaps the wisest of my medical-school preceptors, a pulmonologist practicing in the outer boroughs of New York City, used a game-like teaching method with some frequency. He would tell his fellows and/or residents a clinical scenario, hypothetical or otherwise, leading up to a summary-question for the trainees: What should now be done for the patient?

House staff would be full of ideas, running the gamut of diagnostic and interventional procedures, medications, etc. Occasionally, one of them would be correct. More often than not, however, none of them were. The answer, verbatim, would be, “Do nothing.” The described patient’s issue was self-limited or without a clear-cut medical remedy.

The lesson was that you don’t always have to do something and, in fact, should not. Yes, you’re a highly-educated medical professional. Yes, you have access to all sorts of skilled subspecialized colleagues, high-tech gizmos, and a pharmacy full of miracle-working meds, and there are a lot of things you could do. Indeed, patients are hoping, expecting, or downright demanding that you will. Which is why it can be easy to fall into the trap of doing something, anything, rather than accepting that what you might do will not help, but possibly harm – especially when your inaction may be seen as laziness, stupidity, or something worse. Primary care (and ER) doctors encounter this routinely when they recognize, say, a viral URI, and their patients get angry that no antibiotic is forthcoming. Put slightly more cynically in The House of God, “THE DELIVERY OF GOOD MEDICAL CARE IS TO DO AS MUCH NOTHING AS POSSIBLE.”

The opposite philosophy, increasingly heard from former supporters of PPACA (Obamacare, as it is also known), usually sounds something like: “Well, something had to be done [regarding healthcare].” Such statements befit truly desperate situations, such as being on a sinking boat in the middle of the ocean or atop a burning building with no imminent rescue. Since disaster is certain otherwise, you have nothing left to lose by doing something, anything, no matter how ill-conceived.

There are, of course, some dire circumstances to be found in medicine, and there isn’t always a clear-cut diagnosis with a textbook-dictated course of action. Perhaps because the field’s underpinnings are scientific, and perhaps because we’ve learned a healthy respect for the harm that can be caused by intervention of the wrong kind, we tend to proceed cautiously, trying one or two best-guess moves at a time and seeing how they pan out. Such methods allow us to keep tabs on what worked versus what did not. They also minimize the damage we might be doing at each juncture. If our latest attempted remedy yields no results, or even deterioration, we can quickly discontinue the offending agent.

Imagine, then, that instead of treating just one patient, we’re dealing with almost 317 million. Their healthcare situation wasn’t wonderful; there was definitely room for improvement. But was it really a “something must be done” crisis? Necessitating not just one or two attempted remedies at a time, but a 2,700-page prescription to change all the rules at once (unread by the majority of the politicians who pushed it into law)? Does this sound like good medicine? Is the outcome looking favorable?

Maybe, when the inexorable fallout leads to our next “something must be done” moment, input from those of us actually in the healthcare field will be deemed of somewhat greater value than the first time around.

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