

Elephant Medicine Revisited

*... mental excellence is a splendid
and lasting possession.*

— Sallust (86–34 BC)

Habit rules the unreflecting herd.

— William Wordsworth (1770–1850)
Ecclesiastical Sonnets (sonnet 28)

This editorial is not about elephants. It's about doctors and nurses who, like elephants in the circus ring—the trunk of one holding on to the tail of the other—plod mindlessly along, following without question the diagnoses, decisions, and policies of their colleagues.¹ Sadly, in this parade, the patient frequently gets run over.

Herd mentality—the unwillingness or inability to think for one's self—permeates our profession. Boosted by the medical technology at our disposal these days,² this mental inertia adversely affects all aspects of patient care, especially proper decision-making and effective communication. This inertia also dampens requisite curiosity and impedes self-education. And if it continues at its current pace, the core values of our profession—displaying humanism, striving for excellence, being honest, embracing sacrifice, promoting skepticism, avoiding arrogance, and always putting the patient first—seem destined for oblivion.^{3,4} Consider the following cases:

Patient 1. A 34-year-old woman's complaint of sudden dizziness prompted an immediate computed tomographic (CT) examination of her head. The CT report described lytic lesions in the skull that suggested metastases. Her physician then ordered CT scans of her chest and abdomen, hoping to find the "primary." He also obtained a slew of tests for multiple myeloma.

All of these studies produced normal findings. A neuroradiologist subsequently interpreted the lytic skull lesions as venous lakes—a benign, normal variant. On further questioning at that point, the patient gave a history that was diagnostic of benign postural vertigo, a condition that requires no sophisticated testing.

Comment: The physician in this case jumped from the patient's chief complaint to a cranial CT scan without first taking the patient's history. He also failed to think before ordering 2 more unnecessary CT studies. His mental inertia and reliance on technology exposed the patient to a substantial amount of potentially harmful radiation⁵ and took \$23,600 from her pocketbook, but did nothing for her dizziness.

Patient 2. A 72-year-old woman with hyperthyroidism was hospitalized to undergo thyroidectomy. The anesthesiologist refused to put the patient to sleep, because her preoperative hemoglobin concentration was 9.8 g/dL. He argued that a favorable anesthetic outcome required the hemoglobin concentration to be 10 g/dL or greater. Accordingly, the patient's physician gave her 2 units of packed red blood cells. Unfortunately, the wrong blood was administered, a severe transfusion reaction occurred, and the patient died.⁶

Comment: Treating a hemoglobin "deficit" of 0.2 g/dL cost this patient her life. Had her physician simply repeated the hemoglobin test or consulted with another anesthesiologist, he might have averted the death. Furthermore, the anesthesiologist's widely held notion that the preoperative hemoglobin level must be 10 g/dL or greater for a favorable outcome has little scientific support. In fact, there is strong evidence to the contrary.⁷⁻⁹

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Patient 3. A 69-year-old woman was admitted to the hospital for management of presumed cholecystitis. Her initial blood pressure as determined by a nurse was 135/80 mmHg. With symptomatic care only, her condition remained stable. On the 3rd hospital day, however, a different nurse found the patient's blood pressure to be 70/40 mmHg. This finding alone prompted CT scans of the patient's chest and abdomen, but neither study uncovered a cause for the "hypotension." Although the patient did not appear ill, she was transferred to the intensive care unit with a diagnosis of probable sepsis.

During the next 2 days, the patient received intravenous antibiotics and was seen by a surgeon, a cardiologist, a pulmonologist, and a critical-care specialist—all board-certified. Her blood pressure in the unit ranged from 135/80 to 140/90 mmHg, and because the diagnosis remained unclear, she was transferred to the medical service for further observation.

Two days after the patient arrived on the medical service, a nurse found her blood pressure to be 70/40 mmHg once again. Then, for the first time, a physician examined the patient carefully. That physician, the ward resident, discovered that her right radial pulse was strong and her blood pressure in that arm was 135/80 mmHg. In her left arm, however, the radial pulse was barely palpable and the blood pressure was 70/40 mmHg. A subsequent magnetic resonance angiogram showed severe stenosis of the patient's left subclavian artery.⁶

Comment: In this case, the herd mentality reigned supreme. It took 7 days of observation by far too many physicians before one of them finally compared the pulses and blood pressures in both arms of the patient. Had someone done this at admission, it would have saved the patient at least 2 unnecessary CT examinations, a needless stay in the intensive care unit, and a lot of her money.

One additional point. This woman would have been better served 30 to 50 years ago, when physicians routinely checked the pulses in all 4 extremities and personally measured the blood pressures in both arms. Nowadays, most physicians don't take the blood pressure themselves. They rely instead on measurements made by a nurse or some other assistant and treat the patient accordingly.

Patient 4. A 65-year-old former movie actress had fever of unknown origin for 4 years. During that span, she had sought help from many physicians in several cities, submitting each time to essentially the same studies and the same therapy—all to no avail. On physical examination, she was thin, talkative, and tense, and she constantly smoked cigarettes. Because her story suggested factitious disease, she was watched closely. Soon, she was observed putting the lit end of her cigarette to the thermometer.¹⁰

Comment: Whenever this patient consulted a physician, her "fever" engendered the same herd-like re-

sponse—numerous referrals, myriad tests, and multiple therapeutic trials. Four years passed before someone stepped back, thought about the case, put everything in perspective, and stopped the medical merry-go-round.

Discussion

In medicine today, mental inertia threatens to become the norm. But it has always been around. Look, for example, at the doctor's order sheet in the hospital record of any patient who has been admitted for nonemergent reasons. There, you will typically find an order for the patient's temperature, pulse, respirations, and blood pressure to be measured every 6 to 8 hours. The order usually says, "vitals routine" or "vital signs routine." Either way, the request is mindless. Think about it. How many patients in the nonintensive-care setting really need their blood pressure and temperature measured more than once a day, if that? Moreover, "vitals" and "vital signs" have completely different meanings and should never be used interchangeably. Yet, I am told, "Everybody does it."

I've never known a physician who specifically wrote an order for no measurement of the vital signs, or for measuring them once a day only. On occasion, however, I *have* written such an order merely to see how the nursing staff might handle it. Not surprisingly, they invariably have become visibly upset, emphasizing that their nursing policy requires them to record the vital signs of *every* patient at least 3 to 4 times a day, regardless of the patient's condition. Their response shows that nurses also act at times like elephants, mindlessly doing "what everybody does."

Finally, one other doctor's order merits comment: "Sputum for AFB \times 3." This order, written for patients who are suspected of having pulmonary tuberculosis, requests stains of 3 separate sputum samples for acid-fast bacilli. But why "3"? Again, the answer seems to be, "Because that's what everybody does." To me, such an order makes little sense, because the very *first* specimen often is positive, while in other instances, only the 4th or 5th specimen contains the organism. Consequently, tailoring the order to the specific patient and not to a habitual number would be more appropriate.

Conclusion

In the cases and situations described here, the doctors and nurses all made the same mistake: they didn't think for themselves. They simply followed the herd.

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