Guest Editorial

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Failure Is Not an Option

When things went horribly wrong on the *Apollo 13* mission, Gene Kranz apocryphally said, "Failure is not an option." The statement was followed with an intense diagnostic effort by NASA to determine the nature of the problem and formulate a plan to save 3 lives. I thought about this recently when I took my 95-year-old father, a retired podiatrist, to the emergency department (ED) of a large municipal hospital.

My father is a stoic individual, so when he described his acute pain as a 10/10, I knew he had a significant problem. He developed the sudden onset of lower thoracic back pain associated with moderately severe nausea and anorexia. He had a past history of coronary artery disease, acute myocardial infarction, prostate cancer, primary hyperparathyroidism, and a fragility fracture of his hip. After a prolonged wait, an unidentified individual asked a few questions, took vital signs, and without any knowledge of his history or diagnosis, ordered laboratory tests. The clinician then commented, "The doctor will be with you shortly."

The ED physician, who was residency trained and board certified, arrived an hour later. Failing to introduce himself, he asked 2 questions: the duration and location of my father's pain. This was followed by a brief auscultation of the abdomen and costovertebral angle tenderness on percussion, both of which were negative. He announced that the source of the pain was either due to kidney or musculoskeletal pain. A computerized tomography (CT) scan of the abdomen was ordered. Shortly after, the results of the laboratory work and CT scan were available; both were negative. Subsequently, a pain of 10/10 in a 95-year-old man with an extensive past medical history was treated symptomatically with intravenous morphine. He achieved the expected short-term results, and he was discharged without follow-up.

The next day, not surprisingly, the pain returned. Usually, I stay out of family care. I have seen too many serious lapses in judgment with this type of medicine. This time, however, I felt further input was necessary. I examined his back; he noted point tenderness at T5. After a quick trip back to the ED, thoracic spine films revealed a severe compression fracture of T5. Subsequently, he responded well to therapy with calcitonin and morphine.

So, what is the problem? The problem is a lack of a decent history and physical (H&P) examination, complicated by the ordering of expensive laboratory tests and imaging studies without a clue as to the diagnosis. As a rheumatologist and internist, I have taught physical diagnosis for 35 years. At times, I feel like something of a dinosaur discussing tests such as the anterior crescent shadow or cremasteric reflex. Except for specialists, no one uses these tests anymore. They seem like an antiquated part of a real examination. In their clinical years, students are told just to measure intraocular pressure or order imaging studies. Students must think my detailed examination is quaint. Certainly, much of the physical examination was devised before the availability of routine modern laboratory tests and imaging procedures. I agree that some elements of the traditional examination need to be reevaluated in light of modern medical practice. The question remains—what and how much?

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We all learn shortcuts as we become more experienced physicians. But, how much can we cut before we cut into essentials? Is a 2-question and 2-part examination in a complex 95-year-old adequate? It seems unlikely! What are the costs of this type of shortcut? The truth is there is no way to be sure. The delay in the correct diagnosis is obvious. The delay in focused therapy is another cost. What about money? If the financial cost of the tests and imaging in this case are totaled, they amount to about $770. If this cost occurs only once a week in every ED in the U.S. (estimated to be about 1,800), we are wasting about $72,000,000 per year; I think this es-

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timate might be a conservative one. Even more important, where is the pride in our profession? Have we lost confidence in our ability to the point that we require poorly focused testing to make a diagnosis rather than supporting or confirming our clinical impression? Is it just a matter of time or litigation? Or, is a good H&P examination really unnecessary? The first clinician who saw my father and took vital signs asked where he hurt. As a result, blood and urine tests were ordered. The clinician could just as easily have ordered a misdirected CT scan, because an adequate H&P examination was not performed.

As professionals, we complain about cost and reimbursement. We complain that less well-trained and cheaper providers are usurping our role as physicians. The provider in this case certainly did an inadequate H&P examination. Does it take 4 years of medical school and 3 years of residency to learn to do that? Are we giving away the franchise citing third-party payers, the government, and time shortages as the villain?

Perhaps I am overreacting, but I know my father came away from this encounter thinking the clinicians were unprofessional and cared not a whit about him. Money was needlessly spent; a correct diagnosis and proper therapy were delayed. None of this was necessary if the most basic elements of an H&P examination were performed. That is the responsibility of the physician. That makes us different from other providers. Gene Kranz would not approve; neither should we. It is when we are most confused that we must fall back on the foundations of the profession. "Failure is not an option," for our patients.

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