



When we need to remember that it is more than a job

“I am forever humbled.” So said a heart failure specialist on rounds when I was a resident in the intensive care unit several decades ago. He was talking about the perpetual mismatch between a physician’s level of knowledge and the unpredictability inherent in the management and outcome of critically ill patients. His words ring true for me nearly every day. We should never think we are so smart that we are truly in control of our patients’ outcomes or that we don’t make mistakes—but we also cannot become so paralyzed by the awareness of our limitations that we don’t make decisions.

I have spoken those same powerful words many times on teaching rounds. I also frequently push them to the back of my mind. As a consultant at a major medical center, I am supposed to *know*. It is a fine line we walk.

I know I am not alone in harboring these self-doubts. Ready access to online information does little to assuage the concern that we can never know enough. Have I ordered enough diagnostic tests to be *sure*? Have I ordered too many tests and thus will be penalized for providing cost-ineffective care? Should we follow generic guidelines, or deviate from the guidelines based on our clinical instincts, our own interpretation of the literature, and the patient’s unique circumstances and desires?

And then what happens when we make wrong decisions, or even the right decisions that result in a poor patient outcome, which of course is at some point inevitable? We are told to be open about errors, to be honest and transparent about our limitations, to throw down our elaborate emotional and intellectual defensive shields and expose our vulnerability.

But what do we experience emotionally when we are named in a malpractice suit? We may have done all that we thought we could do: we responsibly explored the diagnostic and therapeutic options, provided empathetic care, and listened to the voice of the patient. Yet an adverse outcome still occurred. The practice of medicine is indeed humbling. We feel crushed. We revisit the patient’s care in a vivid perpetual replay loop in our head. Maybe we didn’t evaluate all the options as we should have. If we had been a bit smarter, a bit more efficient, maybe the outcome would have been different.

Then during a deposition, the plaintiff’s counsel points out the temporal and documentary inconsistencies in the electronic medical record: “Doctor, you say you saw the patient at 2:00 PM, but there was no note finalized until 10:00 PM...and why was your documented physical exam exactly the same as the one from the day before and exactly the same as that of the resident who saw the patient that afternoon?” We now feel crushed, totally vulnerable, emotionally trampled, and often isolated and disconnected from our patients and peers. The intellectualized humility becomes transformed into a sense of inadequacy. Why should I keep doing this?

In this issue of the *Journal* (page 174), experienced malpractice attorney Kevin Giordano explores aspects of the malpractice process as they relate to the physicians

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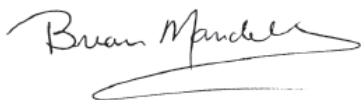
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he defends. He notes how the electronic medical record, a tool ostensibly in place to improve communication and the sharing of medical information between caregivers and patients, can be our worst enemy in a courtroom. He discusses the pressures of our complicated healthcare system that promote documentation errors that he must try to explain away to the jury in our defense, demonstrating that these documentation errors do not necessarily mirror the care and caring of the named physicians. This is critically important information for us to understand and to act on for our personal protection, but it is not his most important message to us.

Mr. Giordano is a sincere, empathetic, and proficient professional. He has spoken for and to many physicians. He has listened to us and observed our behaviors. And as he has defended many of us in a court of law, he has learned to diagnose in his clients the damage that can persist following involvement in a malpractice case and the emotional scars the malpractice experience leaves on physicians. He emphasizes that we must not let the event of a malpractice suit force us to withdraw and strip us of our connection and engagement to patients. If anything, he and Drs. Susan Rehm and Bradford Borden, in an accompanying editorial (page 177), urge us to keep in mind that our personal engagement with patients and the mindful practice of medicine is our *raison d'être* as physicians.

I am continuously humbled by the breadth of the pathology, clinical medicine, and social challenges that I encounter on a daily basis, armed with limited knowledge and experience. It is intellectually rewarding to make an arcane diagnosis or to see an individualized therapy work as I had hoped. But I agree with Mr. Giordano that it is the genuine engagement with patients that provides us with the real joy in the practice of medicine and pushes us to deliver care at a consistently proficient level. We must not forget that, even in the face of significant and emotionally challenging events such as being named in a malpractice suit. It is the nature of our engagement with our patients and our colleagues that make what we do more than a job.

As more physicians in the United States become employed by health systems, I hope that the administrative leaders within these systems truly recognize these issues. As they struggle to balance the provision of safe high-quality care to patients with their increasingly complex financial spreadsheets, I hope that the emotional health of their physician employees is not forgotten. And not just after a malpractice suit.



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