Trust No One

- or Why I might not follow a specialists's advice

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Why might I not follow a Specialist's advice?

One of the lessons that I taught family medicine residents when I was teaching at the residency in Vancouver was to "trust no one." That was a lesson that I learned painfully a number of times in residency and early practice, but which was fully cemented when I started working in Arcata:
There was a patient with a rare condition who had been seen in San Francisco by a neurology specialist. I was asked to do the local monitoring for the medication he prescribed for her, which suppressed the immune system.
After several months, she asked me for a refill on the hormones that she was taking for menopause. I reviewed her chart to be sure that breast cancer screening and other tests were up-to-date, and discovered that she had not had recent screening. I pulled old volumes of her chart and discovered that in the past she had had pre-invasive breast cancer(DCIS) , which no one was following up on. I did further reading, and discovered that one of the main causes of her neurologic problem is breast cancer!
I called her in for breast exam and found a lump in her breast. Mammogram and ultrasound were negative, so I referred her to a surgeon for breast biopsy. He did not think it was necessary, since the ultrasound and mammogram were negative, but I knew that 10 - 15% of breast cancers do not show on those tests. I called him as well as sending a letter but it still took a couple more months to get the breast biopsy that proved her cancer, and by the time her mastectomy was performed she had 15 positive lymph nodes, because in fact the cancer had spread, possibly because of the medicine prescribed by the neurologist, which made her immune system unable to control the cancer.
This case taught me that:
1. The neurologist who recommended the medication and who was supposedly a specialist in the syndrome should have known that this syndrome can be seen as a part of breast cancer, and should have recommended she be tested for that. By trusting him and just monitoring the medicine, as asked, I had gone along with a plan which endangered my patient.
2. When I did my own research on the condition, I not only discovered that fact, but also discovered a much safer treatment which had recently been published, and which I subsequently prescribed for this patient.
3. The surgeon, who should have been the specialist in knowing when a breast should be

biopsied, also would have further endangered this patient's life by not biopsying a lump in a woman with a high risk history and current high-risk symptoms.
(I'm happy to say that this patient is still alive, and still walking, and still doing amazing things for others in our community, despite all of this.)
My take-away was that a good primary care physician will use consultants for advice, but "trust no one," do my own research and pursue the patient's best interests regardless of the opinions of the specialists. This is part of why I spend as much time as I do researching my patient's conditions, reading to be sure that the treatment I'm offering is the most up-to-date, and so on.

Medical Errors : And more medical misadventures. . . .

Overall, medical errors have been said to be the third leading cause of death in the US according to a recent study from Johns Hopkins -
I have innumerable cases like this in my practice:
1. A cardiologist told a woman with classic chest pain she did not need an angiogram - I believe he was ignoring her symptoms because she was female: when I insisted, she was found to have a 95% stenosis of one of the main arteries
2. Rheumatologists insisted patients had "erosive osteoarthritis (wear and tear arthritis) when in fact I was ultimately able to demonstrate that they had either
a. Lyme disease
b. Rheumatoid arthritis
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or some other treatable condition (I have had a number of these cases)
3. ALS was missed by a neurologist for 2 years after I referred a patient with concern it was present
4. And I could go on. . . .
I appreciate the input of my specialist colleagues, but when they recommend a management plan that I think may be harmful, I may be a pest, send someone elsewhere for a second opinion, decline to follow that specialist's advice, attempt to implement the plan but back off if it is not working or causing harm, and so on.

I do not say this for self-aggrandizement, because I am as human and fallible as the next doctor, and I am sure I have had my share of "misses." (I remember one in particular, when I accused a man of being an addict and had organized a family meeting because he had called for an early refill when he was using up his pain meds faster for a month, but realized partway through the meeting with him and his wife that the pain was in a new area, examined him, and ordered an xray that showed he had a previously unsuspected metastatic lung cancer in his pelvis - I felt awful!)

I simply think that I have a special position as a primary care physician, in that I see the big picture for any particular patient, not just one organ system. Further, because of my continuity over time with patients, I have multiple opportunities for them to describe their symptoms and possibly say the magic phrase that will help me make the correct diagnosis. Finally, I am absolutely invested in my patients as people, and I cultivate an attitude of

nonjudgment, which I believe gives patients permission to actually tell me about high-risk behaviors, so that we can address them together.

Do only Bad Doctors make medical errors? What about their licenses to practice medicine?

The other comment I would like to make is that I would never recommend taking the license of that original neurologist, that surgeon who declined to biopsy, the sexist cardiologist, the rheumatologist who missed my patient with Lyme disease, or any of the other numerous providers whose medical errors I have seen. I commonly pick up patients from other primary care providers who have given them problematic drug combinations, who have been treating them for conditions for years without an accurate diagnosis ever being made, and so on. I understand that sometimes these kinds of errors happen because of absolute carelessness and neglect, but more often because our medical care system is broken, that these doctors are working in settings where they have 10 to 15 minutes with a patient, medical records which do not allow for easy tracking of historical problems, challenges with support staff and clinic infrastructure, and so on.

Instead of scapegoating and demanding that those physicians lose their licenses, I advocate for fixing our broken system. I think it is the very rare patient who is actually happy with the medical care they are receiving in this recent decade, and that is not the fault of "bad egg" doctors, but of a Disease Care System with distorted financial incentives, dysfunctional power dynamics, and so on.

Who should not be practicing?

There are a few individuals who I believe should not be practicing medicine:
1. Those with a history of molest and fondling of patients and other similar violations of patient trust
2. Those with active substance abuse themselves
3. Those who did offer to prescribe whatever the patient requested for a fee (there was at least one physician with that reputation, confirmed to me by multiple individual patients, who practiced in our community for a number of years)
and so on.

Is that who is being affected by the current Medical Board Actions regarding opioids?

Unfortunately, those are NOT the physicians that I see currently being challenged by our Medical Board. Since this all has become so public, a number of doctors have reached out

to me who have faced similar challenges - I do not know all of them and their patient care, but I do feel a theme is emerging, in that these seem to be providers with continuity relationships with vulnerable patients who have tried to navigate the route of least harm for their patients. The profiteers, the ones who ran "pill mills," got out when it became clear that this was risky care to provide, while those of us who are in it for different reasons have continued to hold the bag for the pain management practices and providers of the past, many of whom skipped town, suddenly stopped prescribing at high doses, and so on.

Surprisingly, the providers who escalated patients to high doses of opioids and then suddenly cut them back drastically are not being challenged for patient abandonment. A number of my general (non-pain) patients, in their letters of support for my practice, describe friends or relatives of theirs who are suffering or even bedbound, losing weight, or despairing because of similar "care." A patient I admitted to my suboxone program had been suddenly cut off of her pain medications by her previous providers for breaking a narcotic contract. She landed in the hospital for 4 days and has had ongoing congestive heart failure since then as a result of the side effects of withdrawal and this "standard of care."

Similarly, when those patients turn to the street and risk their lives trying to manage their pain and/or addiction with what they can obtain there, those and other physicians can self-righteously blame the victims, the patients who were abandoned, and if those patients join the numbers of those who are overdosing and dying, somehow that is not tracked back to the providers who started them on these medications in the first place, but attributed to some sort of moral failure on the part of the patients.

I do not believe these are "disposable people," and I believe my practice has demonstrated that by imposing some reasonable limits and sticking with patients who are struggling, I am generally able over time to taper them down more safely. So yes, at times I have failed to enforce narcotic contracts, with patients who I felt I still could work with on some level. Similarly, I have not discharged patients with diabetes who continue to eat Halloween candy, even when their numbers have interfered with my good statistics on diabetic management and cost me a bonus. I appreciate that other providers may differ with my methods, and might make different choices about which patients are too difficult to work with, but as I have paraphrased Churchill elsewhere, "Patient-centered care is the worst form of care, except for all the others."

Or in the words of P1's daughter:
" I find it completely ironic, that the first doctor that she has had, that has tried to reduce the amount of medication she takes, that has tried to pursue every possibility to improve her quality of life and sees her as a whole person and not just a collection of symptoms and TRULY HAS provided her excellent care, is now being threatened with losing her license -after all of the years of negligence that she has actually experienced with other physicians."

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