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Book Review: Zebras, or Horses of a Different Choler

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I have taken of late to calling the evening TV news the pharmaceutical hour owing to the barrage of ads for one or another drug that usually conclude by directing the viewer to “ask your doctor about….” Aimed at an aging boomer population that now tells itself that “60 is the new 40,” these ads promise to restore youthful vim, vigor, and virility to bodies debilitated by normal wear and tear and, one suspects, bad habits. Technology will trump nature; pills will, if not arrest time, slow its ravages.

Dr. Jerome Groopman of Beth Israel Deaconess Medical Center and the Harvard Medical School faculty offers How Doctors Think as a caution to the notion that some miracle therapy or cure exists for every affliction. Drawing on his experience both as a physician and a patient and on his discussions with medical colleagues and patients, he reiterates that practicing medicine is an art that requires a serious and sustained dialogue between doctor and patient. What factors, Groopman asks, come into play that determine whether a doctor succeeds or fails in diagnosing a patient’s condition? “While modern medicine is aided by a dazzling array of technologies, like high-resolution MRI scans and pinpoint DNA analysis, language,” Groopman answers, “is still the bedrock of clinical practice.” Later in How Doctors Think he stresses that accomplished diagnosticians, when confronted by a patient who hasn’t responded to treatment and therapy, will reconstruct a narrative from the patient’s symptoms. Groopman paraphrases a colleague who “emphasized to me that sensitivity to language…should be considered with every patient.” The doctor must hear not only the facts of the clinical history but the manner in which the patient delivers the facts; the how can be as important and revealing as the what. As my doctor has said to me more than once “the most important knowledge I have about your condition comes from what you tell me.”

Groopman insists that the primary care physician who first hears the patient’s account of his symptoms acts as a “gatekeeper” for much of what follows. He laments the circumstances that compel primary care physicians to spend less time with patients—primarily insurers’, or “bean counters” as he calls them, concern with cost containment and economic efficiencies—with the result that the doctor must too frequently make a quick diagnosis. While a large percentage of clinical diagnoses are routine, some demand time and careful thought. The initial diagnosis will follow a patient and assume what Groopman terms “diagnosis momentum” where subsequent physicians in their diagnoses follow the direction established by the original. Doctors must learn to recognize and avoid this cognitive trap, know when to put the clinical record aside, and have the patient redescribe the symptoms in order to determine whether some symptom has been missed or been considered unimportant.

In his seventh chapter, “Surgery and Satisfaction,” Groopman recounts his own experience as a patient trying to learn what was causing his right wrist to swell and throb with pain. At first he attributed the condition to carpal tunnel syndrome, but as the pain increased in frequency and intensity, he sought relief from specialists. Over a span of more than three years he consulted five hand surgeons whom he identifies as Drs A, B, C, D and E. Dr A at first admitted he didn’t know what was
wrong with Groopman’s wrist and recommended first splinting it, then after several months unsplitting it. Nothing worked. Finally, Dr A fell into what’s known as a “commission bias”—the “tendency toward action rather than inaction”—and diagnosed Groopman as suffering from “hyperactive synovium.” Dr A essentially invented a diagnosis to mask his uncertainty.

Dr B examined the wrist, found cysts and what he thought was a hairline fracture of the scaphoid bone, and recommended three separate surgeries which would require an eighteen to twenty-four month recovery. Dr B made the cognitive error that Groopman terms “satisfaction of search” where once the surgeon finds something, he tends to stop searching for any other possible diagnosis. Once Dr B found the cysts and fracture, he assumed there was nothing more to be found.

Dr C, a world renowned hand surgeon, gave Groopman a cursory examination and turned him over to a resident for tests and told Groopman he had calcium deposits in his wrist that had stiffened and inflamed the tissue, a condition technically called chondrocalcinosis. He recommended arthroscopic surgery, but when Groopman, aware that treatment with an anti-inflammatory was the appropriate therapy, inquired whether arthroscopy would correct the problem, Dr C basically said he’d figure it out in the operating room. Dr C arrived at not an invented diagnosis as had Dr A but an “inventive” diagnosis to conceal his uncertainty about the origin of Groopman’s pain.

It was Dr D, a young doctor new to Boston, who finally diagnosed the problem by examining and x-ray both wrists which showed in the right wrist a torn or imperfectly functioning ligament that was causing the bones to misalign when under stress. Groopman questioned Dr D on why the MRI had failed to reveal the problem. “Doctors relied too much on such sophisticated scans,” Dr D said, “so sometimes you had to discount their findings if they were out of sync with the clinical picture.” He recommended surgery though admitted he had performed the procedure only once. Groopman had the diagnosis confirmed by Dr E, a more experienced surgeon, underwent the operation and had his wrist restored to 80% efficiency. Though he, like all patients, had hoped for a full recovery, he learns from a surgeon friend that “The perfect is the enemy of the good… nothing that you do in surgery is perfect. Everything is a compromise. Eighty percent of normal after surgery—well, that’s pretty good.” A surgeon should practice candor and avoid “paint[ing] a too rosy scenario” for the patient. Groopman points out that “such [clinical] honesty is not rewarded in today’s society” where “patients shop for doctors” and “some doctors are keen to market themselves.” The lesson to be learned by doctors and patients alike is that doctors should “think in sync with the patient” and “the patient should be helped to think in sync with the doctors.”

Groopman explains how technology sometimes works to inhibit doctors and patients from working in sync with one another. He cites the introduction of “patient templates” which are “based on a typical patient with a typical disease. All that is required of the doctor is to fill in the blanks. He types in the patient’s history, physical examination, lab tests, and the recommended treatment.” While the technology promotes efficiency by reducing the amount of time physicians spend with each patient—the bean counters again—it can also drive a wedge between doctor and patient and “risks more cognitive errors” since the doctor focuses on filling in the template blanks rather than on “open-ended questioning” of the patient to elicit data that may not fit the template. Groopman fears the increasing commodification of medicine which de-emphasizes physician-patient interaction “within a context and in a social system.”

One reads on an almost daily basis or hears in the TV and radio news of the crisis in medical practice—the ever increasing costs, overcrowded emergency rooms, under- or uninsured patients, ineffective and sometimes downright dangerous drugs, and stressed physicians. Groopman addresses these problems and more in How Doctors Think by letting other doctors and their patients tell their stories to illustrate what does and doesn’t work. One finishes the book sensing that most doctors want to do what’s right and helpful for their patients but are often confined by their medical school training where interns are taught “when you hear hoofbeats, think about horses, not zebras.” Worse, the bean counters, in restricting the time doctors can spend with patients or the number of tests they can order, encourage the doctor to focus on horses. Which has its place, “unless, of course,” Groopman remarks, “that one zebra turned out to be the bean counter’s own child.” I think it’s fair to say that for Dr. Groopman accomplished doctors, at whatever level they practice, should assume every patient is that unique zebra. But, all of us, when we visit our doctors need to offer a narrative of our symptoms that allows the doctor to perceive our unique stripes and heal us.

Correction:
in my review of Nathaniel Philbrick’s Mayflower (Bridgewater Review, December 2006), I placed First Encounter Beach in Orleans; it remains in Eastham.