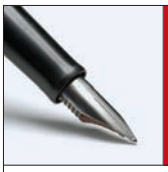

LETTER FROM THE EDITOR-IN-CHIEF

Fighting the Urge to Judge

In a previous column, entitled "Rekindling the Doctor-Patient Relationship", I focused on methods for developing trust with your patients. The intention of building trust is to enhance patient relationships and ensure positive patient encounters.

Judgments can be a significant obstacle to that process, however. In fact, judgments are the surest way to undermine trust, and can potentially lead to delay of appropriate care or to misdiagnosis. Judgments are second only to assumptions as the two most dangerous mistakes in medical decision making.

In this month's Bouncebacks article, Drs. Weinstock and Longstreth explore the common—and dangerous—mistake of making assumptions about a patient's presentation that do not make clinical sense. In a future column, I will specifically address the dangers of assumptions.

We must be equally careful of the dangers of judgments when providing care for patients. Passing judgment of patients is destructive to the doctor-patient relationship, and equally destructive to sound medical decision making.

Take the patient with severe disabling back pain. You have seen several other cases that day with patients you simply deemed "drug seekers," so you are equally suspicious of this one. The patient is pleading for help to relieve the pain, which you incorrectly assume is a request for narcotics. What you fail to remember is that patients are not privy to the fund of knowledge you have as a practitioner. They do not know to ask, "Please fix my ruptured aortic aneurysm" or "Please help me with my spinal abscess." Patients merely know what they are feeling; in this case, "pain." You would be sadly mistaken to pass judgment on those in pain at the expense of a thorough history and physical. If the presentation is not typical of simple musculoskeletal pain, then you have an obligation to determine why.

The second common mistake of judgment: We routinely underestimate how much pain patients "should" be in. Have you ever ruptured a disc in your back? If so, I am willing to bet you never underestimate the pain patients can experience with disorders of the lower back. Personal experiences of pain or illness can be humbling experiences for physicians.

Finally, passing judgments isn't even helpful when it is clear that a patient is indeed drug seeking. The problem is two-fold:

Many have been conditioned by other practitioners to seek narcotics for pain relief. Who's responsible for that?

Confronting a drug seeker in the office can spiral into a disruptive conflict that should be avoided, if possible. The drug seeker will invariably blame you for withholding care if you don't give them what they want. They will paint you as uncaring, often in a loud and disruptive way. The flow of patient care is entirely obstructed and the mood of the office will remain gloomy for the rest of the day. Your care will suffer.

Alternatively, one might attempt a different approach. For example: "I am concerned about the amount of pain you are in. It is not entirely consistent with the non-threatening causes of low back pain. I do not want to miss anything, so I feel it is important to obtain consultation with others to better determine the cause and best treatment of your pain."

At this point, a referral can be made to the appropriate specialist (ER, pain management, or spine, depending on your real index of suspicion). This response shows concern for your patient. It is very difficult for someone to demonize you for that. Most drug-seekers are caught off guard by this approach, and will, more often than not, leave without incident.

The examples presented here illustrate critical dangers inherent in our judgments. Judgments common to everyday life, but of little use in clinical care. The alternative is far more acceptable: Believing a liar is better than missing a catastrophe or minimizing real pain. It is a tradeoff we should all be willing to make. ■

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