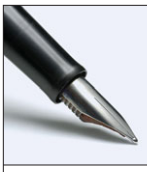


LETTER FROM THE EDITOR-IN-CHIEF

‘First, Do No Harm’ But Don’t Be a Harmful Do-Nothing!

As scientists, we are trained to question through research—to pose hypotheses and test for proof. Science, however, is notoriously flawed and imperfect, and has left a trail of discarded practice standards refuted through additional study or missed statistical error. Many a medical proverb has fallen out of favor this way—but none has withstood the test of time longer than “First, do no harm.” With an almost religious fervor, physicians have embraced the saying as fundamental doctrine and would not dare to challenge its unquestionable truth.

“First, do no harm” has been a subconscious rule of thumb in medicine for centuries now. While not officially part of the Hippocratic Oath (a surprise to most), it was born of the same teachings. The problem with such heuristics is their potential for error. Blind acceptance can mislead, whereby, one does not consider or prematurely closes the door on alternatives. In clinical medicine, this can lead to diagnostic and/or treatment errors.

When ‘First, Do No Harm’...Harms

Unwillingness to prescribe controlled substances is perhaps the best example of overconfidence in the “First, do no harm” heuristic. It is assumed that drugs with the potential for abuse and dependence should be avoided at all costs. Accordingly, patients in pain are judged critically on the legitimacy of their pain. If their pain is deemed clinically “unworthy,” narcotic pain relievers are withheld. Worthiness is determined through a semi-clinical assessment of objective and subjective criteria. While clearly prone to errors of assumption and judgment, we routinely rely on this assessment to designate these drugs as “harmful,” with very few clinical exceptions. And while no one can specifically quantify the error rate of these assessments, it is almost certainly non-trivial.

So, what if we are wrong? What is the risk of our diagnostic error?

Two negative outcomes are possible:

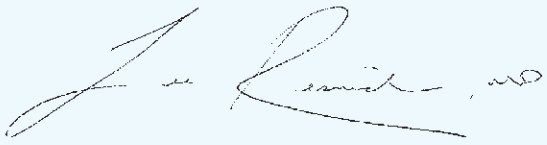
- A missed opportunity to help a patient in need
- A missed diagnosis of potentially threatening nature.

Take, for example, back pain. Clinicians often feel the need to determine the truthfulness and expected intensity of this presentation despite the lack of reliable diagnostic tools. We seek to quickly label those patients we deem drug-seeking or histrionic, often based on simple first impressions. While we defend this step as protecting the patient from harm, all too frequently we are simply protecting ourselves from the discomfort of our own uncertainty. At risk is a missed opportunity to help a patient in pain, or far worse, a missed epidural abscess or tumor. When confronted with the possibility of being bamboozled by a drug seeker for a few Vicodin, we seem willing to accept the risk of undue harm and pain. Our overconfidence in the principle of “First, do no harm” has unwittingly led us to miscalculate overall risk—an error with serious, and ironically harmful implications.

“We need to grow more comfortable and accepting of being ‘conned’ in return for the opportunity to help a patient in need.”

We have, in effect, been bamboozled by our own arrogance and scripture, and failed to account for the implications of our blind faith.

I propose that we reassess the judicial nature by which we interpret our patients’ pain, and more honestly consider the cost of false judgments. We need to grow more comfortable and accepting of being “conned” in return for the opportunity to help a patient in need. I would argue that is the true meaning of the Hippocratic Oath. With no intention to shred the principles of “First, do no harm,” I offer you this counter-principle from the famous Old-English author, Samuel Johnson: “It is better to suffer wrong than to do it, and happier to be sometimes cheated than not to trust.” ■



Lee A. Resnick, MD
Editor-in-Chief
JUCM, The Journal of Urgent Care Medicine