Reflections

Editor's note: The Pharos *is introducing a new section, "Reflections," that focuses on physician experiences related to AΩA's mission of leadership, professionalism, teaching, and service. Each vignette will be a brief (no more than 1,000 words) evocative description, account, or episode with a major point of learning, insight, experience, and/or reflection. Vignettes will be focused on leadership, teaching, education, learning, medical excellence, humanistic qualities in the individual physician, professionalism, and/or ethics.*
It is our hope that readers will find this new section to be insightful, educational, and entertaining, and that they will consider submitting their own reflection for possible inclusion.

God shot me with an arrow

Richard L. Byyny, MD, FACP (AΩA, University of Southern California, 1964)

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I was caring for patients and teaching residents and medical students at the University of Colorado Hospital General Internal Medicine practice in the 1970s. I was evaluating a 48-year-old Latino man who I had been seeing for more than two years. He initially presented with cough, fever, weight loss, night sweats, and production of yellow blood streaked sputum. A chest X-ray revealed a right upper lobe infiltrate with central cavitation. His sputum stains revealed acid fast *bacilli* and the diagnosis of pulmonary tuberculosis. He was started on isoniazid, psa, and rifampin observed therapy by his wife. He improved rapidly.

Twice he returned with a recurrence of his night sweats, weight loss, and fatigue, and his chest X-ray revealed an increase in the right upper lobe lesion. Sputum smears for acid fast *bacilli* were negative, but his culture grew mycobacteria tuberculosis. He told me he had stopped taking his medications, though he had no side effects. With medication, he rapidly improved and was better for almost a year.

He returned a third time with the same symptoms, and another X-ray revealed the same right upper lobe lesion.

I sat down with him, a resident, and a student, and asked him if he was taking his medications reliably. He answered "No." I asked why, and he replied that he wasn't sure, and had no side effects from the medications that were being offered by his wife on schedule.

I asked what he knew about tuberculosis. He answered that he knew it was an infection in the lung due to a bacteria, which caused his symptoms. I asked him if he thought the medication was effective and helping to treat the infection. He answered, "Yes, it seems to work each time I take the medications." I then asked him why he wasn't taking the medication if he thought it was helpful in treating his tuberculosis. He asked me to put his X-ray up on the view box. He got up and walked to the X-ray and pointed at the lesion and said, "See that spot? That's where God shot me with an arrow. You can easily see where it went through."

I asked him why God shot him with an arrow, and he replied, "I really didn't know, but it was punishment for something I did that God was unhappy with. I can't be cured by Western medicine until the spiritual cause is healed."

He was from the San Luis Valley in Southern Colorado and was explaining a spiritual cause for not being curable. I asked him if he believed in *curanderismo,* and if he knew of a *curandero* or *curandera*.

Curanderismo is a traditional Mexican-American healing system from the integration of Catholicism and indigenous holistic healing. It treats and cares for people through religious, spiritual, health-related means and rituals. It is a type of holistic folk medicine. Followers define disease as having both biologic and spiritual causes that can often be resolved only through respect and acceptance by the healers.

The patient told me he knew a *curandero*. I asked if he believed that having a *curandero* would help cure him, and he answered, "Yes."

We organized a consultation with the *curandero* who developed a plan for healing that involved spiritual rituals with the patient and his family. My student, resident,

one of our nurses, and I were invited to participate in the ritual event. The *curandero* used small brooms with herbs to sweep away the curse, and acknowledged the patient's punishment to resolve his guilt and violating God's will.

The ceremony lasted two hours. The experience used the tools of the *currendaro* to heal the patient, and his belief system. The patient agreed, now that God had forgiven him for his transgressions, that he would take his medications knowing that he would now be cured both medically and spiritually.

Dr. Sydney Margolin, a professor of psychiatry and a learned colleague, had taught me that "the reality and life of patients and their problems are richer, more interesting, and more complex than can be encompassed or defined by any theoretical framework," or by scientific method alone. He taught me to have an intense curiosity about unusual people, unique human problems, and cultural differences in the roots of healing processes. He explained that the historical relationship of physicians with priests and shamans of other cultures, including the *curandero,* have a place in medicine and cannot be ignored.

Inquiry and understanding of a patient's issues, awareness of our own professional and personal biases and limitations, and a willingness to better understand culturally different populations and patients can help us to *curar*.

As a team caring for this patient we treated his mind, beliefs, illness, and body as a whole. We understood that our patient's perceived supernatural disorder was interfering with curing him of an infectious disease. Through understanding and respecting our patient's beliefs—and with the help, support—and rituals of the patient and his *curandero,* we were successful in the treatment and caring of our patient and his family.

A quandary resolved

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My friend, Peter Martin, and I were members of the University Hospital ethics consultation service. As an attorney and philosopher, Peter would complain that most of our consults weren't about ethics at all, but usually had to do with poor communication. He said that by talking with the parties involved and conducting family meetings, ethics consultants were often able to resolve the issues, and facilitate patient care. Peter appreciated these good outcomes, but still argued that they didn't specifically entail ethics. I took the position that poor communication resulted in bad clinical care, which was itself unethical.

I received a consult from urology regarding Mr. Williams, a patient who kept pulling out his percutaneous endoscopic gastrostomy (PEG) tube. He was an elderly man who suffered from Alzheimer's and swallowing dysfunction as a result of a previous stroke. He had been admitted for urosepsis, which had resolved with antibiotics. However, he remained delirious for unclear reasons.

He had pulled out his PEG tube several times. To prevent further problems, he was put in arm restraints, which only increased his agitation. His inarticulate cries could be heard down the hall. Mr. Williams' wife and daughters objected to tying him down "like an animal," and suggested giving fluids by mouth, a course his clinicians believed would lead to aspiration. In fact, when his wife covertly gave him sips of juice, he spit them out. Nonetheless, as the patient's health care agent, she took a firm stand that her husband should not be in restraints. She was also opposed to heavy sedation, given his precarious clinical state.

That's when his attending consulted the ethics service. The surgical attending asked me to "make her understand that he *needs* to be restrained."

This was going to be difficult. Mrs. Williams had the legal right to prevent the use of restraints. The urological team might argue that repeated insertion of a new PEG tube was futile since Mr. Williams was only going to pull it out again, and that each insertion carried a risk of tissue damage and infection.

Since his stroke, the patient had lived in a state veterans home where he was confined to bed and a wheelchair. His Alzheimer's was moderately advanced, but he seemed to enjoy watching TV and having the companionship of fellow veterans, although his expressive aphasia limited verbal communication. There seemed to be no definite barrier to him recovering this baseline level of functioning.

I arranged a meeting for late afternoon with Mrs. Williams, her daughters, and members of the surgical team. The next step was to visit the patient, an emaciated elderly man with right hemiplegia, squirming and groaning in his bed. His left arm restraint was loosened so he could move his hand and arm freely.

As I stood beside the bed, I noticed that he tended to touch and rub his upper right arm. You could characterize his left arm movements as random or flailing if you just glimpsed for a moment, but over time his hand kept

coming back to the same area, which seemed a little swollen. When I palpated the area, he reacted violently. Clearly, he was in pain.

I also noticed that Mr. Williams was not on a regimen of pain medication, other than Demerol when necessary, which he had not received for several days. The nurses' notes consistently documented agitation, moaning, and crying out. They expressed frustration each time Mr. Williams pulled out his PEG tube. However, there was nothing about pain. He was unable to request the analgesic, so it was never given.

Could this be the cause of his agitation? Might pain be contributing to his delirium? I spoke with his attending, who was happy to follow-up. An arm X-ray revealed an osteoporotic humerus with a proximal fracture, possibly sustained during transport or transfer. The urologist prescribed an analgesic every four hours.

It didn't take long for Mr. Williams' agitation to disappear, and he became more alert. His new PEG tube remained in place without incident. And the ethical question of restraints was promptly resolved.

I agree with Peter Martin that reasoning from principles is often useful in clarifying ethical issues in medicine, but sometimes they can be clarified—and resolved—at the bedside without resorting to second level deliberation. Mr. Williams taught me that careful observation, along with clear communication, lies at the core of ethics in medicine.

Clinical parsimony: "Personalized" patient care

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In the current cultural-economic era of unsustainably high costs of medical care, Choosing Wisely®, an initiative of the ABIM Foundation that promotes patient-physician conversations about unnecessary medical tests and procedures, provides a stimulus to eliminate many tests and therapies throughout the specialties. It provides multi-sourced advocacy for professionalism in health care, explaining that clinicians of all professions must eliminate unnecessary care. At the same time, risk-averse hospitals and insurers desire the protections of certainty and safety.

During a shift in the urgent care clinic, my new patient was a retired college professor, more than 90-years-old, who complained of four days of unfamiliar, spasmodic bilateral mid-back pain without radiation. At times, and during undisturbed sleep, there was no pain or soreness. No particular activity provoked the pain. Lying flat, ibuprofen, and heat offered limited relief. No recent upper respiratory illness, fever, cough, rash, urinary, or digestive track symptoms. For two days prior to the onset of the spasms, he had been a passenger on a long automobile trip.

Relevant past history included L 3–5 laminectomies 10 years ago, and aortic valve replacement five years ago, but generally good health and activity for his age.

Physical examination showed normal vital signs; firm erector para-spinal muscles; no tenderness over spinous processes; normal spine mobility; good bilateral strength in hip, thigh, and leg muscles; and equal patellar reflexes and femoral pulses. Cardiorespiratory and abdominal exams were negative.

The temptation to order various tests, imaging, and consultation in this senior academic was strong. Was there new spinal stenosis? Zoster and renal disease seemed unlikely, but could there be early aortic dissection or osteoporotic vertebral collapse?

The choice of expensive studies over a course of conservative management at home was eased by this elderly patient's preference—not demand—for the latter. He wanted relief more than a firm diagnosis.

Ordinarily, I would recommend heat, acetaminophen, continued moderate activity, perhaps a muscle relaxant (at bedtime to avoid falls), and specified early follow-up. Did I need to know the results of an MRI, chest X-ray, and urinalysis? We both decided to wait and see.

Most patients are intelligent observers of their conditions, not anxious for an immediate definitive diagnosis, and willing to permit—even suggest, a period of conservative care. Clinicians dedicated to shared decision-making should take the time to recognize this cohort. The yield can be patient satisfaction, cost savings, unnecessary attention to adjunct findings on testing, and avoidance of potential safety issues. To experienced clinicians, this degree of confidence may be second-nature. To trainees and acolytes in large health care systems, especially among specialists, such assumptions may seem too risky.

Calibrating the patient's wishes and choosing wisely comprise good clinical judgment. This time, we both proved right. The happy outcome included advice to break up long automobile trips with stops for stretching and walking.