DEAR DR. JEFF
Jeffrey Nichols, MD, CMD

Living and Practicing With Uncertainty

Dear Dr. Jeff:

When I was in medical school, I admired the knowledge and desisiveness of the senior doctors and even some of the senior residents. Now, having completed years of residency, board certifications, an abundance of continuing medical education credits, and years of practice, I still lack that degree of certainty. I believe that patients, families, and other members of the care team look to me for answers, when what I have are my best evaluations. Do you have any thoughts about this?

Dr. Jeff responds:

When I was in medical school, the chief of medicine was the nation’s leading expert on Wilson’s disease, a relatively rare congenital disorder of copper metabolism. Residents enjoyed presenting grand rounds cases that combined neurologic and liver dysfunction to hear his God-like pronouncements that “This is Wilson’s disease” or “This is not Wilson’s disease.” Perhaps, if you narrow your focus sufficiently, you too could achieve this degree of certainty.

Those of us who practice in post-acute and long-term care work within a world of unavoidable uncertainty. Our patients present with multiple physical disorders, some of which are new and many of which are long-standing. They are taking multiple medications, often for unclear indications, with multiple known side effects and unknown potential drug-drug interactions. Many also have coexisting cognitive disorders, which may make obtaining a history or review of symptoms difficult or impossible. Psychological and psychiatric disorders are extremely common among these patients with pneumonia and stable vital signs and oxygen levels will do better if managed in the familiar nursing home environment, a diagnosis of pneumonia may lead to family pressure for hospitalization — or perhaps to the family rallying to the resident’s bedside. A diagnosis of influenza or RSV should lead to isolation with droplet precautions, whereas a bronchitis diagnosis might allow the resident to share meals with familiar tablemates in the dining room. The influenza diagnosis would certainly lead to prophylactic treatment for any roommates or close-contact staff, and possibly for the entire unit or facility.

In an uncertain world, this situation requires a definitive diagnosis, even if qualified with “in my clinical judgment.” Albert Einstein may have said, “Only two things are unlimited, the universe and human stupidity, and I’m not sure about the universe.” Not knowing is not stupidity, although not knowing that you don’t know verbs on ignorance and may be dangerous. Those who make absolute pronouncements may try to sound certain — and occasionally they really believe that they are. But that doesn’t necessarily mean they are right.

A colleague recently told me there are three kinds of “I don’t know.” One is simply that you don’t know but you could find out. The second is that you don’t know and nobody else knows either. The third is that you don’t know and you don’t know if anybody knows. The most difficult task is to separate the second from the third. One of the delights of the internet is that it simplifies this task. Unfortunately, it doesn’t do a very good job of separating those who do know from those who claim to know but are wrong. A healthy skepticism about sources may help.

Reliable Sources
Careful reading of research articles helps to differentiate which studies may apply to the patient or patients you care for. For instance, many research studies exclude the elderly or include them only as a tiny group whose results are not analyzed separately. Others purport to discuss medical issues in “the elderly” but rarely address the old-old, who are often seen in long-term care facilities. Indeed, the term “elderly” may refer to patients older than 60 — but in one of my favorite articles on hyperension the cutoff for elderly was age 45. Patients with multiple comorbidities are generally excluded from clinical trials, so many important answers that we think “know” are still unknown.

There are also some reliable sources of information that can be used to form sound decisions. In addition to Caring, I strongly recommend that every physician practicing in long-term care read JAMDA: The Journal of Post-Acute and Long-Term Care Medicine. This peer-reviewed journal publishes articles directly relevant to residents in nursing homes and assisted living communities. The review articles represent the best available synthesis, including references for what is known and unknown in major areas of patient care, written by experts in the field. It also publishes in complete format (or with links to the complete versions) the White Papers adopted by the House of Delegates of AMDA – the Society for Post-Acute and Long-Term Care Medicine, which are also well-researched products written by experts in our field. The Society’s Clinical Practice Guidelines provide sound approaches to a variety of clinical conditions with advice for the practitioner and the team as a whole. These guidelines are based on evidence and expert opinion, with each labeled based on the strength of the evidence.

Every resident is a “n of 1” experiment, with a unique history, background, and experiences, genetic makeup, functional limitations, family relationships, responses to medication, spirituality, medical conditions, and goals of care. The other members of the care team are also providing input based on their best knowledge and experience, often developed from an evidence base no more solid than that of the medical literature, and no more directed at frail institutionalized elderly. Wound care products, dietary regimens, behavioral therapies, rehabilitative modalities, and many other aspects of the care plan are all based on a combination of some science, some clinical experience, and a moderate amount of inductive reasoning.

Common Sense
All this often makes our goal to practice evidence-based medicine feel like climbing a greased pole: difficult, frustrating, and messy. There are, however, some basic truths in long-term care. In the immortal words of John Molesky, MD, “Weight loss = Death.” Pain and suffering are always worth treating. Treat the patient, not the laboratory results or the x-ray. Listen to the patient. Taking care of the patient requires caring for the patient. Rehabilitation may provide functional benefits regardless of age and often despite cognitive limitations. And death may not be the worst possible outcome.

Under these circumstances, as clinicians we can only give patients our best advice according to their goals of care. We learn from our experience as well as from medical literature — that is the essence of clinical judgment. If we have listened carefully to the resident and the family, if we have worked collaboratively with the other members of the care team, if we have applied the available knowledge and wisdom from the medical literature, and if we have created advice and a care plan based on these and our clinical judgment, we have done our work as healers. There is never certainty in outcomes, but we can be certain that we have done our best. I acknowledge these circumstances are all stress-inducing and put us at risk for emotional and professional burnout. One of my favorite refrigerator magnets reads “Stressed is just Desserts spelled backwards.” Regrettably, ice cream is not always the answer, but it may definitely be worth a try. Dark chocolate is an evidence-based approach to improving mood and reducing anxiety (J Psychopharmacol 2013;27:451–458). Do not forget to treat yourself well.