COMMENTARY

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When Less is More: A Caring Physician's Dilemma

Recently, an instructive commentary in ***The American Journal of Medicine*** discussed what qualities are needed to be a "good" physician. Empathy, kindness, and a good knowledge base were emphasized.[1] About the same time, another commentary discussed the appropriateness of treating some patients with stable coronary artery disease with intense medical therapy and avoiding referral for coronary stenting. It discussed the findings of many trials demonstrating the effectiveness of medical intervention alone, summarizing data from the COURAGE, ORBITA, and ISCHEMIA clinical trials.[2] The argument of this second paper is based on an important ability of a good physician: the capacity to recognize when potentially indicated medical intervention should not be pursued. The ability to recognize the lack of need for action and then to withhold a specific therapy requires the integration of the above qualities, empathy, kindness, and knowledge; plus, it requires something more. Reflecting on my experiences in over 40 years in medicine, I realize that not acting by not doing the more aggressive intervention, even though others might, is very difficult. This applies to any intervention, including those that are mundane like adding a medication, to those that are very dramatic, like coronary artery stenting. A very current issue concerns trying to avoid endotracheal intubation in patients with coronavirus disease with respiratory failure, which has potential benefits, but is not without risk.[3] Understanding why the conscious act of appropriate inaction is so difficult to perform is worth discussing, because it is not easily understood nor often discussed. This could be helpful for both physicians and patients. Interestingly, although there is significant literature on the general topic of the process of medical decision-making, I could only find limited information on the specific topic of why deliberate appropriate inaction is difficult.

Inaction is often more difficult than action, especially when treating potentially life-threatening diseases. I recognized this soon after starting private practice treating patients referred for consideration of cardiac catheterization. The encounter actually took more effort on my part, if I felt catheterization was not warranted. The biggest hurdle I had to overcome was the patient's expectation that cardiac catheterization and revascularization was almost always of benefit. What many people did not understand was that the timing of any intervention was key to the benefit of that intervention. In addition, it was important for patients to understand that an intervention, especially surgical, might not be indicated today; but could be indicated tomorrow. Coronary artery disease (and many other diseases) can change over a very short period of time. There was another issue that was emotional in nature that I had to address, while explaining the above. I sensed that many patients felt that I did not care about them, if I did not schedule a cardiac catheterization. To counter this impression, an unhurried discussion about risks, benefits, and alternatives, hopefully including a trusted informed family member, was needed. This discussion demonstrated that I cared enough *not* to perform the catheterization. Even then, one could only hope that the patient did not fall into the small group of patients that get into trouble regardless of treatment. This hope was for the patient, but also for me, because a good practitioner must question everything when things do not go well.[9] One does not want to have a feeling of regret or to be open to criticism. It has been demonstrated that some physicians order tests and perform procedures, not based on diagnostic logic, but more to avoid feeling regret or to be open to critisism.[4,5]

When discussing this topic, I am reminded of an asymptomatic patient who was very upset when I told him that his nuclear perfusion stress test, which revealed good exercise tolerance, an old infarction with no ischemia, and a normal ejection fraction, did not warrant proceeding with cardiac catheterization. I simply could not convince him no matter how hard I tried. I finally told him something like, "OK, I give up," and started the process of informed consent for cardiac catheterization telling him all the reasons why it was easier for me to do the procedure while clearly pointing out the potential risks and apparent lack of any clear benefit to him. Fortunately, after a while, he was finally satisfied with medical treatment, and I'm sure he did well as I'm certain I would have heard if he had not!

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For appropriate inaction, there are issues other than patient expectation, or avoiding a sense of regret or criticism, for physicians to overcome. I do not put direct financial interest high on this list, as inaction is difficult for physicians even in situations that do not have direct financial incentives.[4,5] I would say that there are emotional reasons why it is hard to turn down cases. In general, performing procedures that one believes are beneficial and for which one is well trained is enjoyable and fulfilling. We believe, hopefully correctly, in the benefit of what we do, and this causes an inherent bias. In the 1960s, Abraham Maslow wrote about the long-standing theory that people are motivated to act in a certain way by what they know how to do. He is quoted as paraphrasing a time-honored phrase this way, "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail."[6] One can see this bias in other areas of medicine.[7] With respect to cardiology, it has been demonstrated that some cardiologists minimize the risk and overstate the benefits when discussing cardiac intervention with patients.[8] This does not appear to be the result of physicians trying to deliberately be misleading, it appears to be an inherent bias.[5] Physicians appear to be following human nature, which is why the time-honored saying above exists. I also wonder if a myopic view is necessary in order to perform or prescribe higher risk interventions, as they can be anxiety provoking. I remember the transition that I underwent when I was trained in performing cardiac catheterization. I no longer felt the procedure to be as dangerous as I had thought before. I did, however, never forget what the general surgery chief resident told me on my surgical rotation in medical school: "A chance to cut, is a chance to kill."

Physicians face more inconspicuous incentives for performing procedures. One needs to perform enough procedures per year to maintain one's skills. Performing more procedures keeps the hospital busy which ensures the hospital staff, who are generally friends, have jobs. I do not think these have a significant impact on physician decision-making, although I could not find any research on the topic.

We live a in world where "medical miracles" occur frequently and have often become expected. I have seen many patients over the years present with illnesses that were not well treatable in the past that have become treatable today. A prime example is acute myocardial infarction before reperfusion. Reperfusion can extend a patient's life decades. However, this does not mean that all interventions or simply intervening without reference to the timing of the intervention is beneficial. Not all patients are ill enough when seen or are seen at the appropriate time to warrant intervention. Some patients are just too frail to warrant advanced treatment as the harm can outweigh the benefits.

It is important that we remember that there are situations "when less is more." Maybe this commentary will help other medical professionals understand better why appropriate inaction is difficult emotionally and become more comfortable with it. Maybe, if practitioners share this commentary with their patients, patients will understand that when physicians do not do something that might be expected, it is often harder than doing it. Patients might understand that their physicians are often putting themselves at risk for criticism and are taking on this risk because they do care. In the practice of medicine, appropriate inaction can be arduous. In order for good physicians to be able to this, I believe another quality in addition empathy, kindness, and knowledge is necessary; it requires "courage".

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