COMMENTARY

THE AMERICAN JOURNAL of MEDICINE®

# Peeking Inside the Box

A checklist and template mindset is being increasingly employed by physicians. It brings structure to what can be a chaotic environment, prevents us from forgetting to ask important questions, and allows for appropriate reproducibility across different operators.[1] However, while efficient, this approach is not sufficient. When used to gather medical histories and other core information, it can reduce communicating with patients to a pro forma activity that feeds the electronic beast while obscuring opportunities to learn and engage. The data collected may represent a point of entry, a chance or even mandate for deeper exploration—one that is easily missed, however, amidst the swirl of activity surrounding throughput and patient care.

A few months ago, we were taking over the care of a gentleman admitted by our very capable overnight team. The sign-out was: "Sixty-five-year-old man with diabetes, hypertension, hyperlipidemia and atrial fibrillation. Presented with acute motor deficits, stroke code called in the ED. Symptoms resolved and CT negative, so appears to be (thankfully) a TIA. Taking all of his meds, including a direct-acting oral anticoagulant. Needs facilitated work-up to identify preventable causes of stroke/TIA in someone receiving all of the right treatments—including an anticoagulant, statin, and excellent blood pressure and diabetes control. Transthoracic echo, MRI/MRA and neurology follow-up are pending." We went to see him and he was as billed. Well appearing, symptoms resolved, taking all of his meds. Although one more question: "I know from reviewing the notes that you're taking all the meds on your list. But *how* do you take them?" "Doc, I take everything that you guys prescribe, every morning." "But your blood thinner and diabetes meds—those are twice a day." "Yeah—well—it's a pain to take my evening pills, so I stopped them last week. My sugars and blood pressure were still good, so I figured everything was working fine." "Unfortunately, the twice-a-day drugs lose their effect after about 12 hours—which is probably why you almost had a stroke last night." Seems like we need to rethink our plan.

Then there was a patient in his forties, admitted to manage an exacerbation of his known inflammatory bowel disease. The diagnosis was clear and the team was working with our gastrointestinal consultants to determine the next steps. When we met, beyond asking about his acute symptoms, I was interested in hearing the origin story behind his now chronic condition. Disorders like inflammatory bowel disease often have lead-in periods, where the diagnosis can be missed because it's a relatively rare source of abdominal symptoms, or the flags aren't quite red enough.[2] But everything has to begin as something—so learning about the path that led to making a diagnosis can add to our library of illness scripts.[3] And doctors may have few opportunities over the course of a career to encounter unusual conditions de novo, before they've been fully characterized and named. This patient relayed a story of feeling poorly for months before the correct diagnosis was made—emergency department trips, clinic visits, home remedies—all the while feeling worse. Hearing this now, directly from the patient, provided insights into what made his initial presentation stand out, information that can be applied to future encounters. It also served as a reminder about the humbling nature of being a doctor and managing diagnostic uncertainty.

Another gentleman, about 50 years old, had a history remarkable for heroin use. It was a problem for 20 years. And then he stopped. Period. That was 10 years ago. I asked him if it was okay to discuss (it was unrelated to why he was in clinic that day), and he said sure. "How were you able to quit after using heroin for so many years?" He replied, "My grandma, who played a big role in my life and loved me no matter what, told me that watching this was killing her." Those words, at that moment in time, propelled him to approach quitting with the zeal of the newly converted. And that was his springboard to stopping.

In health care, boxes are made to be checked. Sometimes, however, they also hide a treasure trove of information. Knowing when to open the lid and peek inside means staying curious and remaining interested in learning from, and about, our patients. Truly engaging with them to further explore their stories provides a path to deeper understanding

**Funding:** None.

**Conflicts of Interest:** None.

**Authorship:** The sole author is fully responsible for all content.

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https://doi.org/10.1016/j.amjmed.2021.12.013

about both common and unusual conditions, insights into problems that can be difficult to treat,[4] and helps identify instances of medication nonadherence.[5] When you meet your next patient, pick one item from the information that you've so dutifully collected, look them in the eye, and spend a few minutes taking a deeper dive. Then be prepared to listen and learn.

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## References

1. Gawande A. *The Checklist Manifesto: How to Get Things Right*. New York: Metropolitan Books; 2009.
2. Vavricka S, Spigaglia SM, Rogler G, et al. Systematic evaluation of risk factors for diagnostic delay in inflammatory bowel disease. *Inflamm Bowel Dis* 2012;18(3):496–505.
3. Bowen J. Educational strategies to promote clinical diagnostic reasoning. *N Engl J Med* 2006;355(21):2217–25.
4. Kennedy-Hendricks A, Busch SH, McGinty EE, et al. Primary care physicians' perspectives on the prescription opioid epidemic. *Drug Alcohol Depend* 2016;165:61–70.
5. Cutler DM, Everett W. Thinking outside the pillbox — medication adherence as a priority for health care reform. *N Engl J Med* 2010;362(17):1553–5.