Editorial

In the Best Interest of the Patient

MODERN cardiac surgery has brought into sharp focus the benefits to be gained by the patient from effective teamwork by a multidisciplined medical team. Usually included on such a team are physicians skilled in cardiology, radiology, cardiopulmonary hemodynamics, anesthesiology, and surgery. The patient’s welfare is best served by careful consideration of his total problem by the group, individually and in conference. Teaching is also most effective under these circumstances at all levels of medical education, undergraduate, graduate, and postgraduate. It is therefore surprising that in care and teaching dealing with other areas of the vascular system such teamwork has not been so generally adopted. Less than 15 years ago there was a clear-cut division into 2 camps, usually composed of internists versus surgeons. They held sharply to differences in a large number of questions such as the efficacy and scope of sympathectomy for peripheral arterial insufficiency, the use of surgical interruption of veins, and the value of anticoagulants in the control of thromboembolic disease. More recently sharp differences of opinion have been expressed regarding the value of direct surgical procedures for the relief of femoral arterial occlusions and in the management of peripheral arterial emboli.

Both internists and surgeons have made good cases for their positions and most patients are treated effectively. However, is it not almost always in the patient’s best interest for a surgically minded internist and a medically minded surgeon to confer closely on his vascular problem? If this is self-evident, then how is it to be accomplished? The ideal meeting ground for joint observation of patients is in a combined clinic where internists and surgeons study and treat patients with a free and critical exchange of ideas. From the clinic the in-hospital patients should have the identical supervision. Students learn that mature judgment is gained by the distillation of the best ideas in regard to medical and surgical diagnostic and therapeutic modalities.

To cite an example: C.W., a man of 50 years, was admitted to the hospital on June 8, 1949, because of severe pain in the right thigh and calf associated with coldness and numbness of the extremity of 24 hours’ duration. He was somewhat overweight, a tense and dynamic man who was a heavy smoker. Examination of the arterial system revealed it to be grossly normal with the exception of the right lower extremity where no pulses could be palpated. The leg below the knee was cool and hypesthetic and the foot exhibited a pallid cyanosis. Oscillometric readings were 2.5 units above and 3.5 units below the knee on the left side, whereas on the right side there was no oscillation. The heart was in regular sinus rhythm, had normal sounds and the electrocardiogram was interpreted as being normal. The most likely diagnosis seemed to be an atherosclerotic thrombotic
occlusion of the right iliac artery, probably the external branch. Suggestions for therapy included sympathectomy and thrombectomy among others, but it was the writer’s belief that a conservative regimen would probably save the limb and lead to some measure of function. Such a program and the possible results to be had from it had been learned at the knee of one of the senior members of this Journal’s Editorial Board who is an internist. The program included elevation of the head of the bed on 6-inch blocks, reflex heat to the abdomen, protective cotton padding to the extremity protected by an unlit cradle, and abstinence from tobacco. Not only did the extremity survive, but 9 years later the patient has no limitation in walking and readily palpable pedal pulses in the affected foot.

With the developments of the past 10 years it is quite likely that a patient presenting a similar problem would today have an electively timed operative procedure such as thromboendarterectomy or a bypass with a plastic prosthesis. Whether the long-term result would be as good, cannot be answered at this time.

It seems clear that the integrated clinic staffed by internists and surgeons interested in cardiovascular problems with coordinated in-hospital supervision will function in the patients’ best interest. In actual practice the constant rubbing of minds generates sparks that are often revealing and even surprise their originators. In the experience of the author this brings to the staff the deepest of satisfactions.

Jere W. Lord, Jr.

A word or two upon an ethical problem which is often very perplexing—viz., What is your duty in the matter of telling a patient that he is probably the subject of an incurable disease? I can give you no hard-and-fast rule; the temperament of the individual himself, his associations and responsibilities, your own convictions as to the seriousness of the condition—all these must be carefully weighed. The question is somewhat theoretical, since in reality the necessity does not often arise. The announcement has already been made, for no man suffers the anguish of a severe paroxysm of angina without a consciousness of the nearness of the Angel of Death. We are sometimes, I confess, placed in positions of the utmost delicacy, since a man may have not the slightest intimation of his parlous state, and you may become aware of the urgent necessity that he should make proper arrangements to protect his wife and children. In such a case a quiet hint as to the uncertainty of the outlook in heart and artery disease may be enough to set him a-thinking; or, in the case of an “evenbalanced soul,” the whole question may be discussed frankly. One thing is certain: it is not for you to don the black cap, and, assuming the judicial function, take hope from any patient—“hope that comes to all”—and you may dwell with advantage on the aspects of John Hunter’s case rather than on those of Thomas Arnold.—William Osler. Lectures on Angina Pectoris and Allied States, 1897.
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