EDITOR'S PAGE

Trust Me, I’m a Doctor

The healing arts have always relied on trust as a major contributor to clinical success. Healing was almost exclusively due to trust prior to the 20th century. That trust was enhanced by the “magic” of modern science, and the medical profession has inherited an exalted status.

What happened? Much has changed. I do not want to talk so much about the depersonalization of medicine designed to gain efficiency. Surely the brief office visit, the group coverage, and the interchange of doctors due to the growth of specialists and the separation of hospitalists and “outpatient-alists” have had a lot to do with the loss of the warm feeling the public has toward doctors. Instead, I am focusing on the perception that the profession is not adequately concerned with the quality of medicine and is becoming less of a profession and more a business. Hospital/physician integration has been viewed as a step toward more responsible oversight of physician behavior and it can be. Yet, the principle objective many times is to preserve the economic viability of the doctors and the hospitals. Did we ask for this? No. Is it the hand we have been dealt? Yes. Will getting bigger engender trust? I very much doubt it.

The vast majority of physicians I know put the patients’ welfare well above financial gain. They do not see patients as businesspeople but as professionals. However, in this era of mass communication, the dissemination of the opposite behavior is pouring fuel on the fire of public opinion that medicine is just another business. I do not pretend to know the merits of the Maryland case but the launching of a state-wide investigation of cardiology practices does immeasurable damage (1). The suggestion that a simplistic formula of the number of percutaneous coronary interventions divided by the number of diagnostic angiograms will identify cardiologists who should be investigated is not only insulting but also implies that there is some ratio that is correct. This methodology, however, has been suggested and, aside from demonstrating no trust in the ability of the profession to ensure quality and ethical behavior, it would also award those who perform diagnostic catheterizations to excess and penalize those who carefully risk stratify and perform catheterizations selectively on patients with a high likelihood of being appropriately treated with revascularization (2). Of course some would say that all clinical and noninvasive features could be put into a computer to determine who should have a diagnostic catheterization. There is need for the electronic medical record but it surely has not been identified as a dispenser of wisdom or judgment. The greatest role of the physician is to guide the patient in making the best decisions, not to be able to place a stent more expertly than his peers. Removing decision-making about revascularization, which remains contentious even after multiple clinical trials, should in many cases be a multidisciplinary one.

Perhaps the question we should ask ourselves in this time of intense pressure on practices is: what priorities should be given to quality assurance and peer review we all believe should be done? The interventional scientific council of the American College of Cardiology (ACC) working with the Society for Cardiovascular Angiography and Interventions (SCAI) is developing suggestions for hospitals as they continue to struggle to ensure quality through peer review. Most hospitals have implemented conferences and committees to review various components of cardiovascular programs including interventional procedures. The maintenance of competence document on interventional cardiovascular procedures enumerated a number of measures to enable objective peer review (3). We recommended that in addition to review of complications, there should be a review of appropriateness as well. This can be accomplished
by presenting random cases at conferences so that peers can appreciate the quality of patient selection. Consideration is also being given to external peer review when it is felt that objectivity is jeopardized by competitive forces. This may be a daunting task but, if engaged in a collaborative way with the goal of quality assurance, could go a long way toward engendering trust among physicians that will translate to trust from patients and the public at large.

The concept that when multiple therapies are options, multiple opinions can help decision-making, is not new but has been taken to a higher level by the recently published revascularization guidelines of the European Society of Cardiology (4). These now state that revascularization decisions in patients with elective indications should include input from a noninvasive cardiologist, invasive cardiologist, and surgeon. This is an ambitious undertaking and it is easier to write than to implement, but the signal it sends in terms of thoughtful reflection of professionals is designed to ensure quality and regain trust.

Perhaps the decision about revascularization, which remains contentious even after multiple clinical trials, should in many cases be a multidisciplinary one. Then we could say, “Trust us—we are doctors.”

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