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As of this month, the venerable monthly journal of the Rhode Island Medical Society (RIMS) has more readers, more pages, more color and more variety than ever before, while simultaneously sparing the environment and consuming fewer of the Society’s resources. Such are some of the many advantages of electronic publishing. Starting with this January 2013 issue, the journal is readily accessible anytime, anywhere on mobile devices, laptops and desktops. Advertisers and readers now have the convenience of hypertext, live links and occasional video that expands, deepens and enriches the journal’s content. And so, as the Medical Society enters its third century, its journal too enters a new, innovative era. Mindful of its mission to educate and to record, RIMS has been publishing its own clinical journal for 154 years, beginning with the Transactions of the Rhode Island Medical Society, which first appeared in 1859.

The family tree from which the Society’s journal springs also includes The Providence Medical Journal, which was founded by the Providence Medical Association (PMA) in 1900 and appeared quarterly at first, becoming bimonthly in 1902. Starting in 1912, RIMS and PMA merged their two publications into one bimonthly journal under the name The Providence Medical Journal. In 1917, RIMS assumed full ownership of the journal, produced it monthly, and changed the name to The Rhode Island Medical Journal. That title endured for 75 years and returns with this January 2013 issue. (From 1992 to 1995, the Journal was published as Rhode Island Medicine, and from January 1996 to December 2012 it was Medicine & Health/Rhode Island.)

Monthly publication of the RIMS Journal has been continuous now for 96 years, except for a hiatus of one year and three months in 1918–1919, when The Rhode Island Medical Journal was a temporary casualty of World War I. In announcing a pause in publication after the September 1918 issue, the Journal noted: “The Editor, the Business Manager and the members of the Publication Committee are in the service” and assured readers that “When the war is over – when the Hun has gotten his just dues, and our brave fellows have returned to their homes, and life is again normal – The Rhode Island Medical Journal, rejuvenated, will again represent the medical profession of this State. God grant that it may be soon.”

Now, on the occasion of the Journal’s newest rejuvenation, the Society takes pleasure in expressing its deep gratitude to Dr. Joseph Friedman for the quality of vision and the continuity of leadership he has provided. Dr. Friedman has been editor-in-chief since 1999 and now leads the Journal into the digital age. Immense thanks are due as well to Dr. Stanley M. Aronson, editor emeritus, regular contributor, muse and mentor. We also salute the other six past editors of the RIMS Journal and echo Dr. George D. Hershey’s words from the inaugural issue of the Providence Medical Journal of January 1900: “We are rather proud of the Journal, both of its appearance and its contents.”
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I occasionally perform legal consultations concerning malpractice. Although potentially an unpleasant activity, I decided that I should be available to either side in a dispute, not only on the side of the physician. As we all know, only a fraction of true malpractice cases are ever brought to anyone’s attention, and it seems wrong to help only the defendant. Sometimes the plaintiff is, in fact, the real victim and should be supported. Obviously I only agree on behalf of the party I believe was in the right. In addition, now that my son-in-law is a personal injury lawyer, it seems only fair that if I can welcome him into the family, I can act like he’s not the devil incarnate. American jurisprudence rests on an adversarial process; presumably justice sides with the winning arguments.

One case I consulted on concerned an older woman with a significant psychiatric history whose flare of bipolar disease required an antipsychotic drug. She did well psychiatrically on the prescribed drug, although the medicine caused parkinsonism. An anticholinergic medication for bladder spasms was added, which induced a delirium, precipitating hospitalization. In the hospital the connection between the drugs and the neurological impairments was not made. The patient’s mental state returned to normal for reasons that escaped her physicians, although it coincided with stopping her bladder medication. Her parkinsonism, however, did not improve, since the medication causing it wasn’t stopped. She was given a diagnosis of atypical parkinsonism by a neurologist and sent to a nursing home. A few weeks previously she had reportedly been functioning normally, walking, driving and performing all activities of daily living without impairment. She remained at the nursing home for several years, wheelchair bound, unable to walk, while the physician notes reported on her normal mental status and the increasingly remarkable absence of the progression of her neurological disorder. Finally someone got the bright idea that her psychiatric condition was so good that perhaps she could do without the antipsychotic medication. Remarkably, a few months later she walked out of the facility and returned home, having lost several years of independent life because of an unrecognized medication side effect.

That’s a terrible story, but true, and a clear justification for physicians helping patients seek justice. The lawsuit is in its infancy.

We all make errors but, unless we alienate the patient, it is rare for physicians to be sued. How many of us know all the possible complications of all the many drugs we give patients? These days it’s almost impossible to avoid getting a call from the pharmacy that there’s a possible interaction between a newly prescribed drug and another drug the patient is currently taking. In some cases we know this is a theoretical interaction and one that has not actually been documented. In fact, pharmaceutical companies, in order to both satisfy the FDA and reduce their legal exposure, list a litany of potential side effects of every single drug they manufacture, which often scares patients into not taking them. “Well, Dr. Friedman, I never took that drug you prescribed. After I read all the side effects I thought it was too risky.”

I put patients on medications that may cause side effects all the time. Many of my patients are elderly and frail and thus have short life expectancies. When a patient dies, I assume that age and disease are to blame. Might a drug interaction, an unsuspected problem with liver enzymes, or a change in blood pressure be the cause? Perhaps it was my fault? Since, in the realm of neurodegen-

Thoughts on Malpractice

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erative diseases, I never cure patients or prevent disease, and only provide symptomatic care, the guiding principle is always: “If you’re not better you need a higher dose or a different drug.” This means that any drug I am prescribing should be producing benefit or I should increase the dose until it does, or until it produces a side effect.

When is an oversight malpractice? When is ignorance malpractice? The American justice system is clearly an extremely bad approach to addressing the issue. Malpractice comes in gradations of responsibility and where forgivable errors end and unforgivable errors begin is often murky. Our adversarial system is not a good solution. When I was a resident, one of my mentors told the story of reviewing a chart for a malpractice case. His requirement was that he not be told which side the lawyer who hired him was on. The case involved a sick man whose diagnosis clearly eluded the physicians caring for him. Unfortunately for the physicians, the nurse’s admission note stated that the patient suffered from “lockjaw.” And the patient did indeed die from a tetanus infection. My professor noted that he advised the lawyer, that if he represented the physician or the hospital, to settle out of court.

I see no reason why impartial groups could not be set up to deal with malpractice cases. This would provide a fair review in a timely manner. Damages could be assessed elsewhere. There is no reason a committee of physicians and educated lay people could not reach reasonable conclusions within a short period with considerably less expense than the usual 10-year course, not swayed by glib lawyers, nor intellectually cowed by famous experts.

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For Now, We See Through a Glass, Darkly

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Some 66 years ago, in 1947, a resolute group of overworked, newly hatched physicians at Bellevue Hospital – then called interns – ventured to explore the systemic priorities of their profession. They were, as with all initiates, hesitant of what was expected of them. And so they did what they were taught to do when confronted with unanswered questions: They asked more questions.

Specifically, these men and women devised a rudimentary questionnaire, directed to their municipal clinic patients, consisting of a single query: “What do you expect your physician to accomplish?” It was a blunt question bereft of footnotes, definitions, variant subtexts or rhetorical traps. In truth it was a plaintive plea, innocent in its mission, and conveyed by very young physicians not yet experienced in the subtle ways of the world. If the question was explicit, the flood of answers was equally blunt and assertive.

A brief word about the status of American health care in the fourth decade of the 20th Century. Medical care was rendered almost exclusively by solo practitioners or through freely accessed clinics administered principally by municipal hospitals. Federal or state health insurance was non-existent, and other than federal employees, such as the military or certain elected officials, one either paid for services rendered, or one accepted the philanthropy of those institutions, secular or religious, capable of providing free care. Clinic patients were often indigent or certainly poor. Fees, if any, were modest and in municipal clinics frequently ignored. Care was assembly-line brief, task oriented and impersonal.

And the responses to this eminently unscientific enquiry? These young physicians, inexperienced in the science of opinion gathering, expected narrowly focused answers, variations on the generic response, “Cure me of my ailment.” But surprisingly, the avalanche of responses rarely touched upon this obvious goal. Nor were there many responses expressing hopes for pain relief or a return of a lost function such as vision or the use of a paralyzed limb.

Instead, to the astonishment of these young physicians, the dominant expectation was that the clinic physicians should clarify the patient’s future. The...
typical response declared: “Tell me what tomorrow will bring; what will I then suffer from, and how long will I live?”

Had these inquiring young physicians been historians of their ancient profession, they would have readily recognized that their patients were reiterating part of a triad of pleas expressed over the millennia by those seeking aid from earthly rather than divinely structured sources. Three basic questions: “Tell me the nature of my ailment; tell me what I must undertake so that my ailment shall cease; and most important, tell me my future.”

The first plea, to reveal the nature of the ailment, prompted centuries of physiologic research under the rubric of establishing a diagnosis (from a Greek word meaning ‘knowing apart’, that is, distinguishing one malady from another). The second plea for instruction to mitigate the ailment, from another Greek word, therapy, meaning to attend or to intervene, led to centuries of seeking interventions – religious, pharmacological or altered life-style – to lessen the ailment. And the third plea, the future? This, in some ways, was the weightiest burden voluntarily assumed by the practicing physician. They were asked, in Hamlet’s words, to hold a mirror unto nature.

And for this weighty and most ponderous of the three tasks, the ancient Greeks offered yet another word: prognosis. All three of these cumulative tasks represented a challenge to the divine order of nature, striving humans daring to alter the natural course of events.

Can these practitioners of prognosis be called prophets? A prophet – yet another Greek word – defines those who speak on behalf of someone else. The Biblical prophets never claimed to know, first hand, what was yet to be. Rather, they declared themselves to be vehicles for the pronouncements of a higher authority. A prognosticator, in contrast, seeks tangible, contemporary hints to foretell the events of tomorrow. A physician, for example, examines a febrile child, notes reddened eyes and a few skin changes, and predicts that the patient has measles which, within a day or so, will be fully apparent.

It may look like magic but it is merely an educated exploitation of precursor hints (prodromata, also derived from Greek) that tells the educated practitioner that a particular disease will emerge within a day. No magic, only educated guesses much like a meteorologist looking at a cloud formation or at a barometer and predicting tomorrow’s storm.

And those young physicians with their primitive questionnaires some 66 years ago? They found themselves too involved with their quotidian labors to meditate upon the deeper import of their gathered answers.

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**Disclosures**

The author has no financial interests to disclose.