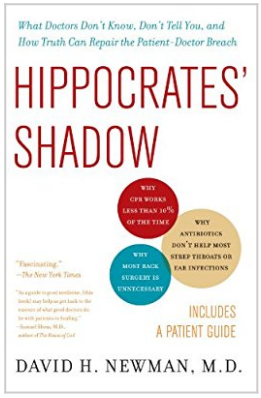

Hippocrates' Shadow

By David H. Newman M.D.

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"Aclear-sighted, heartfelt, and humane story of the needless tests and treatments that cripple healthcare....as a guide to good medicine, it may help us get back to the essence of what good doctors do: be with patients in healing." —Samuel Shem, M.D., author of *The House of God* and *The Spirit of the Place*

In *Hippocrates' Shadow*, Dr. David H. Newman upends our understanding of the doctor-patient relationship and offers a new paradigm of honesty and communication. He sees a disregard for the healing power of the bond that originated with Hippocrates, and, ultimately, a disconnect between doctors and their oath to"do no harm."

Exposing the patterns of secrecy and habit in modern medicine's carefully protected subculture, Dr. Newman argues that doctors and patients cling to tradition and yield to demands for pills or tests. Citing fascinating studies that show why antibiotics for sore throats are almost always unnecessary; how cough syrup is rarely more effective than a sugar pill; and why CPR is violent, invasive—and almost always futile, this thought-provoking book cuts to the heart of what really works, and what doesn't, in medicine.

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Editorial Review

Review
"In *Hippocrates' Shadow*, Dr. Newman sits us down for the doctor-patient chat we've been longing for -- a refreshingly candid, daringly inquisitive discussion of the uneasiness that exists on both sides of the medical care equation these days. There is a cure for what ails us, and Newman doses it in thoughtful, perceptive proposals that make good sense. In the end, everyone feels a whole lot better. There is hope." -- Amy Silverstein, author of *Sick Girl*

"There are few books that I really almost cannot put down, but *Hippocrates' Shadow* is one. A stunning indictment of current medical practice by a hard-headed doc tested in big-city emergency rooms, combat hospitals in Iraq, and at his mom's bedside. If your doctor is this frank with you, you are a very lucky patient, and you are getting a lot better (and sometimes a lot less) treatment than most." -- Melvin Konner, MD, PhD, author of *Becoming a Doctor*

"Dr. Newman's book is insightful and thought provoking. He teaches the reader about aspects of medicine that many of us, lay people as well as physicians, do not understand or appreciate, including the imperfection of the 'science' of medicine as well as the progressive loss of the 'art of medicine.' Anyone who wishes to better understand the promise and limitations of medicine should read this book." -- Geoffrey Kurland, M.D., author of *My Own Medicine: A Doctor's Life as a Patient*

"A clear-sighted, heartfelt, and humane story of the needless tests and treatments that cripple health care -- and how to get rid of them. As a guide to good medicine, it may help us get back to the essence of what good doctors do: be with patients in healing." -- Samuel Shem, M.D., author of *The House of God, Mount Misery,* and *The Spirit of the Place*

About the Author
David H. Newman, M.D., runs a clinical research program and teaches at Columbia University and in the Department of Emergency Medicine at St. Luke’s/Roosevelt Hospital Center. He has also been widely published in biomedical journals. In 2005, as a Major in the Army Reserves, he was deployed to Iraq, where he received an Army Commendation Medal. He lives in New York City.

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We Don't Know

Dr. Newman, phone call, 6800."

"Emergency department, Dr. Newman," I answered, thinking the call was likely to be a doctor's office sending me another patient on a busy Monday.

"T, honey?" She used my childhood nickname, as she always does.

"Mom?"

"Yes, sweetie." She forced the breath between her lips. "Honey, something's wrong. I need some help."

"What do you mean, Mom?" A knot started in my stomach. My mother is stoic and selfless, and doesn't ask for help (she doesn't want to impose). That she was asking for help and "bothering" me at work were both ominous signs.

"It hurts in my stomach, baby. It started a few minutes ago, all of a sudden. I don't know what to do."

"Are you at work, Mom?"

"Yeah."

"I'm calling an ambulance for you. You're going to come here now."

"No, sweetie, thank you, but that's too much drama for the office."

I shook my head. She apparently believed that she could settle gently to the floor like a leaf, passing quietly into the next world, and that this would be preferable to causing a scene.

"Give Heather the phone, Mother."

I spoke to her assistant at the next desk, who was, as I would've guessed, oblivious -- not because of inattentiveness but because my mother doesn't complain. Heather escorted her into a cab and brought her to the emergency department. When she arrived, she was doubled over and visibly short of breath. A colleague I trust and respect evaluated her.

My colleague performed a rapid history and physical examination. She had blood drawn for tests, chest and abdominal X-rays, an electrocardiogram, oxygen administered through her nose, a heart monitor, and two intravenous lines placed in her arms -- all within the first few minutes. Tests for liver disease, pancreatitis, gallstones, internal bleeding, ulcers, gastritis, and kidney stones were normal. Blood tests and X-rays for her heart and lungs were normal, and she showed no signs of serious infection. She underwent a computed tomography (CAT) scan of her abdomen to evaluate her intestines, her appendix, her aorta, and the rest of her abdominal organs, and we did a bedside ultrasound to see her liver and the blood vessels in her abdomen. All of these were normal. And slowly she began to feel better, with no particular treatment.

After three hours of observation and a battery of test results, the colleague I had handpicked to see my mother shrugged sheepishly, apologized, and said, "I don't know, I just don't know. I'm just gonna call it 'abdominal pain.'"

"Undifferentiated abdominal pain" was my mother's diagnosis. It is a trash-bucket term that means we don't know what caused the problem. It also means we have found no reason to believe it's dangerous (arguably good news), and it's likely, though not guaranteed, to go away without any particular treatment. In other words, we don't know what caused it, we don't know what to do about it, we don't know if it'll come back, and we don't know where to go from here. Undifferentiated abdominal pain could more accurately be called a nondiagnosis.

What's perhaps most remarkable about my mother's experience is how utterly unremarkable it is. Mom got better. As inexplicably as her pain appeared, so too did it disappear. Over the next few days she went for an official ultrasound of her liver and gallbladder, and two follow-up appointments with her physician. The nondiagnosis did not change. Roughly 40 percent of visits to the emergency department for abdominal pain are ultimately categorized as undifferentiated abdominal pain; no definitive diagnosis is made and no

successful diagnostic or therapeutic procedure is performed. What's surprising, however, is how rarely doctors say the words "undifferentiated abdominal pain" to the patients who experience the problem. Much more often a provisional, specific diagnosis is given -- maybe "peptic ulcer disease," or "ovarian cyst," or "colitis," but when a physician makes one of these diagnoses, it's often based on what we call "clinical criteria." In other words, we take an educated guess, but we don't know.

An extremely common example of a provisional diagnosis is "gastritis," or inflammation of the lining of the stomach. Gastritis is usually associated with nausea, vomiting, and pain, and can be precisely and accurately diagnosed only by looking at the inside of the stomach through a camera. This requires an invasive test called "endoscopy," and we rarely do it in the emergency department (except in extreme, life-threatening situations). Therefore, while gastritis is a common provisional diagnosis in emergency departments and medical offices, the only method to definitively diagnose it is rarely performed in emergency departments or medical offices. And disturbingly, studies have shown that when physicians think the problem is gastritis, they are frequently wrong.

Abdominal pain is only one example from a long list of symptoms or conditions that, despite its advances, modern medical science cannot diagnose or explain. Do you know what causes the sound of knuckles cracking? No? Nor do I. Ask an orthopedist or a dedicated hand surgeon or a rheumatologist and you may get three different answers. In order to determine the mechanism of knuckle-cracking sounds, the House of Medicine has launched meticulous studies, including one that uses minimicrophones to document and gauge the amplitude and decibel level of the sounds produced. But we have no definitive answer. Do you know what causes memory loss or unconsciousness when a concussion occurs? Neither do we. Do you know what a concussion actually is, at a biological or cellular level? Me either. Do you know what epilepsy is, or what causes the seizures that characterize this condition? Ditto. The list goes on and on. While we can cure some previously fatal cancers, rid the world of scourges like smallpox and polio, and map the human genome, we don't know what makes a knuckle crack.

Comprehending the cracking of a knuckle may seem relatively unimportant, but as a symbol of the vast and uncharted range of biomedical science, it's not trivial at all. Grasping the limits of physician knowledge is critical to deriving a benefit from medical care. Unfortunately, physicians often act as though they know all the answers, and patients often presume that physicians know them, when in fact physicians do not. This combination of unconscious prevarication and mutual misunderstanding is one of the wedges that has forced open the chasm between doctors and patients. As a result of this dysfunctional paradigm, when a diagnosis, or even a cause for a diagnosis, is unknown -- an entirely common and reasonable occurrence, given the state of our science -- people become angry. And in America, anger is often followed by lawsuits.

An example of this, one that is not unique but that garnered an unusual level of popular media coverage, is the story of silicone breast implants and the legal actions and FDA proceedings that followed. Contrary to the number of successful lawsuits that have convinced juries of a link between silicone breast implants and lupus (and other, similar diseases), the research on this supposed link is fairly conclusive: the incidence of lupus among women who've had silicone breast implants is the same as the incidence of lupus among women who haven't had breast implants. Any woman can develop lupus, including those with silicone breast implants, but the two are not related.

Difficult as it may be to understand for frustrated women who develop lupus shortly after getting implants, it is a fact. Lupus is a poorly understood disease of the human immune system that can cause rashes, joint pains, kidney disease, and other serious problems, and while it's not very common, it occurs frequently in women in their twenties and thirties, the same age at which many women obtain breast implants. By random chance alone, then, there was bound to be crossover between these two populations -- but no association has been established. Unfortunately, however, while we seem to have ruled out silicone breast implants as a

cause, we don't know what does cause lupus -- or rheumatoid arthritis, or scleroderma, or the other autoimmune diseases that misguided lawsuits have claimed were related to silicone implants. If we did know the cause, then the frustration of coping with these diseases would be channeled into a cure, and any effort to hold silicone responsible for lupus would be less likely to find support in a courtroom or anywhere else.

The bottom line with lupus, with knuckle cracking, and with much abdominal pain is that we don't know what causes them, and we don't know what to do about it. Given the blistering pace of biomedical advances and technology, one would think that our biomedical knowledge would grow every day, and in some ways it does. But this immense "we don't know" category also grows every day.

Erica shrugged. "I know, I can't believe it either." The physician ID tag clipped to her belt with a photo of Erica's enthusiastic smile seemed out of place, a glib reminder of how quickly life can turn.

Ian shook his head in disbelief while Mark, Cary, and I stared at Erica, confused. "Multiple sclerosis? You're kidding. Wow. Blurriness? That was it? Wow." Ian had never been accused of eloquence, but he was voicing what all four of us were thinking. As residency classmates the four of us had grown close, and Erica was one of the brightest, best doctors I've ever known. She had just been diagnosed with MS.

I tried to understand it. "How? I mean, from what?"

"That's what I wanted to know," Erica said. "But who knows, man, who knows?" She threw her hands up. "I've read about it a lot, but it's like an X-file, this freaking thing. You wouldn't believe it."

"What are you gonna do?" I asked. We were all wondering. We wanted to hear that she would stay a part of our lives. "Can we do anything?"

"Nah, it's chilled out a lot. I feel okay. I think I'm just gonna keep on. It's crazy, huh?"

I breathed a small sigh of r...

Users Review

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