I AM Taking My Medicine

Category: Making Assumptions
written by Joseph Fennelly | August 25, 2019
It was 1962. I was in my third year of medical residency at Philadelphia General Hospital, the only charity hospital in the city.

I was in the outpatient clinic, seeing an African-American patient for the first time. I noted that he was on an anticoagulant, Dicoumaral (similar to Coumadin).

His prothrombin time (a test that indicates the level of blood thinning) was very low—in fact, outside of the therapeutic range. When the range is too low (meaning the blood is too thick) or too high (the blood is too thin), the patient is at risk for serious complications such as clotting or hemorraghing.

Without thinking, I said, "You must not be taking your medicine."

"I *am* taking my medicine, Doctor!" he stated emphatically.

I caught myself, feeling embarrassed. Immediately afterwards, I checked the list of prothrombin times for all of the clinic patients. Much to my surprise, they all were taking ten to fifteen times the usual therapeutic dose.

It was obvious that either the medication was not effective or the laboratory determinations for monitoring the drug levels were flawed, or that some combination of these factors was operating.

I reported my findings to the chief of the medical-school service. The chief was astonished. We took the data to the hospital's CEO. I recall the look of worry, fear and surprise on his face.

The conclusion was that someone in the hospital's administration was profiting by substituting a drug that was inert, lacking in potency or had other defects.

Considering how dangerous anticoagulants can be, with their potentially lethal effects on bleeding and clotting, this was a serious situation. Its ramifications extended to all of the hospital's patients who were on the drug.

I have never forgotten this experience. And I learned a few lessons.

One: Listen to the patient, believe the patient and take a detailed enough history to determine whether or not there may be falsehoods, distortions or other reasons for lack of honesty.

Two: Do not wait for someone else to resolve a problem. Everyone is responsible for the care of each patient.

Three: As people, we make innumerable assumptions on a regular basis, some of which may be culturally driven; as physicians, however, we must search for the patient’s actual narrative. If we do not trust patients, how can they trust us?

Lastly, it reduces moral distress when you engage deeply with each patient.

As an aside, I experienced a rewarding sense that I had contributed to improving the quality of care within the hospital.

Joseph Fennelly
Madison, NJ