

# Modern Medicine Nearly Killed Me

Jeff Unger

I nearly died.

Making a self-diagnosis of acute appendicitis is unpretentious, especially when the patient is a family physician with more than 30 years of clinical experience. The symptoms: right lower quadrant pain, increasing in intensity over a 3-day period and associated with anorexia and chills. I arranged to undergo the appropriate tests, which corroborated my diagnosis. After calling the surgeon, I headed to the hospital for an appendectomy.

Unfortunately, from the moment I arrived in the emergency room (ER) until the time I was discharged from the hospital on postoperative day 9, I became increasingly dismayed by our modern health care system. My surgical abdomen became the subject of stat entries into an electronic medical record (EMR) while the old-fashioned “H and P” were basically ignored. Had I not been a well-trained and experienced physician, I am convinced that I would have suffered a fatal postoperative event. The medical students assigned to my care would never have known that I died, unless they received a notification on their Twitter account.

In the ER, the unsupervised fourth-year medical-surgical rotating medical student wheeled in a large computer and began to ask me questions related to my abdominal pain. Within 5 minutes, the student had somehow acquired all the information he needed for my admission. But wait a minute; my medical history is

somewhat complex, and I was taking 11 different medications on admission, but no one asked me about that. As the student doctor was wheeling his computer back to his lounge, I reminded him that his H and P were deficient. Oh, he did listen to my bowel sounds or lack thereof through a blanket and hospital gown. He forgot to listen to my lungs and never examined my mouth, eyes, feet, or ears. He forgot to check for peritoneal signs. And he never asked about my current prescriptions and other salient aspects of my medical history.

To play devil’s advocate, why do an exam anyway? The CT scan of the abdomen showed evidence of acute appendicitis. Based on that alone, the confident student said he would see me in the operating room in a couple of hours. In response, I opined, “Hey, you forgot a few important aspects of your H and P.” Shocked, the unsupervised student replied, “What do you mean? You have appendicitis. The CT scan confirms your diagnosis. This is the easiest case I’ve had all day. Let’s get you to surgery.”

“OK, ‘doctor,’” I said. “Slow down. You failed to ask me about my medical history. You see, I have type 1 diabetes and am on an insulin pump and a continuous glucose monitor [CGM]. I believe that might be relevant to my comprehensive care plan.”

The student proceeded to roll his EMR computer back into the cubicle. He attempted to search the EMR for whatever additional questions might

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be pertinent in my case. Oops, I guess he needed a little help with his inquiry. While lying on the gurney in pain, I began to teach him how to interview a patient with diabetes. I suggested that he ask about the type of diabetes I had, the duration of the disease, how well my glucose levels are controlled, my most recent A1C, and whether I had developed any long-term micro- or macrovascular complications.

The student appeared lost and confused by my suggestions. Even more troubling, he had never heard of the insulin analog I used in my pump, nor did he have any knowledge regarding my glucagon-like peptide-1 receptor agonist dosing. He had never seen an insulin pump. The use of the CGM seemed to shock his psyche. “Where did you get that device?” he asked. “We’re going to have to take those meters off of you before surgery.” So now this fourth-year, unsupervised student was telling a diabetologist (me) to remove the very devices that allow for intensification of my diabetes care.

“Sonny,” I said, “No one is touching my pump or sensor. As long as I am conscious, I will regulate my blood glucose levels with these devices. Besides, these pumps emit an electrical charge. If you touch it, you will be shocked, and you may need resuscitation!” That was the last time anyone at the hospital told me that they were going to force me to remove my pump!

As the student walked away once again, I could see his mind working in a devious way. “How dare this old-timer question my diagnostic skills?” I could almost hear him thinking. “Who does he think he is?”

In 1980, my senior year in medical school, we had no EMRs. Instead, we received a gifted education. Our supervising interns, residents, and attending physicians taught us how to communicate with patients. We learned to question, listen to, and interpret the data provided by each patient. We listened with our ears,

our brains, and our hearts. We were encouraged to use our hands in a process known as “physical diagnosis.” A rectal exam was mandatory for every patient with an acute abdomen. Tests were ordered to *confirm* our suspected diagnosis—not as primary means by which patients could be diagnosed. We learned to question the lives and disease states of each patient using a “review of systems.” Even negative aspects of this line of inquiry had to be recorded so that we would become used to performing medical inquiries and recording them with the correct nomenclature. An H and P (history and physical) would take 30–45 minutes. We were never rushed, and we were criticized if we took shortcuts. When we had questions about how to proceed, we asked one of our attendings—not a computer. Our time on the wards was spent speaking with patients, looking at X-rays, reviewing laboratory results, or reading in the library. Back then, the term “meaningful use” implied that our laboratory and ancillary testing requests appropriately reflected our clinical impression.

Today, the best students are those who have become adept at computer simulation and data entry. They spend time in a computer lab learning through patient simulations. These students are *not* clinicians; they have become experts at finding WiFi hotspots from which they might access social media. Their hands are better at texting than at evaluating patients for abdominal distension.

Although my laparoscopic appendectomy went well, the postoperative course was complicated by an ileus that persisted for 8 days. I received no food, liquids, or oral intake during that time, yet my glycemic control was perfect.

On the sixth postoperative day, I was still in the intensive care unit, with a shiny nasogastric tube that was draining >2,000 cc of gastric contents. I felt myself becoming dehydrated and even hypokalemic. I was beginning to hallucinate and

become weakened by my acute renal failure and electrolyte imbalance. The attending physicians, none of whom examined me, were not concerned. They may have been had they examined my distended abdomen, looked into my parched, dry mouth, or noted that I was unable to hold my head upright. Finally, in an act of desperation and self-preservation, I demanded that the nurse provide me with a 250-cc normal saline rider and increase the IV infusion rate from 50 to 150 cc/hour. Potassium was also provided.

The surgeon, who did not carry a stethoscope, noted that my abdominal distension was becoming worse. “I can’t understand why your ileus is still a problem,” he said. “Let’s get a barium swallow.” The results demonstrated a functional bowel obstruction with no gastrografin moving beyond the gastric outlet. I could have told him that as I continued to deteriorate.

On post-op day 7, a hospitalist came to see me and suggested that my diabetes was the cause of the ileus. “Yeah, I see this all the time,” he said. “You have gastroparesis. I am going to place you on parenteral nutrition, remove your pump and *meter*, and let the pharmacist manage your diabetes.” This doctor was quickly relieved of his duties by me and my wife. He never returned for a follow-up encounter.

By day 8, the ileus was resolved, thanks, in part, to the role of gastrografin in increasing gastric motility. The hypokalemia, acute renal failure, and dehydration had all resolved, and I was ready to leave the hospital.

As a physician and a patient, I survived this very difficult perioperative course in large part because of my self-advocacy. I was lucky. A regular Joe likely would not have known how to protect himself from or reverse dehydration, hypoglycemia, hyperglycemia, and electrolyte imbalances. Hospitalized patients without medical expertise are at the mercy of medical professionals who

could potentially make inappropriate clinical decisions.

After my discharge from the hospital, I attempted to mitigate my frustrations about my experience with modern medicine by contacting the dean of the local medical school. I explained that her fourth-year students were ill-equipped for clinical medicine. Unsupervised, they were not able to perform an adequate history or physical examination. They did not know how to follow a patient during the perioperative period. In fact, they did not even know how to communicate with patients, although

they always said, “Have a great day. We’ll see you soon.”

The dean seemed stunned by these revelations and appreciated my concern. She proceeded to provide me with the corrective action plan that she had been working on for some time. “We need to implement our patient simulation computer program, which is designed to teach our students how to appropriately interact with their distressed patients,” she said. Really? “What you should do, Dean,” I said, “Is have these medical students unplug their smartphones, computer, and iPads. Let them spend a day or two with one of us ‘old-tim-

ers’ who still work with our hearts, our brains, and our hands. We’ll show these guys how to become caring, intelligent, and dedicated clinicians.”

The dean thanked me for my suggestions and implied that she would have one of her Information Technology guys call me so that I might provide guidance on their patient simulation software. God help us all!

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### Duality of Interest

No potential conflicts of interest relevant to this article were reported.