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**Extrasensory Perception in Clinical Medicine, and Other Offenses**

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In most walks of life, the concept of extrasensory perception is rejected as pseudo-scientific at best, and, at worst, black magic. It is therefore especially strange that large medical institutions blandly accept several manifestations of ESP every day as a matter of course.

It is amazing how much faith the consult writer must hold when he writes “76-year-old man with abdominal pain since morning.” He apparently assumes that the surgeon will divine that the pain is an acute abdomen which should be evaluated as a surgical emergency. The surgeon requesting a medical clearance preoperatively seems to “just know” that the consultant will sense exactly which medical problems exist, what operation is being contemplated, when it is scheduled, and which resident is writing the consult. When we write an x-ray form which reads “Pre-op chest,” the radiologist must use ESP to divine that there is a known history of sarcoidosis. Similarly, the pathologist receiving a specimen labelled “stomach” must know that a previous biopsy had demonstrated carcinoma in that patient. Most amazing, a consultant occasionally learns that he has been “consulted” when he has not even received a consult request.

Although this faith in the imagination and extrasensory powers of ourselves and our colleagues may be commendable, yet a suggestion or two might be in order. It is only common sense at least to work up a patient and do baseline studies before sending him off to a consultant. There is little that the greatest expert can say about a patient’s diabetes if no blood sugar has been drawn. For somewhat different reasons, a rectal exam is in order before sending a consult to surgery for abdominal pain and distention. Otherwise the surgeon who finds and digs out the impaction will need no ESP to know why he was called.

State the Problem

It saves no time to scribble some random words on a consult form or x-ray request and receive an answer irrelevant to the reason for the consult. It would be amazingly helpful if, at the least, every consultant would state a problem and ask a question. In return, every reply should answer a question. What does the writer ask who writes on the consult form: “68-year-old WF with diabetes”?

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would digitalize”? Even worse, what does the conscientious consultant do who wants to discuss the problem or his suggestions when the name of the resident requesting his opinion does not appear on the consult form?

Several points emerge. Unless a consult is written in such a way that it is self-evident, the responsible doctor should call the consultant and explain the problem. Written requests tend to be too short, too easily delayed or lost, often illegible, and often misleading. The clinician desiring a careful small barium enema on a patient with diverticulitis should call the radiologist and alert him. This is infinitely better than crying over a patient with perforated bowel while heaping invective on the radiologist. The doctor admitting a patient with an acute abdomen would do well to call the surgeon himself, instead of waiting for a messenger to meander in with the written form. The converse also holds true for the consultant receiving an obscure consult. It then behooves him to call the writer and ask for an explanation, instead of relying on ESP.

It is useless to request a consult and then fail to read it, disregard it, or time it so that it returns to you the day before a major procedure or an intended discharge. Such gestures must be classified as symbolic consults. They serve no purpose, cost money, alienate colleagues, and waste everyone’s time. It is also a slap in the face blandly to look over a consultant’s 10 recommendations and select one to follow. It softens the blow to call the consultant, explain the change in plan or procedure and ask his advice. Medical doctors should realize that when surgeons outline a suggested preoperative workup, this is considered a prerequisite to surgery. If there are good reasons for not carrying out the whole plan, these should be discussed with the surgeons.

### Instantaneous Evaluation

Rush requests for preoperative evaluations are not so much a tribute to our colleagues’ ESP as to their capacity for instantaneous examination and evaluation. The number of requests for metabolic and cardiac clearance which roll in between the hours of 5 p.m. and 8 a.m. surgery the next day attest to our belief in supernatural powers. The resulting condensed evaluations can only amount to poor, rushed and inadequate service for the patient. What sort of argument can be made for a routine cardiac clearance sent “rush” for cardiac clearance on an asymptomatic 42-year-old male due for operative removal of a sebaceous cyst? For that matter, why send a request for cardiac clearance on him in the first place? Or, even if he were 62, when he has an entirely negative cardiac history, why does he need any routine clearance beyond an EKG?

Is it really necessary for the diabetes resident to write the preoperative diabetic orders on a 77-year-old woman found to have “a little sugar” five years ago and now controlled on diet? Certainly, if the diabetic problem needed evaluation, this could have been anticipated and the patient admitted before the eve of surgery. Otherwise, in the case above, the surgeon should be quite capable of handling the orders. The metabolism resident usually has brief instructions and management suggestions in a handy guidebook. Surely, with such a guide
in his pocket, the surgical resident could similarly be an expert on handling those of his patients who are mild and well-controlled. If he cannot, he is in for a rude shock when he goes into practice.

Accordingly, the internal medicine doctors referring patients for surgery should anticipate the need for cardiac or other clearance and write these in the chart immediately. If not, the surgeons should alert the medical doctors that a given patient will be admitted on a given day, so the doctor can check him during rounds and clear the patient without waiting for a consult. New patients should not be admitted the day prior to surgery if there is a known medical problem requiring evaluation.

**Occult Art or Telephone?**

In short, while modern medicine becomes more scientific, we quietly continue to demonstrate our faith in the occult by giving inadequate information to radiologists on x-ray forms, to pathologists on specimen tags, and to consultants on consult forms. We then compound the error by not preceding or following up our consults with a telephone call. Even a laboratory can become alive and human if the clinician comes in or calls to explain the clinical problem to the technician. The technician is so delighted to be acknowledged as a person and a partner that he will go to great lengths to call the clinician, make special exceptions, and break all sorts of speed records in his effort to help. Similarly, the orderlies and paramedical ward help will extend themselves more readily if the clinician has taken the time to explain the nature of the emergency or the situation at hand.

Without the sort of communication by talking and writing discussed here, perhaps we should all be supplied with a crystal ball. Then, in tune with our modern age, we would at least have a technical aid for our extrasensory perception.
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Henry Ford Hospital Medical Journal

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