Me and Obama

As I write this Barack Obama has recently been elected president of the United States. I have never witnessed such excitement and expectation surrounding a new president during my adult lifetime. His inauguration appeared to be a joyful celebration for the whole country.

I can't help but parallel this momentous event to my own recent inauguration as the new editor of the *BCMJ*. Like Obama, I have been humbled by the adoration and numerous compliments regarding my intellect, charismatic demeanor, and outstanding personality. President Obama has vowed to make a difference and has already made drastic changes in the way his government is perceived and run. Likewise, within the first week of my tenure I made sweeping changes in the *BCMJ* editorial process. These changes were a little scary for some of the editorial staff; however, I am a man of action and therefore, despite some resistance, instituted these crucial new policies. First, I separated the vertically stacked "in" and "out" boxes, placing them side by side, thereby increasing accessibility and transparency of the editorial process. This first change had some naysayers, so after briefly waiting for acceptance I pushed on with my agenda. Second, I began to write my official editorial letters on the computer in MS Word. After the collective gasp quieted I began to disperse them via e-mail. My predecessor, JAW, handwrote all his correspondence, so this was a huge transformational change. In fact, Obama has an easier job impressing his staff and constituents as JAW is not, and never has been, a bumbling warmongering idiot from Texas. The last, and perhaps most drastic change, of which fortunately I don't have to convince Congress, is to receive Editorial Board meeting minutes via e-mail.

Is it possible for one man to live up to the impossible expectations of an entire nation? I wonder if President Obama is ever filled with self-doubt or worried about falling from the high pedestal of public perception—I certainly hope so, as I think this would lead to a kinder and more reflective government. It is naive to think that what happens to our neighbors to the south won't have a huge effect on our economy and well-being. Barack Obama's health care plan is to provide accessible and affordable coverage for all. He plans to reduce health care costs for a typical family by $2500 by investing in health information technology, prevention, and care coordination (I either got this information off his web site or when he took my phone call congratulating him on his election success; I can't recall which). Does this sound familiar—affordable, accessible, and universal? I wait with interest to learn how his administration is going to accomplish this lofty goal. He certainly appears to be an intelligent and honorable man, so maybe this won't be his Waterloo. If his government is able to develop this blueprint of change for a country that has such high health care costs, maybe we could borrow it. This might allow us to bring about effective primary health care reform in our own country, which is currently all the rage.

At least, unlike President Obama, I don't have to worry about impeachment . . . or do I?

—DRR

Keeping up with the good old days

A few months ago I attended my 30-year medical school reunion. Our class of 65 (University of Calgary, 1978) was notable because half the class was female, a big step for the admissions department at that time. There were a few medical staff members who thought it was a mistake to accept so many females, the main concern being that we might finish medical school and not carry on to pursue careers. How wrong they were! In fact, not only did many of us go on to specialize, but most continued to work while raising families.

We had a great time at the reunion, over good food and wine, reminiscing about the highs and lows of medical school training, how we were in awe of our teachers, and how we thought we would never make it through. How long ago that seems now, and yet it's still clear how idealistic we were. We all continue to have active medical careers and agree that medicine holds the same fascination for us now that it did then.

What came out in our discussions, though, were concerns that some of the things we have seen evolve over 30 years may not always be positive consequences of change. I'd like to highlight a couple of those themes.

The first is the importance of the bedside history and physical examination. We were taught that a good clinician could make a correct diagnosis 90% of the time with a thorough history and physical, and for the most part this held true. The clinicians that were excellent diagnosticians (and we had many) would take us to the bedside and within a few minutes have a diagnosis and differential established. This would be either confirmed or altered with the help of laboratory tests and imaging studies. If the tests didn't match the clinical picture, we were taught to go back to the bedside and re-examine the patient. Now what I see happening more frequently is that the tests and scans are ordered first without a clear plan in place. We have all experienced situations where we have made errors or been led astray by relying on tests to make a diagnosis for us. With the abundance of scans available to us, one would like to think it would only be a matter of putting a body in a scanner à la *Star Trek* and, voila, a diagnosis, but not yet. The patient still has the last say. My hope is that we continue to teach good physical examination techniques based on a good understanding of anatomy (like in the good old days). And I don't in any way mean we have to go back to cadaver dissections to learn anatomy; virtual anatomy is amazing. Anatomy should simply remain an important part of the curriculum.

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The second is the trend of using standard protocols and following guidelines (recipes) for diagnosis and treatment of a wide variety of clinical conditions. There are now, in the hospital I work in, preprinted orders for the management of MI, febrile neutropenia, pneumonia, DVT, and asthma. One is planned for diabetic ketoacidosis (DKA) but I am opposed to this. I can't speak with any degree of expertise for the other protocols, but it surprises me that for DKA, a condition for which there is still significant mortality, we are trying to write a recipe for treatment. It is a critical condition requiring continuous, careful monitoring and reassessment of the patient to avoid potentially serious consequences. Adjustments to IV fluid rates and insulin and potassium doses need to be made frequently, and no written protocol can (or should) substitute for this. Obviously standard orders can be overridden and changed by the doctor, but I think the tendency is to use them as written; we just attach a signature. In doing so we become more lax in the attention to details that we should be focusing on. Perhaps one day medical care will be all formulas and protocols, but until then each patient is distinct and unique and no one formula can be applied to all.

I look forward to our next reunion in 5 years. Who knows where medical advances will have taken us by then!

—SEH