This I Believe: Random Thoughts on the Practice of Gastroenterology

George Triadafilopoulos¹

Published online: 5 February 2016
© Springer Science+Business Media New York 2016

Skill

Modern gastroenterology is undergoing a revolution. The specialty has already practically split from hepatology; inflammatory bowel disease is mostly managed by subspecialists; and advanced endoscopy is practiced almost like traditional surgery in high-tech endoscopy units by highly skilled endoscopists who otherwise spend little time in the clinic. Since these trends will continue, we should be prepared to create a new generation of gastroenterologists, those with specialized training and specific disease interests. Many will be still generalists, but others will be starting their focused training earlier, receive a more in-depth education in their field, and ultimately obtain focused and relevant subspecialty board certification. Through such subspecialization, gastroenterologists will need to be part of a large group of practitioners that will guarantee their referrals.

Growth

The end of gastroenterology training should mark the beginning of lifelong learning and development by which the gastroenterologist continuously expands his or her knowledge and technical repertoire. Being a “permanent beta” can be quite rewarding, but it requires discipline, dedication, and dare. Yet, it guarantees a fulfilling professional career, shields us against boredom, and improves

patient care. Now more than ever, there are opportunities for continuous growth through hands-on courses, simulators, live events, and lectures—unbiased and highly effective—put together by our professional societies.

Empathy

If we do not have the capacity to place ourselves in another’s position, assess that individual’s condition, and decide what is best on his or her behalf, we do not belong in Medicine. Even in the modern era of team-based or center-based approaches, most patients seek to identify one person on the medical team who will exhibit such empathy and will serve as a personal guide. As gastroenterologists, we are frequently asked to function as proceduralists in the care of patients, and this is something to be resisted. Connecting with our patients is important to them and gratifying to us.

Time

We owe our patients time—time to listen to their story, time to clarify the nature of their problem by paying attention to subtle details. Most of the time, we will find the answer without having to proceed to elaborate and expensive testing. Listening requires practice and patience, but if it is done properly, it can significantly cut medical costs and minimize iatrogenic morbidity. Spending time also builds trust and bonds us with our patients, who will ultimately have more confidence in following our recommendations. We also need to honor time as a natural healer. Under the pressures to reduce the “length of stay,” we do not allow ourselves to observe the natural history of the disease,

✉ George Triadafilopoulos
vagt@stanford.edu

¹ Esophagus Center, Stanford Health Care, 900 Blake Wilbur Drive, Palo Alto, CA 94304, USA

frequently embarking on potentially avoidable tests and procedures of limited yield.

Health Care Industry

Decisions about patient care are now made in plain-walled, artificially darkened conference rooms, where PowerPoint slides are projected on the screen and every participant carries a mineral water bottle and dossier. The language used is foreign, the patient is a client, the doctor is a health care provider, and the hospital is an accountable care organization. The standards are borrowed from other industries; hotel (or hospital) checkout is at 11:00 a.m., and the length of stay is predetermined, while a series of checklists need to be done, often mindlessly, prior to an endoscopic procedure, similar to flying a commercial jet. I do not even understand how we allowed all these changes to happen in our profession, but I certainly hope that we will return one day to the personal touch, to the individual attention that each one of our patients deserves.

Guidelines

It started as an effort to synthesize the available knowledge and generate the next key questions for research. Select groups of individuals would meet, sponsored by a professional society, look at the evidence or lack thereof, and finalize a document on a particular topic—a well-intended effort, useful to the busy practitioner, or at least we thought so. Then came guidelines from other societies on the same topic with different recommendations, followed by European and Asian guidelines, each with its own highlights. We now have guidelines for each disease by each professional society or group that sometimes appear at the frequency of 2 years. Aimed at total surveillance and mind

control, this new totalitarianism has subtly and at times forcefully permeated physicians' lives. Many of us cooperate, some object, but we are all part of it.

Electronic Health Record

Nobody disputes the merits of an electronic health record, with its easy or even remote access to information, and nobody objects to the quick availability of radiologic or endoscopic images at our fingertips. But can we ever figure out the real medical history of a patient through pre-structured smart phrases? I think not. Cluttered with immaterial information, mostly cut and pasted from a (probably) inaccurate original source, the record serves as a marvelous billing tool, a legal defense, and a deterrent (and not always a good one) to medical errors. It is essential that we, as consultants, preserve and transmit the originality of our thought based on a carefully elicited history and expert physical examination; this will only enhance the electronic record.

Disruption

Disruptive new technologies soon will be rendering traditional gastroenterology obsolete. These advances should be welcomed and supported, since they will be less expensive, more patient-friendly, and less labor demanding. The progress in biology and technological innovation are poised to bring forth out-of-the-box concepts on disease recognition and management. As clinicians, we should partner with researchers in fostering new ideas and generating the needed evidence and valuation. It is unfortunate that centralized government and private agencies are not rewarding creativity instead of using buzzwords, such as cost-ineffectiveness and lack of evidence.