Reader comments

WHEN DOCTORS DENY

Thirteen years ago, a colleague of mine did a labiaplasty on my 18-year-old daughter for medical reasons. What was supposed to be routine has become a nightmare for her. Not only did he remove all of her labia minora, but he also denervated her clitoris. When he saw her postoperatively, he told her she was fine, maybe a little “atrophied.” Because of this obfuscation, years went by before she really understood how damaged she was. By then, the statute of limitations had lapsed and she had no recourse.

Still seeking closure on this disaster, my daughter recently went to one of his peers who confirmed the extent of her injury and even called the initial ob-gyn to let him know what he had done. Despite this evidence, he refuses to admit he caused it. In the most pathetic of excuses, he proposed to me that she either had additional surgery or mutilated herself. How does a physician get this deep into denial?

This doctor is a leading ob-gyn in the state and universally respected. Certainly, he has helped thousands of women and children. So why can't he admit he has made such a serious mistake?

Somewhere in our careers, we lose touch with our emotions and our patients' tribulations. We suppress our natural responses, deny our feelings, and unlearn how to say “sorry” when a patient is suffering. We learn to lean heavily on denial. We see perfectly healthy people with catastrophic illness and compartmentalize it so we don't have to worry it can happen to us. In the hope of treating disease, we cause tremendous suffering with medicines and surgeries that have horrendous side effects and complications. We employ denial to shield ourselves emotionally from the misery we cause, but it only tends to make us more callous. Our lab coats make us “different,” enforce our denial and allow us to not identify too closely with our patients, lest we constantly be faced with the reality that we will all end up as patients with some lethal disease.

The constant threat medical malpractice creates more distance between our emotions and our patients. Rather than surrender to our compassion and acknowledge a patient's misfortune, we remain silent for fear of implying our guilt. For want of an “I'm sorry,” a lawsuit becomes more likely.

Having said that, I still don't know how my daughter's doctor could be so devoid of compassion and honesty

that he could still deny he mutilated her, especially when he knows the acknowledgment would give her some closure. How could he be in such denial? Somehow our generation of doctors has to be better. We have to admit things go wrong and we contribute to patient suffering. For our profession, for our patients, and for ourselves, we need to reject denial in favor of truth. We need to face our patients sympathetically with honesty, not denial.

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1. Wiwanitkt V. Types and frequency of pre-analytical mistakes in the first Thai ISO 9002:1994 certified clinical laboratory, a 6-month monitoring. *BMC Clinical Pathology* 2001;1(1):5.

TROUBLE WITH TROPONIN OR OTHER REASON?

We read “The trouble with troponin” with great interest.¹ In the article, the problem of troponin investigation is mentioned. A laboratory test has its specific sensitivity, specificity, precision, and accuracy. Nevertheless, we would like to mention an infrequently mentioned problem, preanalytical error. Preanalytical error is the error that occurs in the step before the analytical process by the analyzer in the medical laboratory. This error can cause a problem in the troponin test and the interpretation of the result.² Good examples of such errors are incorrect use of anticoagulant during blood collection and poor specific preparation. The preanalytical error is very common in clinical practice and is a problem that can be seen in any clinical setting regardless of the accreditation of the quality of the medical laboratory.³

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2. Herman DS, Kavsak PA, Greene DN. Variability and error in cardiac troponin testing: an ACLPS critical review. *Am J Clin Pathol*. 2017; 148(4):281–295.
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The author reply

The reader's comments are appreciated and shed light on a source of error not addressed by our editorial. Pre-analytical errors should be considered when

testing yields unexpected results. False elevations can result from heterophile antibodies, microclots or debris. False negative testing is rarer, but can result from endogenous antibodies against troponin itself. Small effects on assay results have also been reported with hemolysis, icterus, and lipemia. We believe, however, that test performance can be significantly improved by not testing patients for whom acute myocardial infarction is unlikely and unexpected.

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