

# Seven Sins in Modern Medicine

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## Admit it, you're guilty of at least one of these.

I recently came across an article from my residency training titled “The Seven Sins of Medicine.”<sup>1</sup> Based on a 1948 lecture by Richard Asher, MD, the article proposes that, although there are a multitude of medical sins, seven are of primary importance: obscurity, cruelty, bad manners, over-specialization, love of the rare, stupidity, and sloth.

Reading the article again, I wondered how these sins might apply in today's environment, and I came up with seven sins we often struggle with as family physicians:

**1. Not communicating with leadership.** More physicians are working in settings where they are accountable to a higher level of leadership, yet in many organizations the two sides do not understand one another. Often leaders say they support (or oppose) a new process or project but have no idea what they are supporting (or opposing). Perhaps it would help if we communicated with leadership like we communicate with patients: Avoid jargon, keep it simple, and use the “teach back” method to ensure understanding.

**2. Not putting patients at the center of care.** Asher described how our enthusiasm to find an answer or fix a problem can lead us down a path that our patients do not wish to go. A better approach is to honestly discuss why tests or treatments are needed, inform patients of the risks and benefits, and guide them in their decision making.

**3. Not building relationships with our team.** Most physicians know how important it is to have good manners when dealing with patients, but how often do we forget our manners while dealing with nurses, colleagues, or other staff? To have an effective team, we need to build good working relationships and treat each other with respect.

**4. Not practicing evidence-based medicine.** As family physicians, we are often expected to be a “Jack of all trades” yet can also be accused of treading on our specialist colleagues' turf. To find the right balance of when to treat and when to refer, we should embrace evidence-based

medicine and practice within those bounds. The result will be excellent care for our patients.

**5. Not investing in care coordination.** Although neurosarcoidosis may be interesting to diagnose and treat, more often we as primary care doctors deal with hypertension, diabetes, coronary disease, obesity, etc. Providing excellent care coordination for these common chronic diseases is how we can have the greatest impact on our patients' health. Spanophilia, love of the rare, should not be our focus. We need to stick to the basics.

**6. Not using common sense.** We've all heard stories about insurance companies sending a medication alert for a patient who has passed away or a diabetic foot exam reminder for a patient who has undergone a bilateral, below-the-knee amputation. To avoid these types of mistakes in our practices, we have to think before we act. Do not order a test simply to fulfill a requirement. Ask, “If I order this test, what will I do with the results? Will it change the care I provide?” When considering a new policy or procedure, ask, “If we implement this, will it improve care or enhance efficiency?” If you implement just to meet a standard, resentment will ensue.

**7. Not letting others help us.** In an environment in which speed is of the essence, we can easily become frustrated when a patient doesn't understand our explanations and a visit seems to be taking too long. We forget that it is possible to improve access to care *and* give patients the time they need. The key is to use your team. You might not have the time to educate someone regarding diet and exercise, but your dietitian or nurse can help.

Although our sins may have evolved over the years, Asher's conclusion is timeless: “Please adopt this attitude with everything I have said, and realize that much of it may be nonsense.” **FPM**

1. Asher R. The seven sins of medicine. *Lancet*. 1949;254(6574): 358-360.

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