Dr Google or Dr Lazy?

Sir, I was recently on call for nephrology, and something happened. I was rung by a first year junior doctor at 1 am, saying that a patient’s ‘MEWS score was 6’. The patient had had a renal transplant that day. A score of 6 is very high. It should trigger a rapid senior review, and possible intensive care referral. Modified early warning score (MEWS) is an electronic early warning score based on simple clinical data (pulse, respiratory rate, temperature, etc.). In our new(ish) PFI hospital, it is collected by a nurse in an electronic way. The nurse was not worried about the patient, and would not have called the junior doctor, unless the MEWS score had ‘told’ her too. After I asked the junior which aspects of the MEWS score were scoring high, it sounded like pulmonary oedema to me.

As I tried to wake up and engage my brain, I remembered that the doctor had not told me her impression of the patient’s clinical state—specifically those old-fashioned things, the history and examination. The doctor had not even seen the patient, but was merely passing on the MEWS score from the nurse to me. So, I said I was pleased that I had been rung but could she take a history and examine the patient, do a chest X-ray, call a registrar and ring me back? She did, it was pulmonary oedema. We dialysed the patient and he is now fine, with a functioning transplant. Job done.

In the morning, I was initially very pleased with the hospital’s excellent IT system. I felt that the MEWS system had worked, alerting me to a potentially serious situation probably 2 h before it has become clinically obvious. In fact, my story could be interpreted another way. Rather than ‘phew technology saved us’, ‘IT makes us lazy’ could be the conclusion. A senior nurse and junior doctor may now wait till the computer (MEWS score, in this case) tells them to act, rather than look at the patients.

Who do I blame? Myself actually. ‘We’ (the Luddite oldies) have allowed medical training to degenerate into a thing that creates ‘Macdonalds doctors’ (‘we don’t have to understand why it’s a Big Mac’). We do not like to challenge the medical students, throw them in the deep end or ask them about the evidence for the benefits of statins. We allow them to stay their comfort zones—i.e. small group teaching, the lecture and the i-phone. It is easier to say ‘go away and prepare a mini-presentation on X or Y’, rather than let us do some bedside teaching on chest examination.

Some have debated whether Google makes us stupid.1 Certainly, handheld computers and Dr Google, have made endlessly copied, compiled and condensed information immediately available. But is this information too easy to access, making young (and older) physicians unintentionally lazy? Or has our laziness created Dr Google? Probably a bit of both. Dr Google saves lives the world over, every day.

However, ‘we’—doctors, nurses and patients—need to learn to teach the next generation ‘how’ to use information technology. In conclusion, is the main function of IT—as in my story—to ‘cover the backs’ of the lowest common denominator doctor (who reflects the quality of my training) and trigger senior reviews? Or, should it be to supplement care? I suggest the latter, and propose a new doctrine: ‘In medicine, IT should be used to supplement clinical care, research, teaching or management – not replace it’.

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Reference


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