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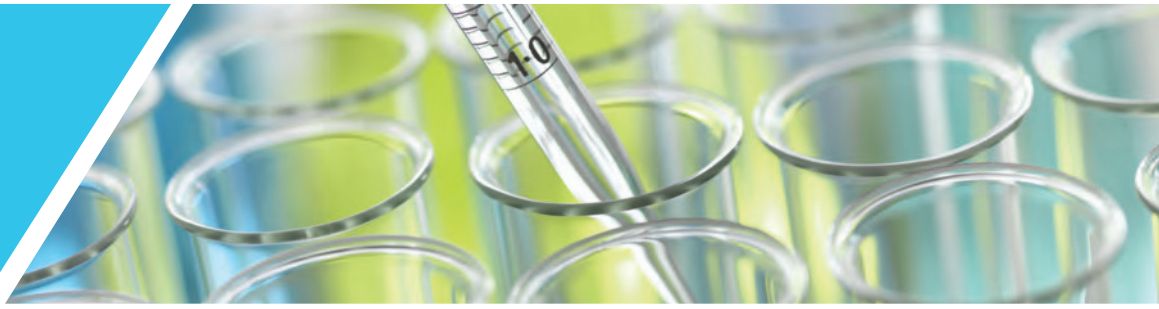

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Bloodletting in the 21st Century?

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I often think about what doctors in the future will think of our current practice of medicine. We are rapidly entering the Star Trek diagnostic paradigm of sticking people in machines that tell us what is wrong, or at least sticking them in a machine to "document" or confirm that what was found on a physical exam is a bona fide abnormality which can be digitized.

I know that these introductory sentences have revealed that I'm old and that I believe clinical exams and clinical impressions are important. But, being older, I also can reflect back over the changes in medical practice that I've lived through. I recall that when I was a resident, the best treatment for Bell's palsy, a problem in the facial nerve which causes unilateral facial weakness, was emergency surgery to widen the canal, allowing the nerve to expand, and thus recover more easily. It was "the standard of care" until a brave otolaryngologist noticed that he often saw patients who had healed on their own, without the benefit of surgery and decided to study it. Surgery was quickly abandoned and patients have done much better on their own without the surgery.

Subarachnoid hemorrhage patients used to be kept on sedatives, in dark, quiet rooms, lying in bed for two weeks before they could have surgery to repair their aneurysms. The rationale was that earlier operations caused arterial spasm and stroke. The low stimulus environment was to prevent sudden rises in blood pressure that might cause re-bleeding. This was counterproductive since patients did not tolerate the stimulus deprivation, especially knowing that they had a time bomb in their brain. They, not infrequently, flipped out, to use non-technical jargon.

Of course, there's a long list of things that we do much better these days, but we are undoubtedly doing a lot of things that are equally unjustifiable, possibly even counterproductive. This thought was triggered by a review article in *Annals of Internal Medicine* (2015;Sept 1; 163:173), on the value of epidural steroids for spinal stenosis and radiculopathy.

The article echoed one published in this journal (2013;96(1):12) [http://www.rimed.org/rimedicaljournal/2013/01/2013-01-12.pdf] which concluded that the injections were not really supported by data. The *Annals* article found that the injections produced an early, mild improvement in pain that wore off quickly.

Epidurals are widely used for back and neck pain, and back and neck pain are very common problems. I doubt there is a single day when I don't see one or more patients who have received or are scheduled to receive epidural injections. Either corticosteroids, or corticosteroids plus lidocaine, are injected. Given the highly variable responses, including no relief, immediate relief, relief for a few days, and relief for months, it is not possible for me to have a sense of whether the injections have any efficacy. Certainly some patients have had dramatic improvement, but placebo does that as well. I suspect that the injections are popular because the problem of spine-related pain is so complex and so common, and that treatment for those who fail physical therapy and exercise is pain medication or surgery. Thus, anything that can be done short of surgery and can be done safely is worth doing, whether the benefit is placebo or not. Of course, there are other ways to interpret the conflicting and unconvincing results of the various studies. The reports may be confounded by poor patient selection, poor technique with the injections or some other failure of methodology. A more compelling analysis might invoke the notion that the treatment is quite effective for a sub-population who have particular syndromes, but not for the whole population. We have learned that cancers have a wide panoply of physiologies, genetics and biochemistries, that render one breast cancer treatable with one regimen but that does little to affect another breast cancer. It is likely that spinal stenosis or radiculopathies

may have different underlying pain mechanisms that, in an analogous fashion, make some of them responsive to epidural injections. Or, that some people respond better to placebo than others.

How long will unproven remedies continue to be used? Probably as long as they are paid for. All doctors, myself included, have our own beliefs based on our own experience. I think it is uncommon for "evidenced-based medicine" to trump our own "experience-based medicine" when we saw our last three patients improve miraculously with some unproven, or even some disproven remedy.

These observations make me think about bloodletting. I think this was in vogue for about 2000 years in the western world. I am unsure if it was used in other continents and cultures. It had a rationale, namely drawing off the "bad" humors in the blood, to be replaced, presumably, by "good" or wholesome blood. There is little reason to believe that doctors today are much smarter than doctors of yesteryear, so it must have seemed pretty clear back then that bloodletting worked. In retrospect we might wonder how the competing influences of an enhanced placebo effect, which we ascribe to the more invasive procedures, against the variety of deleterious physiological effects of losing blood when you're already ill, balanced each other.

Perhaps new funding mechanisms spawned by the PCI (patient-centered initiatives) in Obamacare will determine who, if anyone, benefits from interventions like epidural steroid injections, and help either end an expensive procedure, or determine the "correct" criteria for identifying who will respond.

My own opinion is that nothing will happen until insurers decide that common procedures need to have data to support their use, and will themselves band together to fund studies of treatments like epidural injections. Experience tells me that I should not hold my breath. ❖

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From the Shiftless Lazy to the Contemplative Scholars

STANLEY M. ARONSON, MD

[Editor's Note: For the next few months, RIMJ will be presenting commentaries by the late Stanley M. Aronson, MD, the Journal's former editor emeritus. We appreciate Gale Aronson's offering them to us for publication.]

Laziness may be defined as the willful aversion to work, generally physical work. Laziness may assume many forms and settings, but at the least it portrays a human capable of certain labors but unwilling, voluntarily, to engage in such activity. Or, in 19th Century description, "laziness is an unwarranted repose of manner in a person of low degree." If, on the other hand, inactivity is observed in the members of the nobility, it may then be called an interlude of soulful reflection or merely creative meditation or even earned leisure.

The origin of the word, lazy? Quite uncertain but likely a descendant of the Italian *lazzarone*, a noun describing a low social class of itinerants in Naples and identified closely with street begging.

Although the words are closely related in meaning, laziness must still be distinguished from sloth, indolence, lethargy, lassitude and purposeless meditation, sometimes called daydreaming. Laziness, during the advent of the Industrial Revolution, had been elevated from an unwarranted spell of aimless indolence called *acedia* by the church elders. One British statesman then declared: "I look upon indolence as a sort of suicide; for, in laziness, the man is effectively destroyed, though the appetites of the brute may survive." And yet another, "for Satan finds mischief still for idle hands."

Idle, a synonym for lazy, is derived from a West Germanic tongue and initially defined something that was useless or inept, as in idle threats. By the 18th Century it took on the broader meaning of worthless, vain, and unproductive, as in an "idling motor."

Indolence, from the Latin *dolor* meaning pain or distress, in its first appearance signified something free of pain; then in time, a disposition to avoid work, and finally a phlegmatic, lazy demeanor.

Yet how many great ideas, scientific epiphanies and immortal works of art have arisen during moments of quiet reverie?

Lethargy, meaning a morbid drowsiness, is from the Greek denoting forgetfulness and is descended from Lethe, the river of forgetfulness, in Hades.

Lassitude, describing a weariness, languor or moral exhaustion, is from the Latin, *lassus*.

And sloth? Taken from an old English word meaning sluggish. Sloth, over the centuries, has absorbed collateral meaning such as uncivil, uncouth and even cowardice.

Somewhere in Europe's 18th Century, the turning point was reached when machinery began to replace much of manual labor, particularly in the textile industries, and concurrently the pace of living accelerated as scheduled factory employment replaced home-based crafts. From an indolent era in the past, marked by record plagues, crusades, institutionalized ignorance and a reluctance to change, Europe quickened

The Thinker, sculpture by Rodin.

its pace, and introduced the integrating elements of industry into what had been a closed society; literacy was urged; schedules were now published; clocks became the guiding instruments in the society that had become more interrelated, more structured. And accompanying the civil changes of the Industrial Revolution came the earnest belief that idleness was a major sin and clearly an emerging threat to the integrity of a newly modern society. Sin and particularly laziness, from something intensely personal, had become a public menace, from a private deficit to a public indecency.

But all is not lost. Our society is increasingly strengthened by sturdy citizens – sentinels of society's moral fabric – who have given themselves the thankless task of judging the work habits and even the moral principles of their fellow humans, seeking out those "that the devil finds idle." This form of voluntary inspection, devoid of any hint of humor, is said to be an inevitable byproduct of the Industrial Revolution – indeed one of numberless new public burdens emerging in that historic era. Were it not for these self-appointed guardians of our collective morality, it is likely that a campaign against the inroads of laziness would cease, the bridges would falter, our traffic lights would fail and sermons would no longer explore the entrails of sinful sloth.

Idleness and spiritual apathy, assuredly, are the foes of productivity, but not necessarily the enemies of creativity. When society has satisfied its basic needs for shelter and nourishment, surely it can allow, even encourage, some to devote themselves to a life of contemplation.

Yet how many great ideas, scientific epiphanies and immortal works of art have arisen during moments of quiet reverie? And for the rest of us not endowed with genius, there is always the gift of undemanding contemplation, the serenity of inner silence and that wondrous feeling of merger with the natural world. ❖

Author

Stanley M. Aronson, MD, was Editor emeritus of the *Rhode Island Medical Journal* and dean emeritus of the Warren Alpert Medical School of Brown University.