How to Protect Yourself from Abusive Medical Doctors

There are some important lessons to be learned from my recent encounter with a medical specialist over the care of one of my patients from the Midwest.

The patient is a middle-aged woman (I will call her Marsha) with a history of precancerous changes in the tissues lining her uterus (endometrial hyperplasia). Over the past two years her condition had progressed to an early stage cancer diagnosed by repeated biopsies. She had consulted two surgeons who had recommended a hysterectomy as the treatment. Marsha has been following a healthy diet; but this discussion is not about diet but about obtaining helpful and respectful medical care based on scientific research rather than a doctor's best guesses and professional prejudices.

During early **October of this year (2011)** Marsha sought a second opinion on what she should do about her condition from a young Obstetrician/Gynecologist. I will refer to this doctor, who graduated from medical school in 2002, as Anna Hopeful, MD (not her real name).

My first and only telephone conversation with Dr. Hopeful was on the evening **of October 5, 2011**. She was obviously concerned about the patient's welfare, but demonstrated a lack of good manners and verbal skills. Her behavior was aggressive and her language was inappropriate (using vulgarity you might expect from a drunken sailor about to get into an evening brawl outside of a bar). Over the five minutes of our one-sided conversation, she accused me of killing the patient by causing her to commit suicide due to delaying surgery (a hysterectomy). She threatened to report me to the medical board and accused me of being ignorant of the thousands of studies that proved this patient would be cured by removing her uterus. She told me I had no business voicing my opinion on this matter because I was not a specialist, as she was in women's diseases, and that I should limit my involvement to what I was trained to do as a general doctor, such as taking care of diabetes. In my forty-three years in medicine, her efforts that evening to humiliate me were unprecedented.

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My response was that I too was interested in the patient's welfare. As the patient's primary care doctor and her advocate, I asked to see the research that supported her recommended treatment, a hysterectomy. I explained that a healthy diet *as an alternative to surgery* was not my recommendation or part of our disagreement. My request was only for reasonable scientific support for the benefits of surgery. I believe all treatments must stand on their own merits. If surgery has been shown to work then the patient should have this treatment regardless of her food choices.

Dr. Hopeful realized her phone conversation with me was unprofessional, to say the least. That evening (**October 5, 2011**) I received an email that included a weak apology. Dr. Hopeful wrote, "Peer-reviewed international literature has little data on patients not treated with either radiation, chemotherapy, hormones or surgery, since these have been the standard treatments for many years… I also consider myself an advocate for this patient and will fight for her. I apologize for my intensity. Let's work together to provide this patient with recommendations that will best serve her."

My email response to Dr. Hopeful that same evening was, "Thank you. I appreciate your apology. Being a doctor can bring on a lot of stress, especially being a surgeon, and an oncology surgeon."

Later that evening **on October 5**, I received an email from Dr. Hopeful with the articles she believed supported her viewpoint. My

guess is she never thoroughly read the materials she sent to me. **On October 6**, I e-mailed her my responses to the papers she sent to me: "I could find no research for survival benefits from hysterectomy for any stage of endometrial cancer. In fact the papers you sent said there was no benefit. Am I missing something? Here is my review of the articles sent." (You can see the articles she had sent and my reviews at the end of this discussion.)

On October 7, in response to my critique, Dr. Hopeful defended her position by writing, "We will have to agree to disagree about our interpretation of the literature."

Later that day I replied, "Excuse me. We will not agree to disagree with what the literature says. The science is clear. If you do not admit this fact and properly inform the patient of the lack of scientific support for your recommendation for surgery for her condition, I will send these communications between us to the patient. Furthermore, I will send a letter of complaint to your hospital, your state Medical Board, and your professional medical board."

I wrote Marsha a brief letter **on October 6** explaining that Dr. Hopeful and I had been in contact. Her response to me came **on October 9**: "It is lonely and scary to take a stand that my family physician, local oncologist and close friends disagree with. My two best friends have been operated on for cancer—one breast and one endometrial—and it is awkward trying to explain my medical choices to them. So thank you for getting involved. I am very grateful."

I explained in more detail my position to Marsha **on October 10**: "I asked Dr. Hopeful for information that supported a survival benefit from the surgery she recommended to you for early endometrial cancer. She did not provide this support. In fact, the scientific papers she sent to me clearly said that no survival benefit has been found for surgery. Dr. Hopeful now knows these conclusions from the scientific literature. Independently, in my extensive review of the medical research on the topic of surgery for endometrial cancer I have been unable to find any reliable studies supporting a survival benefit after this treatment. I am not recommending against or for surgery for you. I cannot recommend that you not have surgery, because I have no proof that surgery will not cause you to live longer—this negative conclusion has not been shown with adequate research. On the other hand, at the present time, I have no evidence that surgery will prolong your life, thus I cannot recommend for it. Someday doctors may make a positive finding, but until they do I cannot tell you to have surgery. (You might have thought that after doing several million operations for this condition over the past 70+ years that someone would have performed some analysis that would help patients and doctors make better decisions. That does not appear to be the case.) This is a personal decision you must make after being presented with correct and available evidence. I am making a plea to your specialists that you be informed before you make that decision. There are many state laws that require doctors to inform their patients about the benefits and risks of treatments recommended. I strongly recommend that you seek other expert opinions on your condition. When you see these doctors please demand an answer to at least this one crucial question: Is there any scientific evidence that your recommended treatment will prolong my life or improve the quality of my life? Please inform them (your other doctors) that I am one of your primary care doctors and that I would like to be involved in all communications."

On October 14 the patient wrote to her specialist doctor: "Dr. Hopeful: I had a right to know what all the science says (or doesn't say) about my disease to make an informed decision. Instead, on my initial visit, you resorted to scare tactics. You didn't tell me your recommendation was based on a hunch. Some may consider this unethical…As you well know, surgery is serious business with possible serious consequences."

On October 25 the patient wrote to me: "I didn't have any more communication from her (Dr. Hopeful) since October 15 when she sent her good wishes…She has not waivered from her stated position that 'cancer caught early, treated with a hysterectomy, leads to cure in most women (80-90%)'…But I admit it has been tempting to get a hysterectomy just to quiet all the many voices that are dumbfounded I'm not getting 'the cure.' This has caused me more stress than dealing with the fact I have cancer. This includes my family physician, who Dr. Hopeful also called. I can't persuade my family doctor to call you (Dr. McDougall), but she treats me with respect and will not abandon me just because I disagree with her."

Lessons to Be Learned from the Dr. Hopeful Encounter:

Doctors Have the Potential to Do Great Good and Harm

Only the most intelligent and talented people are accepted into medical schools. As a result these exceptional professionals have the potential to do great good—or great harm. After at least seven years of post-college graduate medical education on the emotional, mental, and physical condition of the human being, you would expect a physician to be a powerhouse of goodwill for his or her patients. Unfortunately, too many doctors fail to keep the welfare of their customers at the forefront, as their main concern. The needs to boost their own egos, self-preservation, and the quest for more money often result in inappropriate care and harm

the patient.

In the case of Dr. Hopeful, I believe that she failed to correct the inaccurate information she initially gave Marsha and me in order to "save face"—her self-interests took precedent over Marsha's welfare. A simple admission that she was wrong about her having scientific backing for a hysterectomy would have brought about great emotional relief for Marsha, in addition to giving her the opportunity to make a decision to accept or reject surgery based on accurate information.

I interpreted her aggressive language during out phone conversation as a sign of Dr. Hopeful's insecurity. My request for the medical research supporting her recommendation probably came as a surprise to her. My guess is that few of her colleagues had ever questioned her authority; plus, she probably never considered the possibility that her years of training were faulty. Dr. Hopeful, being a gynecological surgeon, almost out of reflex, jumped to a hysterectomy as Marsha's solution, regardless of the scientific evidence—The hysterectomy is the biggest (and most profitable) tool in the gynecologist's tool bag.

Too many patients treat their medical doctors as if they were god-like in their importance, never questioning their recommendations. This subservient relationship puts the patient's life totally in the hands of a fallible person. (Read my Hot Topics on Working with MDs for more information on dealing with your doctors.)

Lying with Statistics

Doctors often mislead patients by providing inaccurate and irrelevant, but startling, facts. In Marsha's case she was told, a "hysterectomy leads to cure in most women (80-90%)." This is misrepresenting the truth. Because this disease is very slow growing, and in most cases remains confined to the superficial tissues of the uterus, five years after diagnosis 80% to 90% of women will be alive and well even without a hysterectomy. The research done so far has demonstrated no improvement in survival regardless of the aggressiveness of the treatment. I predict that, like with prostate cancer, when the research is eventually performed on large numbers of women, no survival benefit will be found. Dozens of excellent large studies have been done on men who have had cancer discovered in their prostate with a biopsy. In over 97% of the cases this cancer either never spreads outside of the gland to cause harm or the patient dies of something else long before any evidence of cancer spreading outside of the prostate occurs. In that 3% where cancer is aggressive and harms the patient, it has already spread beyond the limits of surgical resection long before discovery; thus, these men are not helped by surgery either.

The Male-Dominated Medical Business Disrespects Women

In the US most doctors are men. For many reasons, female, compared to male, patients are more aggressively treated with pills and surgeries when suffering from similar conditions. The case of prostate cancer is an excellent example. Men these days are told by the U.S. Preventive Services Task Force (USPSTF), the American Cancer Society, and almost all other organizations that the PSA test is unreliable and leads to great harm, and therefore, men should avoid it. Once diagnosed, men are also informed that they have options for treatment: they are offered surgery, radiation, or no treatment at all (watchful waiting) for prostate cancer. Why the options? Because these three choices result in the same survival outcome based on four decades of reliable research. The main difference that results from their choice of treatment is the side effects: those choosing aggressive treatment have a high risk of becoming impotent and incontinent.

Why are men so well informed about cancers of their reproductive organs and women are not? I believe this is because male doctors can relate to their own male anatomy. Men, however, cannot empathize with a woman faced with the surgical loss of her uterus. They often think this is "a throw away organ," of no use since the woman is past her years for having babies. Regardless of misunderstanding generated by gender, the surgical loss of a woman's uterus has a huge impact on her life, often resulting in depression, sexual dysfunction, and physical illnesses, including an increased risk of heart disease.

General Doctors Need to Act As Patient Advocates

Generalists (like family doctors and internists) need to stand up to specialists and defend their patients. However, in the US medical climate doctors are afraid to question other doctors' behaviors—especially those actions of the revered specialists. Yet there is no one better equipped to serve this vital function for you than your own personal doctor. In Marsha's case it would have simply been a matter of her family doctor taking 10 minutes to look over the few unsupportive papers Dr. Hopeful had sent to me. For some reason, she did not find the time or the will to act in Marsha's best interest.

Practicing Self Defense

When you have no one else to depend on (like your generalist doctor) then you are left to your own means. No one is more interested in you than you are. Therefore, you need to gather all your communication skills and take action. Ask simple direct questions (look directly into your doctor's eyes when you ask). The most important question to ask is: "Will this treatment cause me to live longer and/or better?" Next, ask for the scientific evidence in support of any recommendation. The burden of proof lies with those selling the goods and services, not with the buyers. You need an acceptable level of proof before accepting your doctor's prescription.

You will need to become a medical expert on your specific problems, and these days this is possible because of the Internet. Go to your search engine (Google) or a medical site like the National Library of Medicine (www.pubmed.gov). Do your homework before your doctor's office visit. Then during your visit, after 10 minutes of conversation with your doctor, you should hear from him or her, "Wow! You know as much about your diseases and I do." And your response will be, "Of course I do doctor; these are my problems and I want the best care and results possible."

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Studies Sent to Me by Dr. Hopeful and my Responses

Here is my review of the articles sent to me by Dr. Hopeful to support a hysterectomy for Marsha. You will note first that there are not thousands of articles, and just from the titles of these few articles she emailed, you can see that about half are irrelevant to our conversation (they are about radiation and hormone therapy). None of these papers suggested any survival benefits from surgery, and those that addressed survival made it clear that no survival benefits have been shown after a hysterectomy for any stage of uterine cancer.

Article Sent for Support: Endometrial Carcinoma. Peter G. Rose, M.D. *N Engl J Med* 1996; 335:640-649.August 29, 1996

McDougall's Comments: This article shows no research on survival benefits from surgery. These statements are made in the article: "Although pelvic radiation therapy is widely used, its effect on survival is not established; only one randomized study has been reported. Aalders et al. randomly assigned 540 women who had undergone hysterectomy and postoperative vaginal radiation therapy to additional pelvic irradiation or observation. Although pelvic radiation therapy improved local control of disease, survival did not differ in the two treatment groups. Whether the addition of pelvic irradiation is appropriate in the absence of extrauterine metastases in women who have undergone complete surgical staging awaits the results of a recently completed randomized study of the Gynecologic Oncology Group."

"A case-control study with matching according to clinical stage and tumor grade found no significant difference in survival between women treated surgically and those who received primary radiation therapy."

Article Sent for Support: Creasman et al. Surgical pathologic spread patterns of endometrial cancer (a Gynecologic Oncology Group study*). Cancer* 1987;60:2035.

McDougall's Comments: This paper identifies no data on survival. These statements are made in the article: "This study does confirm that a significant number of patients with Stage I disease can have extrauterine disease. It suggests that certain patients have significant risk of lymph node metastases and histologic evaluation of the regional lymph nodes is warranted. By applying this information to individual patients, hopefully the true extent of disease can be determined, appropriate therapy applied, and survival improved."

Article Sent for Support: Boronow R. et al. Surgical staging in endometrial cancer: clinical-pathologic findings of a prospective study. *Obstet Gynecol*. 1984 Jun;63(6):825-32.

McDougall's Comments: No evidence of survival benefits from surgery shown.

Article Sent for Support: Marziale P et al. 426 cases of Stage I endometrial carcinoma: a clinicopathological analysis. *Gynecol Oncol*. 1989 Mar;32(3):278-81.

McDougall's Comments: 5-year survival rate was high despite the high average age of the patients (74.7% between the ages of 51 and 70). No evidence that surgery prolonged life shown.

Article Sent for Support: Gal D et al. The new International Federation of Gynecology and Obstetrics surgical staging and survival rates in early endometrial carcinoma. *Cancer* 1992;69:200-202.

McDougall's Comments: Irrelevant to discussion.

McDougall's Comments: These statements are made in the article: "There was no significant statistical difference in survival among patients with different substages within surgical Stage I (i e . ,IA, 100%;IB, 100%;and IC, 88%), whereas the distribution of adjuvant therapy among these substages was not statistically different (P = 0.17). Thus, survival was not significantly affected by depth of myometrial invasion in patients who had negative peritoneal washing and no involvement of lymph nodes or the peritoneal washing and no involvement of lymph nodes or the peritoneal cavity."

Article Sent for Support: International Federation of Gynecology and Obstetrics. Annual report on the results of treatment in gynecologic cancer. Stockholm: FIGO, 1985.

McDougall's Comments: I could not find this article.

Article Sent for Support: International Federation of Gynecology and Obstetrics. Corpus cancer staging. *Int J Gynaecol Obstet* 1989;28:190.

McDougall's Comments: I could not find this article.

Article Sent for Support: Kitchener HC. Surgery for endometrial cancer: what type and by whom. *Best Pract Res Clin Obstet Gynaecol* 2001;15:407-415.

McDougall's Comments: No studies provided to show benefits. These statements are made in the article: "There has never been a convincing evidence base to demonstrate the effectiveness of more extensive surgery in terms of improving survival… There was no difference in survival but there was a benefit in terms of a reported reduction in morbidity, principally short-term due to radiotherapy."

Article Sent for Support: Vergote I et al. A randomized trial of adjuvant progestogen in early endometrial cancer. Cancer 1989;64:1011.

McDougall's Comments: Irrelevant to discussion.

Rouanet P et al. Exclusive radiation therapy in endometrial carcinoma. *Int J Radiat Oncol Biol Phys* 1993;26:223-228.

McDougall's Comments: Irrelevant to discussion.

Creutzberg C. et al. PORTEC Study Group. The Postoperative Radiation Therapy in Endometrial Carcinoma. The morbidity of treatment for patients with Stage I endometrial cancer: results from randomized trial. *Int J Radiat Oncol Biol Phys* 2001;51:1246-1255.

McDougall's Comments: Irrelevant to discussion.

Hormone therapy in advanced and recurrent endometrial cancer: a systematic review. Decruze SB, Green JA. Int J Gynecol Cancer. 2007 Sep-Oct;17(5):964-78. Epub 2007 Apr 18.

McDougall's Comments: Irrelevant to discussion.

A phase III trial of surgery with or without adjunctive external pelvic radiation therapy in intermediate risk endometrial adenocarcinoma: a Gynecologic Oncology Group study. *Gynecol Oncol.* 2004 Mar;92(3):744-51. GOG 99

McDougall's Comments: Irrelevant to discussion.

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