More Information on Infection and Infarction

To the Editor:

Blasi and colleagues (August 1997) have made a solid contribution to the increasing evidence that Chlamydia and other organisms are part of the pathogenesis of coronary disease. I was particularly taken by their data confirming a high prevalence of upper respiratory tract infection (about 20% of patients with acute infarction) in the 3 weeks prior to admission. Though they missed our report, this is supportive of our finding in a prospective age- and sex-matched controlled investigation of a prevalence of 28% for upper respiratory tract infections in the 2 weeks prior to admission for acute myocardial infarction, vs 14% in the control population. This again raises the question of “infection and infarction” raised in the late 1980s with implications for myocarditic mimicry of infarcts and the precipitation by infectious processes of true infarction.

David H. Spodick, MD, DSc, FCCP
Saint Vincent Hospital
Worcester, Massachusetts

REFERENCES

The Ethics SOAP Note

To the Editor:

Ethically based medical decision making is a vital component of medical practice and an important focus of contemporary medical education. Despite its recognized importance, however, many medical schools graduate students who enter residency training without a firm grounding in, or a facility with, its practice. These resident physicians are generally well trained in a modern biopsychosocial approach to patients, are comfortable with the standard subjective, objective, assessment, and plan (SOAP) note format, and are usually very facile in its use as a tool for organizing their thoughts around a medical case. I, therefore, propose that the SOAP approach be used as an organizing instrument to aid physicians-in-training in sorting out the many ethical dilemmas that arise in routine residency medical practice.

Ethically based medical decision making requires that physicians-in-training be familiar with a few basic concepts of contemporary biomedical ethics: specifically, patient autonomy (a patient’s right to decide) and physician beneficence (the obligation to do good), nonmaleficence (the obligation not to do harm), and justice (the obligation to be just and fair). Ethical or value-based medical decision making also requires knowledge of a patient’s personal values. As importantly, it also necessitates that physicians become aware of their own values and the role these values play in decision making. Finally, ethically based medical decision making requires reinforcement through practice.

Thus equipped, a physician-in-training is better able to approach ethical uncertainties and difficulties with an organizational framework for achieving clarity in difficult or ambiguous circumstances. My recommended use of the SOAP note is as follows:

1. The subjective component of the SOAP approach to ethically based medical decision making is focused on the resident. Specifically, residents are asked to state the problem in their own words, from their own perspective. This can take the form of “I am uncomfortable with . . . .” Initially, when residents state the problem, there is no emphasis on being more or less specific. The clarity comes later, after a more thorough exploration of the problem.
2. The physician-in-training is then asked to present the objective facts of the problem or case, including any relevant medical and social factors. Making a list can be helpful.
3. An assessment of this objective information in the context of the stated problem is then undertaken. At this time, it is appropriate to revisit the subjective component and restate the problem in more specific terms. The assessment must take into account any relevant concepts in medical ethics, as well as any human values information that may have an impact on decision making.
4. Finally, a plan is then developed to address the subjective problem. A number of alternative solutions may be outlined and explored. There is no emphasis on closure at this point but rather on the implementation of a plan that will lead to closure. The plans can be specifically related to the stated subjective problem; alternately, at times it is appropriate for the plan to lead to consultation with an ethicist or hospital ethics committee.

This use of the SOAP format as a teaching tool for value-based medical decision making in the medical ICU has proven helpful in my work with medical students and medical residents. I, therefore, recommend it as a useful teaching tool.

Robert S. Crausman, MD, MMS, FCCP
Primary Care Internal Medicine Residency Program
Memorial Hospital of Rhode Island
Pawtucket
Brown University School of Medicine
Providence