Uncle Marvin Test: a patient's guide

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If you have a blood clot in your leg, and your doctor tells you not to worry, you just may want to ask about Uncle Marvin.

There are few relationships traditionally more sacred than that between patient and physician. As a patient, you expect both an empathetic ear and a compassionate heart. As a physician, you have sworn an oath, declaring allegiance to a tradition that for more than two millennia has pledged to act always "for the benefit of my patients . . . for the benefit of the sick."

Regrettably, many of these fundamental principles are increasingly under attack.

Paradoxically, one of the most important challenges we are just beginning to face represents an outgrowth of one of the most exciting and progressive trends in clinical research -- "evidence-based" medicine. The goal of evidence-based medicine is to critically evaluate different diagnostic and therapeutic procedures.

Increasingly, such studies are detailing instances where expensive MRI scans, elaborate blood tests, or new high-tech drugs don't actually make a difference in treatment, and thus are not medically indicated.

As a consequence, patients are now spared considerable -- and unnecessary -- anxiety and discomfort, while the health care system is spared additional expense.

Insidiously, under the rubric of evidence-based medicine, a number of studies addressing the "cost-effectiveness" of different procedures have now started to appear in many well-respected medical journals. One such study asked whether patients with blood clots in their legs are likely to harbor undetected cancer. While the authors found a significantly increased risk of cancer in these patients, they concluded that extensive cancer screening "does not seem to be cost-effective," and thus, generally should not be done.

A second recent study examined whether patients should be screened for constricted blood vessels in the neck. Again, the conclusion was that while affected patients would benefit from surgery, screening itself was not "cost-effective."

Although these studies may seem like natural and appropriate extensions of the original investigations of medical efficacy, they are fundamentally different. While much of the earlier research focused on the benefit to the individual patient, the two studies cited above implicitly or explicitly urge physicians to make decisions on the basis of economic considerations.

That is, physicians are to consider not only the benefit to the patient, but also the cost to the entire system.

The best way to really appreciate the difference between these two perspectives is to apply what we call the "Uncle Marvin" test, which simply involves asking how the physician would treat a favorite uncle.

If a diagnostic procedure isn't medically necessary, Uncle Marvin would be encouraged to avoid it; however, if a particular procedure might be beneficial, than you can bet Uncle Marvin would be encouraged to get it, whether or not it was considered "cost- effective."

The real tragedy, of course, is that all patients deserve to be treated like Uncle Marvin. Does cost matter? Of course it

does, but cost-effectiveness must not be allowed to replace medical effectiveness as the fundamental standard for patient care.

We believe physicians should always act in the best medical interest of the individual patient. To do otherwise violates the essential trust that constitutes the core of this most ancient and increasingly fragile relationship. Patients are burdened enough by concerns and fears about themselves; they should not have to worry about the motivations of their physicians as well.

Abstract (Document Summary)

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