Rational Ignorance

Diagnosis is arguably at the heart of “the art of medicine.” That is especially true for those drawn into the field of internal medicine, for whom deciphering the pieces of the puzzle and arranging them into a definitive, unifying diagnosis is the ultimate thrill. What to do about it, well, that can be figured out or looked up after the fact. The first step is always finding the answer to the question. But what about when that elusive diagnosis isn’t clear, and the only means to finding the answer is potentially devastating to the patient?

Mr. S was a 54-year-old man with an interstitial lung disease not otherwise specified, based on an inconclusive biopsy from years earlier, who’d spend the last month in the hospital, when he ended up under my care in the ICU for further management. From our first meeting, he made it clear what he did and didn’t want: he wanted to get better if it was possible, but he wanted an honest answer if it wasn’t, and then he wanted to go home. No more intubations, no more prolonged hospitalizations. That was that.

But he didn’t get better, no matter what combination of antibiotics, steroids, and immune modulators we came up with. And then came a new thought – was there any chance that another lung biopsy could reveal a potentially reversible, i.e. treatable, process? A lung biopsy meant surgery, which would necessitate an intubation, but this was in the hope of gaining new information, so didn’t that make it okay? After much discussion, and the acknowledgement by all involved that the risks were high but there remained a tiny sliver of hope, he agreed to the elective intubation and surgery.

The next two weeks were a series of sedation vacations, transient arrhythmias, spiking fevers, creatinine bumps, and failed weanings, all leading up to what we knew was going to happen. The biopsy result was indeed conclusive, but it confirmed that there was nothing more to be done. And so, with his family at his bedside, the patient was sedated to comfort and then extubated, passing away within hours, in the same ICU where he’d hoped not to die.

The ultimate end for this patient was inevitable; he was going to die, no matter what course of action we took, and it was going to be sooner rather than later. Initially I held on to my justification for what had occurred. Yes, the cost of pursuing the biopsy might be immeasurably high, but he understood and accepted the risks, trusting the “expert” opinions of his doctors. And we couldn’t know for sure if he would’ve ever made it home, even without the surgery.

But while preparing this vignette, I learned the concept of “rational ignorance.” The term speaks for itself, and is very fitting for this particular scenario. Did we truly have this patient’s best interests in mind when we pushed for the biopsy, or was it merely that our unease at our own ignorance was enough to convince ourselves, and then him, that it would make a difference? In the end, we got our answer, but he
paid the price. I was never able to ask him if it was worth it, but I no longer have the luxury of rational ignorance since I’m sure he would only tell me what I already know.

Lindsay Hoffman