EDITORIAL

Rooting. . . *against* the patient?

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Sorry, that title wasn't fair. I mean, *of course* no one roots against their patients! Absurd, haha, my god man! Except…what else do I call that feeling when I soooort of hope that this really is a torsion now that I've committed a teenager to surgery? Surely a pearlescent, pink testis is a win, but then, what of me? What kind of urologist flubs the archetypal emergency consult? No smug fist bumps occur at confirmation of a mottled gonad of course, but isn't there something about being correct that feels… nice? Must I find consolation in the dusty adage, "If you're not taking out a few normal appendixes, you're not operating enough"?

The concept of differential diagnosis is testament to the fact that the huge spectrum of pathology has a limited set of manifestations. A geyser of acid reflux can feel like a heart attack; an inexplicably sore leg can be a pulled muscle or a tumor tenting the dura. We use the language of "red flags" and "zebras" to keep the bad ones front-of-mind. Still, we hone our clinical radar to rank the possibilities and we want to be correct. When we make management choices and deal with the fallout, the stakes suddenly rise, as our thinking is transferred from our brains to patients' bodies in the form of a testis removed or a renal mass left to smoulder.

I (*We? Anybody?*) have felt this disquiet of a number of times. I perseverate a bit over a hypoechoic 1.5 cm testis mass with a reasonably convincing physical exam because I can't walk back from an orchiectomy for an infection or a bleed. Seeing the pathology report for a benign testis is a bit deflating and explaining to the 26-year-old how this came to be is somewhat uncomfortable. Seeing the seminoma synoptic is validating, but surely the surveillance and survivorship this man now faces are bigger problems?

Sometimes, the issue is muddier, although the stakes perhaps even higher. Consider the radical cystectomy with negative pathology. I know that p0 status is a big win for the patient and suspect that it doesn't mean the bladder was actually just fine but it still raises the spectre of the overcall, and urinary diversion is a big price. In the 30 seconds after seeing the report, and as I prepare to see the patient, would this have been easier if there had been a touch of residual tumor in that specimen?

A couple more examples before I try to think about what this feeling really is. Hydronephrosis caused clearly by long radiation strictures and not faulty anastomotic suturing is still bad news. Absolution from technical fallibility is no salve, but maybe the slightest solace? Excavating an oncocytoma makes us yearn for a pathognomonic test, and maybe a grade 1 chromophobe? Choosing surveillance for a 3.5 cm renal mass in an 83-year-old is a data-informed, good decision much of the time; it is, however, a sort of bet — perhaps explicit — against that patient's very long-term survival. We expect their natural life to run its course before the tumor determines it, but we are not really expecting them to celebrate their 100th.

Reading this, I have some trepidation around the whiff of egotism and insensitivity. In highlighting a fleeting puzzlement, I don't mean to overstate it. It's really not a syndrome or marker of misanthropy or selfishness; in fact, these feelings are rooted in the opposite. We run up against the interface of our diagnostic capabilities and the true state of the patient *all the time* (our orchalgia and idiopathic overactive bladder patients spring to mind) and have to make a call, appropriately consequence-weighting the differential. In the examples above, the choices made are indeed rational, patient-centered ones based on the available information. The *results* of a decision may be irksome or even regretful, but they do not retroactively debase the quality of the decision at the time it was made.

Some of this no doubt relates to the well-established cognitive bias of loss aversion (though in this case the deed is done). We are more unhappy with the loss of $50 than we are happy when we win the same amount, and when the outcomes of our clinical decisions do not meet our expectations, we may overweigh feelings of regret and the stress of communicating these outcomes with patients. This also portends the

risk of recency bias — when a low-probability event is in the immediate past, we are likely to think it more common and therefore higher in our next differential. Less fancy than slipping into mental heuristics is the simple fact that we want to be correct. We are the central character and the hero in our own lives and when euthymic, we must believe that we are capable and well-intentioned. When the world doesn't align with this, the dissonance is unpleasant.

Perhaps by strategizing how to manage this phenomenon, I'm rendering false pathos out of whole cloth and waxing philosophic. Still, I find it vexing, and it dovetails with managing actual complications, so here we go.

First, recognize that it's not about the physician. We ought to feel things as clinicians, so I'm not advocating the depersonalization that is a hallmark of burnout (see the excellent June 2021 *CUAJ* supplement), but rather that the patients are the focus, and we wish the best for them and always act in their best interest.

Second, reconcile with the limited resolution of our diagnostic apparatus. We can think endlessly about underlying pathology and etiology, but the tools we have to reach conclusions are limited. When a test simply can't tell us *the* answer, we use our skills to choose a path forward anyway. The testis may be benign, but the choice to remove it was appropriate.

Third, if you worry about or perceive resentment, call upon your medical communication skills. When making recommendations, conceding uncertainly and laying out the possible futures is appropriately humble, and is effective expectation management. Similarly, cheerleading when less-serious outcomes occur (the normal testis at exploration, the oncocytoma or inflammatory testis mass at resection) shows that we act in patients' best interest and are indeed relieved when our suspicions are not confirmed. We have toolkits for breaking bad news and disclosing complications that facilitate this process.

Last, reflect on your decision-making; it may actually be that there was a gap or a ball-drop to learn from. Even if not, you can now "update your priors" about the clinical scenario, while remaining vigilant about recency bias the next time you encounter it. Decisions don't happen in a vacuum: they fall within the matrix of evidence, plausibility, and experience. If your thinking was sound, it will be sound the next time.

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