

## The idea of adequacy

Gary Simpson\*\*

<sup>a</sup>Unit 1 Penshurst, 32 Emonyeni, Hillcrest

\*Corresponding author, e-mail: [drgcsimpson@gmail.com](mailto:drgcsimpson@gmail.com)

**“Deceptively simple, endlessly complicated”**

These are the words that flash in my mind when approaching clinical decisions. As I have progressed in my career and accumulated knowledge, these words remain true, re-enforced time and again.

Balancing what is quoted as “normal” with the clinical tools I have at my disposal and applying them to my patients to find their “normal” is ever challenging. ‘Learning’ my patients remains deceptively simple but endlessly complicated.

The question is simple: “More fluids?” The answer to this question is NOT

Herein lies the topic of this correspondence; and, it is found throughout our clinical reasoning. Not what is normal, but what is adequate and appropriate for this patient with this pathology and at this time. The dynamic idea of adequacy. “What is the appropriate MAP (mean arterial pressure) to achieve?” “What sats reading is appropriate for this patient?” “What targets will I defend and which will I tolerate?”

“What is adequate and appropriate for my patient?”

At medical school, and as I teach more interns, I realise that a subtle way to assess their maturity and development is to talk about the idea of adequacy: their ability to debate and defend their chosen target; their confidence to allow sats (saturated oxygen) to drop to 88% in a COPD patient; their ability to calm the panicked nursing staff; their ability to titrate inotropes to reach a target MAP during neuroprotection; to tolerate an elevated PaCO<sub>2</sub> level with normal pH; to take into account the shift in a patient’s autoregulation curve during anaesthesia; and, to buck the trend of a sedation hold in a ‘precious airway’

knowing the benefits of a sedation hold do not outweigh the risk of losing an airway.

I always encourage my colleagues to report vital signs with terms like ‘appropriate’ rather than ‘good’. “Mr Smith has an appropriate urine output of 0.8mls/kg/hr” is far more helpful than “Mr Smith has good urine output”.

This concept loosely extends to situations where some colleagues prefer to treat numbers and monitors rather than the patient in front of them. The old adage applies: “If a single number on your display is ‘off’ then it’s the monitor, if two numbers are ‘off’ then it’s the patient”. (Obviously I’m not advocating ignoring information – rather critical analysis of it.)

Recently, an Emergency Department colleague of mine was horrified, when I was reviewing a patient I suggested we aggressively wean his adrenaline. That was until I shared the patient’s outpatient notes with him. The patient was known to our cardiology team with end-stage dilated cardiomyopathy, who presents monthly for follow-up. However, almost like a script, his low blood pressure (BP) was flagged; and, an enthusiastic medical officer readied an inotrope, placed a central line and prepared for an arterial line. When the patient walked in, he greeted everybody he knew and waited his turn in triage for his vital signs to be taken. However, despite him reassuring all the staff of his condition, he received a new line and a rush from his newly initiated inotrope boost! Thus, an appropriate and adequate BP for this particular patient is not the same as an appropriate and adequate BP for any other patient. Yes, a low MAP is not normal, but it is normal for him.

Adequate and appropriate targets are essential in our day-to-day clinical reasoning; and, the idea of adequacy is integral to our daily practice.

Received: 14-11-2015 Accepted: 14-12-2015