Leaving the Equipment off the Field

Imagine Josh Allen dropping back to pass with the Bills trailing by five in the closing seconds of the Super Bowl. He spots a receiver streaking toward the end zone, cocks his arm—and suddenly realizes he doesn't have the football. All he can do is wave helplessly as time expires.

Ridiculous? Of course. No professional athlete would willingly take the field without the most fundamental tool of the game.

Yet in hospital medicine, we occasionally do the clinical equivalent.

We tackle some of the most complex diagnostic challenges in medicine while leaving one of our most valuable resources sitting unused on the workstation in front of us.

The Comfortable Trap of Delegation

There is a subtle comfort in ordering a subspecialty consultation.

A complex patient arrives. The diagnosis is uncertain. The stakes are high. We place the consult, send the message, and somewhere in the back of our minds comes a reassuring thought:

"The experts are on it now."

Consultants are invaluable. Every hospitalist can recall countless occasions when a consultant identified a diagnosis we never considered or recommended a therapy that changed the patient's course. Their expertise is indispensable.

But consultations are designed to **augment** our clinical reasoning—not replace it.

A recent case served as an uncomfortable reminder.

The Anatomy of a Miss

A medically complex patient was recently admitted to one of our hospitalist services. The diagnosis remained elusive despite an extensive evaluation and the patient was unstable, so an appropriate subspecialty consultation was requested.

For a variety of reasons, however, the consultation never became a formal bedside evaluation. Instead, it evolved into what has become increasingly common in modern medicine: a series of secure chat messages and brief electronic exchanges.

Recommendations were offered remotely.

The advice was accepted. Treatment changed. Everyone moved on.

Except no one had actually identified the underlying diagnosis.

The consultant had not personally evaluated the patient or synthesized the full clinical picture hidden throughout the electronic record. Equally important, no one on the primary team stopped to ask whether the recommendations truly fit the entire story.

The patient was ultimately discharged on a treatment plan that was incomplete and, in retrospect, inappropriate.

The easiest response is to criticize the consultant.

That would also be the wrong lesson.

Consultants often provide opinions while juggling clinics, procedures, emergencies, and dozens of patients. A curbside opinion is exactly that—a curbside opinion. It was never intended to substitute for comprehensive clinical reasoning.

The hospitalist remains the physician with the widest view of the entire game.

The Oracle Problem

Sometimes we unintentionally treat consultants like modern-day oracles.

We ask a focused question, receive an answer, and instinctively assume the recommendation represents the complete truth.

But medicine rarely works that way.

Every consultant sees the patient through the lens of a particular specialty. The hospitalist is uniquely positioned to integrate all the pieces into one coherent picture.

That responsibility cannot be delegated.

The Equipment Sitting on Our Desk

Today's hospitalist practices in an era unlike any before.

Evidence-based clinical resources such as UpToDate, DynaMed, and Open Evidence are no longer simply electronic textbooks. Increasingly, they incorporate sophisticated search capabilities and decision-support tools that rapidly synthesize current medical literature, generate broad differential diagnoses, identify unusual disease associations, and highlight overlooked possibilities.

These resources do not replace clinical judgment.

They strengthen it.

Had someone spent ninety seconds entering this patient's constellation of laboratory abnormalities, symptoms, medications, and clinical course into one of these evidence-based resources, an alternative diagnosis would likely have appeared prominently in the differential, along with recommendations for confirmatory testing.

The diagnosis wasn't hidden.

The information was sitting inches away.

We simply never picked up our equipment.

The Efficiency Paradox

Every hospitalist understands the reality of modern inpatient medicine.

An eighteen-patient census. Multiple admissions before lunch. Rapid responses. Family meetings. Discharge barriers. Three secure chats arriving while you're still answering the first one.

Under those conditions, accepting a quick recommendation can feel like the fastest path forward. Ironically, shortcuts that bypass careful thinking often become the most time-consuming decisions we make.

Missed diagnoses generate additional testing, prolonged hospitalizations, readmissions, unnecessary treatments, frustrated families, and endless chart reviews that consume far more time than a brief literature search would have required.

As one of my colleagues jokingly observed, *"Nothing takes longer than the shortcut that didn't work."* There is more wisdom in that statement than we'd like to admit.

Step Up to the Plate

None of this argues for fewer consultations. Quite the opposite. The best patient care occurs when thoughtful consultants and thoughtful hospitalists challenge each other's thinking. But every recommendation deserves to pass one simple test:

Does this explanation truly account for everything I know about this patient?

If the answer is "I'm not sure," that uncertainty should trigger curiosity—not complacency. Three habits can help:

1. Trust—but verify.

A consultant's recommendation is enormously valuable, but recommendations offered without a complete evaluation should be viewed as informed guidance rather than unquestioned fact.

2. Bring your equipment onto the field.

Evidence-based clinical reference tools and modern decision-support systems are not admissions of ignorance. They are simply another piece of professional equipment—no different than an ultrasound, a CT scanner, or an echocardiogram. The best physicians use every reliable tool available.

3. Never surrender ownership.

Hospitalists are the only physicians continuously integrating the patient's history, physical examination, laboratory data, imaging, consultant recommendations, family concerns, and day-to-day clinical trajectory. That comprehensive perspective belongs to us, and so does ultimate responsibility for the care plan.

The Final Play

The next time a complicated case leaves you with an uneasy feeling after a hurried curbside recommendation, resist the temptation to assume someone else has solved the puzzle.

Open the reference. Challenge the differential. Ask one more question. Think one step deeper.

The goal isn't to second-guess our consultants. It's to become even better partners with them by bringing our own complete clinical reasoning to every decision.

Josh Allen would never walk onto the field without a football.

Aaron Judge would never step into the batter's box without a bat.

Hospitalists shouldn't walk into complex diagnostic decisions without every evidence-based tool available.

The best clinician on the field isn't necessarily the one with the narrowest specialty or the loudest voice. More often, it's the physician who combines experience, curiosity, humility, and the discipline to use every tool available in service of the patient.