Medical omniscience

W G Pickering

The incalculable number of medical problems and questions to which the medical profession has no certain answer is balanced by the incalculable number of times that its members none the less provide one. Many patients, not unnaturally, want definitive answers on diagnosis, prognosis, and side effects. When doctors are uncertain or do not know, they think that the patient should believe otherwise. An answer, any answer, it is felt, assuages the patient's fear and anxiety, as well as confirming a doctor's omniscience. Abating a patient's anxiety indubitably promotes their health, but what if the answers given are wrong?

Doctors can be comparatively certain about some matters—for example, uncomplicated appendicectomy or antibiotics for impetigo. They can give an educated guess about some others—for example, Bell's palsy, treated asthma—and have little idea about others—for example, the outcome of some major operations, the value of antidepressants, the side effects of many drugs. That they sometimes dissemble with their confident answers is an involuntary habit that can be medically dangerous, not to say dishonest.

The dangers of a premature diagnosis

The diagnosis is often unknown in the early stages of many illnesses. There are grave risks in authoritatively suggesting a diagnosis at this stage. Consider a child with the common medley of symptoms of abdominal pain, fever, and vomiting, which can be the start of a score or more of childhood diseases, some benign, some, if missed, disastrous. The general practitioner tells the anxious mother: "I think it is mesenteric adenitis [benign and self limiting]. Give fluids and paracetamol and your child should soon be better." Sensible of other possibilities, the doctor continues: "Call the surgery again if things do not settle." The mother, who privately thinks that the problem might have been appendicitis, has had her anxiety moderated and, not unnaturally, takes her eye off the ball. Her threshold of suspicion is raised: doctor's diagnosis is equivalent to doctor's understanding. New and changing symptoms in her child are attributed to the doctor's diagnosis. The child does not get better, and the mother calls the surgery again three days later. The child is admitted with a ruptured appendix and an abdomen full of pus.

The provision of a named diagnosis changed the medical course by altering the mother's perception and subduing her natural instinct. (It also made it less likely that the doctor would be called again in the near future.)

Consider a 59 year old man with a history of peptic ulcer who reports that he has heartburn and difficulty in swallowing. The doctor opines that it is the old problem, although the symptoms are different. In truth, the doctor is uncertain but provides a satisfying end to the consultation (for patient and doctor) by saying, "It is the ulcer. Take these pills, but come back and see me if things don't settle." The heartburn improves, but the dysphagia does not. Doctor has said it is the ulcer, so the patient's anxiety is ameliorated. Patients often have a touching faith (and trust) in doctors' edicts, which sustains them throughout mounting medical problems. Twenty weeks later the patient returns to the doctor and an oesophageal carcinoma is diagnosed.[1]

The provision of a diagnosis again changed things, and the beneficiary was not the patient. Notice that these sorts of incidents often pertain to potentially treatable diseae.

The safety of uncertainty

Being uncertain is part of normal medical practice. However, doctors rarely write, "Don't know" in the records. It is as though the doctor needs to come up with a diagnosis so as not to seem impotent or deficient to the patient (and colleagues). Yet it is safer to candidly write, "Diagnosis: don't know" and then append a differential diagnosis. This method has the important advantage of keeping the patient and doctor alert, so deterring complacency. Also, any new doctor reading "don't know" in a record has his or her attention immediately alerted and is less likely to follow the wrong path.

Signs and symptoms, even investigations, must not be squeezed into an unpromising diagnosis. Hospital doctors and general practitioners alike know how often they are dazzled by one diagnosis, even when there is an odd feel to the case. The eventual correct diagnosis makes this thinking paralysis poignantly evident.

Innumerable other questions, including operative outcomes, side effects, and prognoses, can only

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Don't knows

sometimes be confidently addressed. A medical response of "I don't know the exact answer" is a preamble to be seriously considered. Patients may, eventually, appreciate such candour, for they can choose to decline the proposed medical intervention without torturing themselves that they are missing a sovereign remedy—one which, in truth, may be anything but.[2]

Patients should learn that "don't know" does not mean suboptimal medicine or "don't care." Doctors should understand that "don't know," especially in matters of diagnosis, is a signal, not least to themselves, that vigilance and thought must be stepped up. Provided that the term is always seen as the flashing light indicating unfinished and perhaps urgent business, it is indicative not of clinical weakness but of clinical strength.

1 Martin IG, Young S, Sue-Ling H, Johnston D. Delays in the diagnosis of oesophagogastric cancer: a consecutive series of cases. *BMJ* 1997;314:467-70.
2 Pickering WG. Does medical treatment mean patient benefit? *Lancet* 1996;347:379-80.

Doctors' autonomy

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It was 1947. As the door closed behind Lord Moran, Nye Bevan turned to his permanent secretary, who was pouring generous measures of pre-war whisky. "Rotten negotiators, doctors. I would have given consultants twice that salary if he'd asked."

Sir Bartholomew sat down before replying doubtfully, "He certainly seemed anxious to conclude negotiations, even if it meant accepting a rather low offer." He paused. "Minister, what were you hoping to achieve?"

"Keep down expenses in this new National Health Service, obviously."

"Hmm." Sir Bartholomew frowned. "Minister, no doubt you recall the proportion of costs that will go on doctors' salaries." He slid a sheet of foolscap in front of the minister and tapped a column of figures. Bevan scanned them quickly and registered surprise.

Sir Bartholomew smiled. "Not much, is it, Minister ? The real expense is here." He pointed to a different column. "Drugs, investigations, other treatments. It all mounts up. And who tells patients they need these things?"

"The doctors, naturally. That's their job."

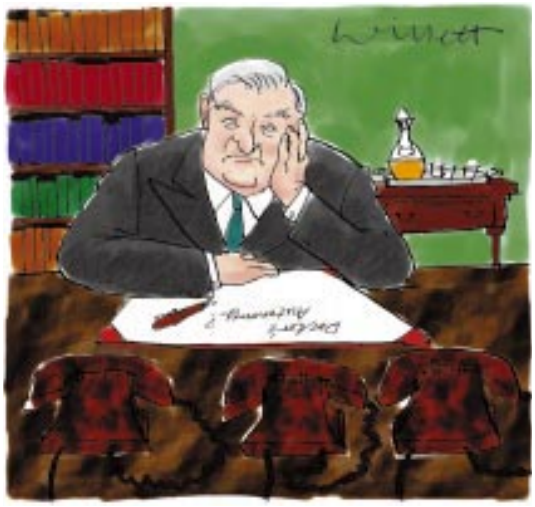
"Precisely. Negotiating a small salary for consultants will do little to contain healthcare expenditure. What you should have done, Minister, was to negotiate away their power. It is not inconceivable that Lord Moran's motive in agreeing so readily to a modest annual financial emolument was to draw negotiations to a premature close before you realised this."

"So," said Bevan slowly, "paying the doctors off was a waste of money."

"Not at all, Minister. Merely insufficient. To control expenses, you need to…."

Bevan interrupted. "Control the doctors. I see that. But I can't tell doctors when to prescribe what to whom. They'd never allow it. Professional autonomy. Clinical independence. Duty to the patient."

Sir Bartholomew helped himself to another drink. "Minister," he began, "the need for health care is infinite. The amount we can spend on it is not infinite. And it is our job to apportion the nation's resources. Ergo, in a nationalised health service it is our job to decide who gets what, not the doctors'. It is far too important to be left to lay people. It is the job of professional administrators and managers. That is to say," he corrected himself smoothly, "of elected misters."



Bevan was unconvinced. "These are independent professionals. They won't want to become civil servants!"

It was Sir Bartholomew's turn to look puzzled and indeed a little shocked. In his view, such an effortless gravitation, were it to occur, should strike doctors as supreme, undeserved good fortune. He let it pass.

"Of course not, Minister. You can't take independence away from them. You wait for them to give it up voluntarily. All it requires is patience and a strategy."

"Strategy?"

"Restructuring. Firstly, you take the burden of administration from doctors by developing a complex management structure to run hospitals. Then, once the running of the hospital is out of their hands, rearrange things so that hospital administrators employ doctors."

"I can understand doctors employing administrators," said Bevan, "but not the other way around."

"Of course not. It's ridiculous. So you dress it up. You point out that the new structure allows doctors no say in management. You suggest they become part of the administrative hierarchy to have a voice in decisions affecting clinical services."

"You mean, make doctors accountable to administrators to get back some of the influence they had in