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Editor's choice

Knowing when not to operate

Good surgeons know how to operate, better ones when to operate, and the best when not to operate. This famous saying surely applies right across medicine. It takes wisdom, experience, strength, and courage not to intervene.The minute that a surgeon cuts the skin or a physician prescribes a drug, harm is done. The benefit of a treatment will have to exceed that harm before the doctor is doing good. Unfortunately, many treatments have no benefit or only marginal benefit. Thus doctors can dedicate their lives to medicine and at the end have done only slightly more good than harm.

These thoughts are prompted by this week's journal. An Edinburgh group looked at the association between varicose veins in the legs and the "symptoms" of varicose veins (p 353). The prevalence of trunk varices was 40% in men and 32% in women, and the "symptoms" of varicose veins—heaviness or tension, feeling of swelling, aching, restless legs, cramps, itching, and tingling—were also common. Unfortunately, the association between varicose veins and the symptoms was too low to be clinically useful. The implication is that surgery won't do much for symptoms. Yet the NHS in England and Wales carries out 50 000 operations each year and spends £400m-600m treating chronic venous insufficiency.

Cervical screening is another major activity of the NHS, and for years the inverse care law applied in that many women at low risk were screened repeatedly while many women who died of cervical cancer had never been screened. Now the NHS does a better job of screening the right women, but debate continues on the value of screening postmenopausal women who have had several negative tests. Authors from London and Nottingham have constructed a mathematical model to look at the implications of stopping screening such women (p 356). They conclude that if such a policy began when women were 50 then there would be resource savings of 25% for smear tests and 18% for colposcopies—at a cost of perhaps two cases of invasive cancer for every 100 000 women each year. Is that a bargain? How can we answer such questions?

What might doctors do with the time saved from operating on varicose veins or screening postmenopausal women for cervical abnormalities? Enjoy themselves might be the best answer, but probably they will spend much of this time reassuring patients with somatisation disorders. A group from Liverpool has been studying doctors' techniques for explaining such problems, and many are doing badly (p 372). Don't deny the problems or collude with the patient's explanations. Rather, try to provide a tangible explanation, exculpation, and an opportunity for self management.

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