The place of judgement in medicine

'The patient may well be safer with a physician who is naturally wise than one who is artificially learned.'[1]

'Working to rule can do even more harm in medicine than it does in industry. The practice of medicine requires a fresh judgement for every patient.'[1]

THESE quotations come from Theodore Fox's article 'Purposes of medicine', published in 1965. Since then there has been little emphasis upon the need for wisdom or judgement in medicine.

Despite the efforts of academic general practice, graduates from our medical schools seem to have been persuaded that medicine can be practised by some form of rule book. If the recommended procedures are followed the right diagnosis and appropriate treatment will almost automatically ensue and there should be no room for uncertainty. As a result they find the inevitable uncertainties of hospital medicine and even more those of general practice hard to cope with.

The practice of medicine is risky and difficult. Risk taking is necessary because the price of being on the safe side is often intolerable. Being on the safe side leads to waste of resources and iatrogenic harm. When the prior probability of disease is low investigations lead to large numbers of false positives which prompt further investigation and spurious diagnoses. Using drugs to lower blood pressure exposes the person, recategorized as a patient, to their side effects and to the consequences of perceiving themselves to have a life threatening disorder. While prophylactic mastectomy diminishes the possibility of death from breast cancer, it must usually be judged that the price of safety is too high.

Wisdom and judgement are close friends. Both rely on adding weight to the imponderable, value to that which cannot be quantified. Unfortunately, judgement has been mocked by the tautologous addition of 'value' to the word. Tautologous because judgement is about adding values and weights to probable consequences of action. Alas, it is easier to criticize folly than to extol wisdom. Wisdom and judgement seem to be hard to grasp, nebulous virtues which may appear to be the prerogative of the aged, if not the senile.

There is little or no obvious recognition of the value of wise judgement. Occasionally one reads in the obituary columns of somebody whose curriculum vitae was not outstanding but who was seen as a 'doctors' doctor'. It would not be a wild guess that such physicians were valued by their colleagues, not because of their learning or their skill, but because their actions were tempered by wise judgement.

Even the most apparently straightforward consultation requires the exercise of judgement in order to make wise decisions. How certain is the diagnosis? What information should the patient be given? Should uncertainty be shared? What are the consequences to the person of the disease label? What is the probability that investigation will clarify rather than confound? What are the risks of missing the diagnosis of a serious disorder at this stage of the illness? What are the costs, risks and potential benefits of treatment? What prompted the decision to consult — pain, anxiety about the meaning of symptoms or the need to take up the 'sick role'? As a general rule reliable and proven answers to these questions do not exist, yet they cannot be ignored if doctors are to offer wise advice.

The first requisite for wise judgement is appropriate knowledge. This extends beyond knowledge of those symptoms and signs which indicate disease, to include knowledge of prior probabilities. These prior probabilities are very different for general practice patients and those patients referred to hospital. Judgement requires the ability to distinguish between those things which are relatively certain and those things which are matters of opinion. It needs to be underpinned by that healthy scepticism which offers the possibility of setting a limit to error.[2] Scepticism which provides some protection against fashion, some protection against accepting the received wisdom of superiors, teachers, consensus and the written word.

Experience contributes to judgement and is of two kinds. Some experience is generic, that is it refers to patients in general rather than in particular. 'In my experience such cases do well on...' Such experience may be a fallacious guide and do little more than allow the repetition of the same mistakes with increasing confidence. It is certainly no substitute for the randomized controlled trial.

The other sort of experience is patient specific and relies on knowledge of the individual. It is much more a characteristic of general practice than of hospital medicine as it is based upon continuity of care and observations made over a number of episodes of dis-ease and over time. A recent paper has demonstrated that such knowledge substantially improves the doctor's ability to predict the presence of urinary tract infection.[3] Knowledge of the people who may have disease is sometimes as important as knowledge of the disease which people have.

'Doctors, like other people are "hot for certainties in this our life", and, like other people, they would welcome any commandment that could not be questioned and thus absolved them from painful decision.'[1] The exercise of judgement, no matter how wise, is a risk taking behaviour and discomfits those who are 'hot for certainties'. As consensus statements, guidelines, advice about accepted practice and statements about quality assurance multiply, those who do not follow not only feel that they may be in error but also that they may, in the event of misadventure, be at risk of medico-legal proceedings. For example, it is difficult to ignore the guidelines recently promulgated by the British Hypertension Society which suggest a more aggressive approach to drug treatment in elderly people than in the relatively young.[4] I believe these guidelines to be based on a false premise but should I choose to ignore them and my patient suffers a stroke I can imagine being arraigned in court. On the other hand if I treat and the person has a stroke it will be ascribed to an act of god. Yet such guidelines are based upon evidence which overvalues improvements in the prevention of morbidity and undervalues the consequences of labelling and the side effects of treatment. They oversimplify the complex and suggest that data derived from populations are applicable to every individual who seeks help.

Doctors, by a person's decision to seek advice, are given a mandate to exercise judgement on that person's behalf. This, at least to some extent, flies against the popular movement to grant patients full autonomy and the right to share. If the doctor decides that it is inappropriate to mention the distant possibility that the symptoms might betoken multiple sclerosis he or she is guilty of a degree of paternalism. Doctors cannot ask those who have cancer if they want to know the truth, doctors must exercise judgement as to the gains and benefits of such disclosure and face the possibility that their judgement will be wrong.

The exercise of judgement in medicine is analogous to the exercise of judgement in the courts of law. Having heard or collected the evidence the physician reaches a decision which is a

probability statement which in the absence of certainty carries the possibility of error.

There is a place for rules in medicine, rules which can only be broken in exceptional circumstances and which if ignored carry the possibility of grave harm. Such rules can only properly exist when there is good evidence of their value. For the most part good rules are concerned with potentially life threatening situations, in which failure to make an appropriate response may have serious consequences. In a sense these are simple situations in which there can be no difference of opinion about the immediate necessities.

Such simple situations are the exception and the notion that rules can be devised for medicine as a whole carries the danger of great harm. As knowledge grows rules become more appropriate. Because the nature of a car engine is well understood it is easy to devise rules for detecting faults. Because of our ignorance it is impossible to devise rules which will always apply to the individual who seeks our help.

There is a growing tendency, prompted by a desire to improve standards in medicine, to promulgate guidelines and consensus statements. This is potentially dangerous as it attempts to simplify situations which are inherently complex and not amenable to management by rule. As a result physicians may be forced to act in ways which will harm their patients in order to protect themselves from possible action in the courts.

Most decisions in medicine are not simple and straightforward but require the exercise of judgement to advise the best option for each patient. Attempts to oversimplify, even from the best of motives, carry the danger of widespread iatrogenic harm. We must take care that guidelines remain just that, and are not taken to describe accepted and desirable practice. We need to cultivate judgement and come to accept that its inherent risks are in the best interests of our patients.

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References

1. Fox T. Purposes of medicine. *Lancet* 1965; **2:** 801-805.
2. Skrabanek P, McCormick J. *Follies and fallacies in medicine.* 2nd edition. Glasgow: Tarragon Press, 1992.
3. Nazareth I, King M. Decision making by general practitioners in diagnosis and management of lower urinary tract symptoms in women. *BMJ* 1993; **306:** 1103-1106.
4. Sever P, Beevers G, Bulpitt C, *et al.* Management guidelines in essential hypertension: report of the second working party of the British Hypertension Society. *BMJ* 1993; **306:** 983-987.

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Health checks — time to check out?

THE British family heart study, reported on page 62 of the *Journal*, involved 3850 patients from 26 practices in 13 towns across the United Kingdom. It shows how research in general practice should be done — with the active involvement of general practitioners, other members of primary care teams and local family health services authorities and health boards.[1] It shows that large scale, pragmatic clinical trials which can inform government health policy can be conducted by university departments of general practice. It shows that clinical questions of importance to primary care can be answered within primary care. That is the good news, that health checks have been good for general practice research. The bad news is that the workload generated by health checks is daunting. The most important statistic from the British family heart study paper is that 79% of patients merited follow up for one or more risk factors.

The burden of health checks lies not in screening but in subsequent intervention and follow up. We know from the south east London study that screening for cardiovascular risk in general practice achieves nothing unless an effective intervention is offered to reduce the risk identified.[2] The recently reported three to five year follow up of health checks carried out among 502 men in one practice in Wales confirms this observation.[3] The final results of the British family heart study, and the first year results of the parallel Oxcheck trial,[4] will be published in the near future. Whatever the level of benefit shown, if the resources for effective intervention are unavailable in most practices, it is unethical to continue to offer health checks. But it is also unethical to ditch the baby with the bath water and to abandon all responsibility for preventing coronary heart disease.

Some preventive interventions in general practice are of proven effectiveness and we owe it to our patients to offer them. Much of the confusion about the value of preventive medicine arises from a failure to differentiate between potential risk reduction and the extent to which this potential can be realized in clinical practice. The fact that clinical trials of cholesterol lowering drugs have not shown a reduction in overall mortality does not mean that the epidemiology is misleading and the potential to reduce risk by lowering cholesterol level does not exist. In many ways the epidemiological findings, based on long-term comparison of mortality between individuals and between countries with different cholesterol levels, are more robust than the clinical trials. It does mean that realizing the potential is not easy and depends on finding an intervention strategy which is effective and can be sustained over time. The two primary care interventions which are of proven effectiveness are the treatment of hypertension and the provision of smoking cessation advice and support.[5] We also know that practice nurses have a key role to play in these interventions. In blood pressure management, systematic care from nurses is still the most likely way to achieve success.[6] Similarly, although initial advice from practice nurses to stop smoking is of doubtful effectiveness, systematic follow up of motivated patients by nurses as part of a team approach can achieve a three month sustained smoking cessation rate as high as 19%.[7]

What about exercise and diet? There is little doubt that cardiovascular risk can be reduced by increasing exercise and by following a healthy diet. As lack of exercise and a high saturated fat, low vegetable diet are endemic in the UK, the potential for health gain is great. But the feasibility of giving effective advice within the resources available in general practice remains unproven. There has been only one controlled trial of exercise promotion in general practice reported from the UK, which was limited to two practices in the New Forest and showed a small increase in the number of patients exercising.[8] Until we are sure we can provide effective advice on diet and exercise, there seems little point in investing scarce practice resources. Providing