The campaign for common sense in medicine

On entering medical school we were taught that the most fundamental skill for a medical student to learn was how to elicit an accurate history from a patient, requiring communication skills, an inquisitive mind and, above all, patience. Once the scene was set by the history, the examination would proceed to add depth, colour and clarity to the patient's story-board narrative. History taking should generate a hypothesis, which is either confirmed or refuted by the examination. This generates a working diagnosis, which leads to a minimum of appropriate tests to refine. After all, we can only run after we have learnt to walk.

Historically, this was what made medicine in Great Britain great: methodological reasoning and clinical acumen. Yet increasingly we seem to have forgotten the works of William Occam, Reverend Thomas Bayes and Thomas Hutchinson, and have increasingly developed a 'test first, question later' mentality. We ignore the history, rush the examination and order a smörgåsbord of biochemical, haematological and radiological tests, fishing for a result and then treating it. We concentrate on the most serious or nebulous diagnosis, ignoring the more common or more likely and rarely consider a differential.

At the dark heart of this disintegration of medical practice in the UK is the fear of litigation and the perception of failure by 'missing something'. We prefer to believe in a seemingly flawless and objective 'test' rather than an imperfect and subjective 'judgement'. Making a rod for our own backs, we 'protect' the most inexperienced doctors from making judgements, expecting only those with more experience to do so, and in so doing de-skilling all concerned.

Furthermore, a test might be positive but it is only of use and significance if we have a context in which to place it – raised D-dimer anyone?

What will this cost?

Tests all have costs. For the organization there are both financial and opportunity costs; for the patient there are costs in terms of morbidity (radiation exposure, complications of invasive investigation, hospital-acquired infection during the prolonged stay) and emotional harm, especially when putative diagnoses are raised which may result from false positive or negative tests. Inappropriate tests can also lead both to treatment that is unnecessary, and to more tests, often over a prolonged period (e.g. serial computed tomography scans following discovery of an incidental benign nodule), further increasing patient anxiety and potential morbidity.

Perhaps the biggest cost of ignoring the basic principles of the above approach to the patient is damage to our professionalism and to our profession per se. Doctors are trained to have the clinical skills to elicit the appropriate information and then to use their judgement to weigh up that information effectively and efficiently in order to make both diagnostic and treatment decisions.

The explosion of guidelines might be partly to blame. While they have their strengths, clinical guidelines do not foster a culture of critical appraisal and evaluation of the usual disparate elements in the history and examination, which so often cloud diagnostic decision making. They are often rigid and strait-jacket thinking along specific lines; they are based on typical presentations, when in reality clinical medicine is rarely so straightforward. More importantly they are increasingly enforced by paramedical staff as rules not guidance. For a junior doctor to stray from a guideline leads to criticism and opprobrium from non-medical colleagues.

To use guidelines, the critical appraisal skills for which a doctor has been trained are unnecessary. You don't have to be a doctor to use them.

Fundamentally, we all believe we hear the patient, but do we actually listen to what is said? We can diagnose a pulmonary embolus without touching the patient's bruised chest, cellulitis without asking if the patient's swollen and red leg is normal for him/her and an acute coronary syndrome based only on a raised blood troponin level.

We are all guilty of over-investigating – to cover ourselves, just in case, to 'rule out' unlikely alternatives when the answer is staring us in the face and trying to tell us. All the examinations, research and courses in the world cannot teach common sense; this must be seen first hand in practice, by our students and juniors and we must take the time to teach this and teach it well, for we reap what we sow. BJHM

KEY POINTS

- Patients are over-investigated irrationally.
- History and examination, not tests, are the key to the correct diagnosis.
- Doctors must learn and teach critical appraisal and clinical acumen.
- We must stimulate not stifle free thought.

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