Uncertainty, fear and whistling happy tunes

Katherine Wallis MBChB, MBHL, FRNZCGP

ABSTRACT

Uncertainty in medical practice is ineradicable, despite great scientific advances over the last century. Uncertainty provokes fear, not just in patients but also in doctors. Patients cope with their fear by seeking the advice and reassurance of doctors; doctors, on the other hand, cope by denial and self-deception.

But today, in this scientific, truth-seeking age doctors are encouraged to share their uncertainty with patients in order to 'empower' patients and improve doctor–patient relations. While in theory doctors might agree with this approach, in practice they continue to deny it and instead whistle happy tunes—deceiving both themselves and their patients.

A disclosure of uncertainty requires an acknowledgement of uncertainty and, in practice, the ability of doctors to acknowledge and to tolerate uncertainty is limited.

Whenever I feel afraid, I hold my head erect
And whistle a happy tune, So no one will suspect
I'm afraid.
While shivering in my shoes, I strike a careless pose
And whistle a happy tune, And no one ever knows
I'm afraid.
The result of this deception, Is very strange to tell
For when I fool the people I fear, I fool myself as well![1]

If one thing in this life is certain, it is that the practice of medicine is a practice in uncertainty. Renée Fox,[2] in her landmark studies of uncertainty in medical practice in the 1950s, characterised three types of uncertainty: the uncertainty of medical knowledge, the uncertainty of the practitioner, and the uncertainty in discerning between these two types of uncertainty (is the answer out there somewhere and I just haven't come across it, or has the answer not been discovered yet?). In clinical practice we face uncertainty about the diagnosis, compounded by the inherent variability in how patients perceive and describe their problems; uncertainty about the treatment, as we know patients respond differently to treatments and that applying general knowledge to individuals is flawed; and uncertainty about the role that we are expected to play today: are we to be rational scientist, shaman, social worker or counsellor?

Over the last century great advances in medical knowledge have been made, leading some enthusiasts to believe that uncertainty in medicine could be eradicated. It was hoped that, with enough research, all questions would be answered and that illness and suffering could be dealt with by a rational scientific approach, making intuition and spiritualism redundant. Such hopes, however, look increasingly unlikely ever to be fulfilled, in part because medicine, if it is a science at all, is a science of individuals. There are no great generalisable truths to be discovered and applied; the expression and the experience of illness will always remain unique. Randomised controlled trials will never be able to tell us how a particular individual will respond to a particular treatment. As Kant once remarked, 'Out of the crooked timber of humanity no straight thing was ever made'.[3]

Uncertainty exists in all facets of life, but in the health care context in particular, uncertainty breeds anxiety and fear. There is a Chinese proverb claiming that 'more people die of fear of their illness than die of the illness itself'. As often as not it is fear, born of uncertainty, that prompts a patient to seek the opinion of a doctor. Patients want to know whether their symptoms are significant, what can be done and, preferably, also to be reassured that all will be well. However, given that we must all die one day, there will come a day when all will not be well. It is the doctor's role to sort out and communicate the known from the

The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

THIS ISSUE: Our guest ethicist and GP Katherine Wallis discusses balancing the acknowledgment to patients that medical practice is uncertain with managing their fears and anxieties.

unknown, and to manage the patient's anxiety and fear.

For the doctor's part too, there is fear. From the confusing, inaccurate, or even contradictory information[4] presented we must sort the relevant from the irrelevant and establish a management plan. We can never be certain and yet still we must act, even if only to advise a 'wait and see' approach. And with action, of course, comes responsibility. We can be guided by probabilities, but individual differences reduce our ability to predict from generalities and there is the constant risk of error. Error is unavoidable, not only because of the limitations of medical knowledge and the limits of the human intellect, but also because of the 'necessary fallibility of a knowledge of particulars'.[5] The fact that we must act before certainty can be established (if it ever can be) makes clinical medicine, not a rational science nor an art, but a 'practice'.[6]

Elstein, who spent much of his life studying diagnostic decision-making, estimated that the rate of diagnostic error in medical practice was approximately 15%.[7] This figure has subsequently been corroborated.[8] These diagnostic errors, however, are only errors in hindsight: At the time the diagnosis was made it seemed the most likely, most reasonable and therefore the most correct diagnosis to make. As a doctor in Paget's study remarked '...the errors are errors now, but they weren't errors then'.[9]

Experienced practitioners use heuristics (rapid pattern recognition processes)[3] to reach a diagnosis. This intuitive decision-making process saves time and gives the correct diagnosis most of the time;[10] however there is a price to pay for this efficiency: Predictable error. Sometimes the *most likely* diagnosis, rather than the *correct* diagnosis, is made. As James Reason says: 'Our propensity for certain types of error is the price we pay for the brain's remarkable ability to think and act intuitively.'[11]

In hindsight the correct diagnosis is obvious, but in the complex, chaotic, and uncertain world of clinical practice the *most likely* diagnosis at the time seems the *most reasonable* one to make. Thus there is a trade off between efficiency and accuracy.

In such a mire of uncertainty and error, how can either doctor or patient make a rational decision about treatment, let alone continue to practise? To cope with the fear, doctors employ various strategies designed to reduce either the responsibility or the uncertainty.[12] Responsibility can be reduced by referral, by deferring to guidelines and protocols, or by abandoning the patient in a misconstruing of patient-centred medicine. Uncertainty, on the other hand, can be reduced by specialisation (developing 'special interests'), or by an appeal to 'in my clinical experience' arguments; in other words, the long-favoured technique of denial and self-deception.

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Self-deception is not, of course, unique to doctors. Most drivers consider themselves 'better than average' drivers and 94% of college professors rate themselves in the top half of their profession.[13] Nevertheless, in medicine there is a particularly long and entrenched tradition of self (and patient) deception. The justification has been that, in order for healing to take place, a profession of certainty is required.

Today, while doctors might accept (in theory) that medical knowledge is uncertain, in practice they continue to profess certainty. In practice the art of self-deception is alive and well. In front of patients, doctors instinctively suppress and deny their knowledge of uncertainty[6,14] in favour of providing reassurance and hope. And, given the patient's desire for reassurance, and the essential uncertainty of clinical practice, whistling such a happy tune might just be the pragmatic approach to take.

Katz considers that the denial of uncertainty in medicine has something to do with making sense in a complex and confusing world so that action is possible. There are limits to living with uncertainty; the resultant fear can paralyse. In practice, given that we must act in uncertainty,[14] self-deception might just be essential.

Today, however, doctors are encouraged to take a different approach. They are encouraged to share their uncertainty with patients as a means to improving doctor–patient relations.[15] Disclosure of uncertainty, or truth-telling, is about empowerment, about setting patients free to decide and to act rationally according to their true nature. But does knowledge of uncertainty, the truth, really set patients free?

> The view of the classical Greek philosophers, shared by much, though perhaps not all, Christian theology, is that it does. 'And ye shall know the truth, and the truth shall make you free.' (Gospel according to St John, chapter 8, verse 32). Ancient Stoics and most modern rationalists are at one with Christian teaching on this issue.[3]

Telling the truth is 'good'. Doctors believe this (in theory) and medical regulators promote it.

And yet, for some reason, arguments against truth-telling in medical practice have persisted for centuries. In 1672, French physician, priest and philosopher Samuel de Sorbiere cautioned young doctors looking to establish themselves in practice 'what not to say':

> ...in order to safeguard your interests, I must tell you that medicine is a very imperfect science, that it is quite full of guesswork, that it scarcely understands its subject matter, nor is it familiar with the things employed to maintain it; that the more enlightened only feel their way in it groping amidst a thick gloom; and that after having considered seriously all the matters which may be useful, collected all one's thoughts, examined all one's experiences, it will indeed be a wise physician who can promise relief to a poor patient.[16]

Of course medical knowledge has progressed dramatically since 1672; nevertheless, the net amount of disease and suffering does not appear to have been reduced.[17] Much remains unknown about how best to 'promise relief to a [particular] poor patient'. Thus critics of the uncertainty-sharing doctrine persist, arguing that patients want to deceive themselves, and to be deceived about the deficiencies of medicine, and that, rather than improving doctor–patient relations, such disclosure actually damages the relationship reducing trust, confidence and patient satisfaction.[18] Questions remain, however, as to whether the noted deleterious effect of the disclosure of uncertainty is due to the way the uncertainty was disclosed or the uncertainty itself.

Despite the scientific commitment to truth and the increased access to information today, healing is not a rational science. In practice, we can eliminate neither the uncertainty nor the fear; there will always be room for clinical judgment, for appeals to 'in my experience...' arguments. It is possible that the knowledge of uncertainty might set patients free to choose, but it won't set them free from fear. Nor will such knowledge set doctors free from fear and enable them to act. Perhaps the disclosure of uncertainty does interfere with our effectiveness as healers? Perhaps patients do still need to be set free from anxiety so that they can heal?

The problem with the disclosure of uncertainty is that, not only might it kill off our patients and our practice, but that it might also kill off us. Doctors have some of the worst statistics when it comes to suicide, divorce and substance abuse. Perhaps we should be bolstering, rather than tearing down, the strategies developed over millennia to aid survival in practice? As that well-known physician Dr Hibbert, who chuckles rather than whistles, says: 'Before I learned to chuckle mindlessly, I was headed to an early grave myself.'

Hibbert: Lisa, I'm afraid your tummy ache may be caused by stress.

Homer: Well, that's a relief.

Hibbert: Heh, yeah. Anyway, when it comes to stress, I believe laughter is the best medicine. You know, before I learned to chuckle mindlessly, I was headed for an early grave myself. (chuckles)

Homer: Give it a try, honey. (Lisa tries to chuckle).[19]

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