The Juggler – being wise in the modern NHS

> A virtuous, ordinary life, striving for wisdom but never far from folly, is achievement enough. Michel de Montaigne

In March 2016 I had a fascinating conversation for an hour with two young general practitioners. I shall call them Penny and Eleanor. The purpose was to explore their understanding of being wise in medical practice. Our conversation was wide-ranging with, at its centre, the story of a patient they both knew. I will start with that story (disguised to protect anonymity, otherwise faithful transcription throughout).

> Eleanor: I was just thinking of that patient we both know – she has purely fatigue and she's convinced it's something in her mouth. So it's very difficult. Complaints of fatigue are so common. She's an incredible woman; she's very high-flying, very gifted at what she does, but she has these episodes of profound tiredness where she can't do her music – she plays the piano – and she can't do her composition. She has started to link this with an infection that followed dental treatment and has seen Max-Facs [maxillo-facial surgeon] on numerous occasions and has had surgery which hasn't really helped and although the pattern recognition for the stress side of things is quite common, the specific details of the surgery and her thoughts on it is unique and quite difficult, because she is quite convinced that it's all linked with this infection.
> William: …and she's intelligent and …
> Eleanor: …yes very intelligent, she comes in with everything written on an ipad…
> Penny: …and mind maps - digitally generated.
> William: So every patient is unique and so the challenge is to have a way of thinking about that uniqueness.
> Eleanor: Almost, you have to understand as much where they are coming from. Now this woman is a computer programmer. She is very used to problems being presented to her, and I imagine being able to think ….
> Penny: …very logical.
> Eleanor: …Yes! Very logical, Oxford graduate, very intelligent and having something outside her control, perhaps she can't immediately fix, but she's open to the fact it could be in her head. It's tricky because she keeps going back to wanting more and more surgery, private referrals to Max-Facs.

Pattern Recognition

In her initial description of Margaret's case, Eleanor mentioned 'pattern recognition'. Earlier she had said this:

> Eleanor: When you see a patient you can kind of… have a flavour…that can be triggered when you see other patients in the future, with a similar flavour about them. I was thinking about a lady I saw yesterday with really awful headaches. She'd been on the phone with triage and she came in very very distressed and I quickly asked, what she thought was causing this and she very much felt it was all stress-related which I think then enabled us to cut one type of work out….and when you start to see those patterns, recognition of different patients over time… I think you can learn patterns from patients.

Eleanor's 'flavour' is a variant on the commonality that defines a diagnosis: pattern recognition applies just as much to medical diagnosis. In fact, you could give a medical diagnosis to both of her patients: somatoform disorder for Margaret and tension

headache for the second lady. The difference is that you cannot measure a 'flavour', so they fit uncomfortably with quantitative research methods such as the randomised control trial. With little interest from academia, biotech and pharma industries they have a second class feel about them and the label alone does not help much with what to do next. Here is Penny and Eleanor:

> Penny: I just think as a job we are relying an awful lot on our intuition and decision making that is not necessarily based on something that we have learnt in a book. As each day goes on I realise that actually …some things are just medical ….
> Eleanor: …and you can just move through…
> Penny: .. [but many things are not, so] it's not a job that somebody who is just medically-minded, could probably be satisfied with …and want to carry on doing.

From Bruce Charlton:

> *The need to relate the practice of medicine to the rest of the human world is unavoidable….When medicine is the only system of thought available to a doctor, when all available time and energy are spent on medicine, when the doctor is only an expert technical specialist then how can he or she become aware of the incompleteness and imperfection of medicine? Medicine must be seen in context, practised with wisdom.*
> [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1372488/pdf/brjgenprac00038-0039.pdf]

This balancing challenge is not new. The Classical Greek philosophers and poets were very well aware of the need for wisdom to combine both the hard technical and the soft feeling parts of humanity. Aristotle wrote that wisdom requires both *Sophia* and *Phronesis. Sophia* is theoretical wisdom concerning universal truths. It includes *episteme* which is a type of knowledge that is logically built up, teachable and sometimes equated to science. *Phronesis* is practical wisdom, related both to virtue and practical details. It includes *technē,* meaning a craft. So in Classical Greece wisdom was a combination of knowledge (including universal truths) and practical, virtuous know-how. https://en.wikipedia.org/wiki/Phronesis

If we take it that the contemporary wise GP has the *episteme* (and even *Sophia*) from their undergraduate education, and *phronesis,* from their postgraduate years, what could she offer to Margaret? The generation of GPs trained in the 1960s and 1970s had the option of becoming skilled as GP psychotherapists in the style pioneered by Michael Balint. This was achieved through GP discussion groups. This approach might be helpful to Margaret and could be characterised as *phronesis.* But it is now uncommon to find time and energy in the whirl of work experienced by doctors like Penny and Eleanor. In most areas, there is no other similar NHS option available to patients like Margaret. http://balint.co.uk

Being Intuitive

> Creativity is knowing what to do when the rules run out, or there are no rules in the first place. Frank Levy

So the young doctors are relying on intuition. This came up in the first few minutes of the conversation:

> Penny: I find myself talking to patients not necessarily about medical things. They're asking for advice, but it doesn't come from textbooks whatever … [*hesitantly*] It

comes from …the advice they are seeking …I try to support and give, but often I can hear my dad talking, or my sister….I don't think that's a bad thing, so long as it's not a prejudiced view… we learn wisdom from others.

During postgraduate training these 'others' turn out to be good GP teachers. After becoming fully accredited, it is the ethos or culture of the team. Eleanor spoke about her sessional work in the local memory clinic for patients with suspected dementia:

Eleanor: You're making diagnoses, but it's not like when you have a piece of histology and you know whether it's cancerous or not, it's a subjective decision, and yet you are having to give a label of dementia or not and I find that one of the hardest things - breaking bad news when the decision is based solely on the history you take and not on anything …. Sometimes you can get CT Brain Scan changes, but normally it's based on the history….that is very much turning something subjective into something objective…so there's a huge amount of wisdom, knowing the patient and you're trying to ascertain all that within 20 minutes and I initially found that incredibly stressful …I wasn't sleeping … it's just because of the decision …every time you tell somebody they've got dementia it's …devastating.

William: Has it got easier?

Eleanor: It has got a bit easier…umm… it's experience in part, and also, umm, realising that I'm not on my own, having spoken with the other doctors realising that it is subjective and that it's OK sometimes not to make a diagnosis, to delay that and not to feel like it's the wrong thing to do …Um... and giving myself permission to say, even if you suspect quite highly this is going to be a dementia, to give a diagnosis of mild cognitive impairment and when to give hope, and having the flexibility to do that, and the confidence and pattern recognition and seeing different patients in different settings, and understanding they have problems and the degree of problems the family are having and that's what improves it.

From Marcel Proust:

We don't receive wisdom; we must discover it for ourselves
after a journey that no one can take for us or spare us.

Judgment

Eleanor described learning to exercise judgment during her sessional work in the memory clinic. She felt the pain of responsibility when the (apparent) safety of rules, measurements, statistical predictions are either unavailable or irrelevant. Eleanor's experience and the supportive team enabled her to cope with this. But how does she know that the team are not subject to some kind of groupthink? Teams can reinforce bad practice as easily as good practice. Here is a quotation from James McCormick's brief 1994 essay, 'The Place of Judgement in medicine' in which he poses eight questions that may go through the clinician's mind when exercising judgment: [http://paracelsus-heute.ch/cms/literatur/011_wiss_einsiedler_symposien/PDF_1_symposium/83McCormick.pdf]

Wisdom and judgment are close friends. Both rely on adding weight to the imponderable, value to that which cannot be quantified……Even the most apparently straightforward consultation requires the exercise of judgment 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.

Later, McCormack extols the importance of knowledge and scepticism ….

The first requisite for wise judgement is appropriate knowledge…. Judgment 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. Scepticism which provides some protection against fashion, some protection against accepting the received wisdom of superiors, teachers, consensus and the written word.

….and his worries about too many rules even in 1994. Of course we now have very many more protocols, guidelines, standards and the Quality and Outcomes Framework….

The practice of medicine is risky and difficult. Risk-taking is necessary because the price of being on the safe side is often intolerable….waste of resources and iatrogenic harm….'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 absolve them from painful decision.' [quoted from Theodore Fox 'Purposes of medicine' The Lancet, 1965] ….*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….In a sense these are simple situations in which there can be no difference of opinion about the immediate necessities…Most decisions in medicine are not simple and straightforward but require the exercise of judgement…*

Here is a speech from Penny that vividly portrays some of the these issues from her lived experience:

Penny: … starting when newly qualified … timid is (laugh)…I don't think you trust your decisions as well, but the more …the longer you are in the job, the more you move through, you are always either …you are thinking in your head, what is the worst that can happen? … if I, not ignore that, but if I leave that, watch this, don't treat that, and actually the more you think about, the easier things become then because you end up with two decisions: act, don't act …don't act – review, that sort of thing. I think it's not that easy at all and I discuss cases all the time with you guys and with senior partners and I don't think you can get by in the working day without sharing …sharing the burden, because basically, I find with every patient, you know, there's several different…and everyone will do different things from the one I might do and it might not be what you would do, and you realise that when we have meetings and things, and there isn't …and I say this patient's… it's not that simple, there's no right or wrong – try this, if that doesn't work we'll stop that

and try this and …(sigh) in some ways that is the role of the GP isn't it, because we get lots of specialist letters back saying, please start frusemide, spironolactone and this and check bloods weekly blah, blah. Then the patient sits down in front of you and says 'I feel dizzy, I feel awful, and I'm not going to do this'. And you quickly realise you are not going to be able to titrate these things in the timeframe that …and you end up doing your own thing. Little bit by bit, and actually and as long as we try reaching the end point that is safest for the patient, I think we have a lot of…I feel like half the instructions never get done as quickly as they are suggested but actually where is the harm in that, as long as you are listening to the person in front of you?

Penny is learning to pace her practice, to hold the uncertainty and ambiguity, even to enjoy the syncopations. Marshall Marinker, one of the early pioneers of general practice as a bona fide academic discipline, described general practice as:

'The jazz of medicine'.

Time

Of course, lack of time is a perennial complaint from staff in the NHS, especially from general practice and we've already heard about the challenges of Eleanor's 20 minute consultations in the dementia clinic. Here is another exchange with Penny and me. I open by referring to some remarks before the recording started about how many unread letters both Eleanor and Penny had.

William: OK, yes, we're back where we started aren't we, with that having so many letters to read and eventually running out of time. So let's talk about that!

Penny: Yes, it's time. Time's a big one. Time management. And these are the people we are using wisdom on: they tend to be the ones who are complicated with multiple morbidities, difficult social circumstances or family surroundings, where you don't get to know them in one or two consultations. You get to build a relationship, get to this point where maybe you are both stuck for a variety of mental health or physical health reasons.

At the end of the conversation:

William: Do you want to carry on doing it [general practice]?

Penny: Yeh, definitely …if it wasn't so busy! I think something needs to change in terms of workload, it's ridiculous! I think I would enjoy the work a whole lot more if it wasn't' so pressured, because as a job, it's a great job.

William House March 2016