

MEDICAL PRACTICE: IS THE TEXTBOOK ALWAYS RIGHT?

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Most practicing doctors are aware of the gap between their practice and the book. They usually regard what the book states as the correct thing and anything short of or different from it as incorrect or inferior. Doctors working in highly developed institutions in developed countries, which frequently provide tertiary care, usually write chapters of textbooks. The situation in most hospitals in developing countries and in small clinics is quite different.

The aim of the doctor is to do what is in the best interest of his patients in the environment he or she is working in. This should be the yardstick by which a certain behavior is judged as right or wrong. What is an appropriate decision in one place may be inappropriate in another. Sticking to the book is not always the proper behavior. Following are examples of this at various stages of the relationship between doctor and patient.

Physical Examination

Women are a special problem in our community when the examiner is a man. They frequently resist exposing parts of their body. Some may request to be examined with their cloths on. The doctor has then two choices. One is to refer the patient to a female doctor. The patient usually does not like that either because she trusts the doctor she has come to and wants to be treated by him or because of the inconvenience of having to go to a different place and have another booking. The second choice is to do what the patient wants and examine her with clothes on.

The doctor has to judge whether such an examination is acceptable in the circumstances. Examining the abdomen

with a thin internal cloth on does not interfere significantly with palpation but it interferes with inspection. In some cases, it may be reasonable to assume that this is unlikely to affect your judgment and doing it should not be considered wrong. Taking blood pressure with a thin sleeve on usually does not interfere with measurement^[1] and doing it to a patient who wears a sleeve that cannot be wrapped up is another example.

Investigations

Many tests done in our institutions are not as accurate as they are described in the book. The values given to them in the book in the form of sensitivity, specificity, predictive values and likelihood ratios may be quite different from the values they have in our actual practice. Their weight in the diagnostic and management process may consequently be considerably less than the weight given to them in the book.

In other words, their value compared to the information obtained by history taking and physical examination may be considerably less than what is stated in the book. This should always be kept in mind in making a final judgment on diagnosis and management. It should also reflect on the decision to do the test in certain situations when the probability of a diagnosis or a management action built on clinical criteria (pretest odds) is high and the likelihood of it being affected by the test result is low (because the likelihood ratio of the test is low). For example, if you have a very strong suspicion of typhoid fever on clinical grounds and your laboratory is not reliable, it may be prudent to treat the patient without wasting time and money by asking for a Widal test.

Treatment

A certain treatment, especially complicated procedures, is advised when it is judged that its possible benefits outweigh its possible harms for the patient concerned. Consequently, it should be judged according to the situation in the place of practice. It should not follow the instructions of the book blindly. Those who write book chapters usually work, as stated earlier, in advanced institutions with higher expertise and better facilities.

The results of various therapeutic procedures and their complications are not the same as they are in less developed places. Consequently, the balance between benefits and risks is different. So, a treatment, which according to the book is indicated in a particular situation, may not be indicated for the same situation in the place one is working in. Dialysis is an example. In a place where maintenance dialysis is good with few complications and a reasonable quality of life of patients, one may advise patients with chronic renal failure to go on maintenance dialysis when their creatinine clearance comes down to 10ml/min. One would expect their life on dialysis to be better than it is without it and their long-term prognosis better.

In another place where the quality of maintenance dialysis is poor and complications are many, one tends to wait longer until the patients' condition becomes severe enough so that their life on dialysis in spite of its poor quality and frequent complications represents an improvement on their life without it. The policy may then be to wait until creatinine clearance comes down to 5 ml/min. before putting the patient on maintenance dialysis as it is indeed the case in less developed parts of the world^[2].

References

1. Hovsrpian R, Al-Haddad M, and Abdulla K: Comparison of blood pressure measurements in bare arm, clothed arm and forearm. J Fac Med Baghdad, 1996; 38: 221-4.

2. Swyter J: International ESRD experience: An anthropological perspective. Dialysis and Transplantation, 1985; 14: 328-38.