Editorial

What are we here for?

What are we here for? As medics that question may be more important than we might like to think. Theodore Dalrymple pointed out in a recent article in The Spectator[1] that on the few occasions when doctors have gone on strike the death rate has fallen. He goes on to quote a professor from his medical student days that this – much more than any ethical considerations – is the main reason why doctors never should go on strike. If we did it wouldn't take people long to realise that we are an unnecessary as well as an expensive luxury. So we must ask … do we do any good at all? Most people who are ill get better on their own with no medical intervention at all. We forget this as the patients whom we meet in our surgeries, clinics or wards are a self-selected group of the more severely ill. If we are honest most of these also get better on their own.

Intuitively we feel Dalrymple can't be right. But if we are to survive as an independent profession we need to depend on more than intuition. Saying "doctor knows best" probably never did impress but it certainly doesn't in these cynical days post Shipman, Alder Hey and Bristol. A Google search for medical scandals worryingly produces over 1.8 million results. Restricting the search to the UK still produces over 100,000 results. Can we demonstrate to the world as well as to ourselves that we are worth paying for? The short answer is – yes we can. But that means maintaining rigorous standards and punctiliously auditing all that we do.

"Audit" almost always raises a groan as we think of yet more forms to fill in to pacify faceless managers striving to meet politically-driven targets of no clinical relevance. We must suppress the groans. Apart from any window-dressing audits needed to satisfy the pen pushers, we need constantly to test what we do - whether we call it audit or not. Healthcare in the UK costs many billions of pounds, about 70% of which is our salaries. To demonstrate that we are worth it we need to be able to demonstrate that our interventions are beneficial. We can only do that if we can produce the figures.

We can't all do high-powered research. Not many of us will get a Nobel prize. But we are all capable, in a modest way, of keeping a record of what we do and what the outcome has been for our patients. Where there is an accepted gold standard we can compare ourselves with that. Where there isn't a gold standard maybe we can contribute to establishing one, or it might become obvious that what we have been doing isn't even a bronze standard and needs to be changed.

But is there another explanation of Dalrymple's paradox rather than simply that doctors are a waste of space? I think the answer may be risk compensation. Risk compensation is the phenomenon that individuals change behaviour when there is a perceived change in risk. A simple example of this would be that we would all drive more carefully and slowly if there were sharp spikes in the centre of our steering wheels. Driving standards may

be paradoxically worsened by crumple zones, seat belts, airbags and other safety devices fitted to our cars. Similarly if people know that medical help is always near at hand they may indulge in more risky behaviour. When I was a medical student in the 70s I remember the junior doctors' strike during which the A&E departments were deserted. Overdoses stopped when the punters realised there might not be a stomach pump to rescue them.

So, yes – I think we do indeed do some good, although perhaps not as much as we would like. But we need to be able to show it.

Reference:

1. The Spectator 6th October 2007 p.23