Clinical disagreement:

A silent topic in general practice

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ABSTRACT

This is a viewpoint article on the concept of clinical disagreement in general practice. It is a silent topic in the medical literature and yet evident in many aspects of clinical practice. Three types of clinical disagreement are described as well as examples of clinical disagreement encountered in practice. Doctors are quiet about clinical disagreement because many illnesses in general practice are self limiting and so it may not matter, or they feel uncomfortable about being public on disagreement because it impinges on aspects of the doctor-patient relationship. There may be a 'natural' level of clinical disagreement either within one practitioner's clinical practice, or between practitioners. More research is needed on clinical disagreement because it influences the behaviour of patients, doctors, and students. Such research will help develop strategies for identifying and managing clinical disagreement.

The silent topic of clinical disagreement

A search in Medline with the terms 'clinical disagreement' will result in a zero result. Yet the topic of clinical disagreement is alive and well in everyday clinical life. The media often reports how doctors disagree with one another and patients were no better for the disagreement. In New Zealand debates about the acceptable level of error among pathologists looking at cervical tests, or whether general practitioners should do blood tests to screen for prostate cancer are recent examples. There have been articles published showing the variability between doctors, but they often miss the point about clinical disagreement. For example, as far back as 1983 Marks and Hillier compared the opinions of 77 UK general practitioners and seven specialists about childhood asthma.[1] They found the two groups of doctors differed from one another in the diagnosis and management of asthma. Interestingly there was no follow-up research article, or letter, in the years that followed. How did the disagreement between the general practitioners and specialists arise? Was there anything the specialists or general practitioners could do about it? Did it really matter?

I am sure that an imaginative reporter could conjure up a conspiracy story: On the one hand doctors take solace in the scientific basis of their work, and on the other hand they are very quiet about disagreements in their practical life. Surely disagreement is the basis of scientific endeavours?

Although there has been no count made of the possible kinds of disagreements in general practice, I conjecture that 'everyday' disagreements arise from the doctor-patient relationship, and that 'clinical' disagreements arise from relationships between doctors. There are many examples in the daily newspapers of the consequences of 'everyday' disagreement. Furthermore there has been a body of medical research on how the communication skills of the general practitioner can impinge on the quality of the consultation[2] and sometimes such skills require the general practitioner managing 'everyday' disagreement with the patient. In contrast, clinical disagreement is a silent topic. If science were the true foundation of clinical behaviour, then perhaps we would expect to hear more about general practitioners opposing views on a clinical issue.

Types of clinical disagreement

Clinical disagreement often has to do with how a general practitioner has to explain to a patient why their opinion differed from a colleague's. An example from my own general practice a few years ago: The more I read about the prescribing of antibiotics for ear infections in general practice, the more convinced I became that the argument for routine use of antibiotics was rather weak. One day I decided to prescribe antibiotics less often. A few months later, a mother returned to the practice to complain about my policy. Her five-year-old child still had ear pain a day after a consultation with me for an earache. Another general practitioner saw the child for the second consultation and reprimanded me for my policy. I was asked to quell my enthusiasms for research evidence. However, the recent guidelines continue to endorse my opinion.[3] This example illustrates the first of three types of clinical disagreement that occurs in situations where two or more doctors examine the one patient and come to different conclusions.[4] The second type of clinical disagreement occurs when the

general practitioner's clinical decisions over history, diagnosis, or treatment differ if compared to hard evidence such as biopsy reports, x-rays, CT scans, or scientific studies. And the final type of clinical disagreement occurs when one doctor examines a patient over time and disagrees with a previous clinical finding.

One reason why clinical disagreement is not a hot topic in the general practice media is because the majority of patients who see their general practitioner are healthy or have self-limiting illnesses.[5] In this context, the differing opinions among general practitioners will not matter one way or other. General practitioners very rarely see patients with other colleagues in the same consulting room, so their clinical disagreement very rarely comes to light. What makes clinical disagreement particularly invisible is its relationship to the everyday experience of being a general practitioner. Full-time New Zealand general practitioners will report anecdotally that the experience of their work is a changing, fleeting, phenomenon – if only because the average general practitioner consults with about 7000 people a year and will remain in a general practice for about 14 years.[6] In this context, general practitioners become aware of their experiences only when something unusual, dramatic, or novel occurs. Let me give you a trivial example. None of us consciously experiences the toilet doorknob we turn every morning. However, if the doorknob disintegrated in your hand, as happened to me the other day, then you remember that as an experience. In the same way general practitioners tend to forget the experiences of consultations unless there is something unusual, novel, or dramatic. One such example is when a patient points out very loudly that some other doctor thought you were wrong, or worse still, goes to a medical disciplinary committee to point out the clinical disagreement. Such experiences are unpleasant.

Doctors tend to keep quiet about clinical disagreement because of the uncomfortable feelings associated with it. Perhaps general practitioners ought to feel open about the novel, dramatic, or unusual events in their lives.[7] However there are many restraints in making clinical disagreement a public phenomenon. Clearly privacy issues are a major restraint for a general practitioner debating the clinical disagreement over a particular case. I have no evidence as to actual response to clinical disagreement except for those extreme cases that land up in the courts where the patient suffers because of the clinical disagreement. In New Zealand most general practitioners are involved in peer review sessions with their colleagues (often on a monthly basis). I have observed clinical disagreement occur in such sessions; generating heated discussion. However, there is no research into the actual response to clinical disagreement. It is of little value to study only the extreme cases that land up in courts because in that punitive context we learn little about everyday clinical experiences.

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Research examples of clinical disagreement

In a qualitative research project, I asked Wellington general practitioners about how they compared with their colleagues in the management of asthma, I found clinical disagreement in the use of antibiotics for acute asthma attacks. For example one general practitioner said, *'In a lot of cases, and especially children, so often it is an acute infection which triggers the asthma... So why not use antibiotics?'* Whereas another general practitioner said *'I would very seldom give antibiotics, as I feel more confident treating a wheezy chest with anti-wheeze medication...'* Guidelines about the management of acute asthma do not recommend the use of antibiotics,[8] and yet 18 per cent of doctors in both general practice and hospital settings continued to prescribe them for acute asthma.[9] The general practitioners reported complex reasons for their behaviour. These included either pressure from patients to prescribe antibiotics, or a lack of confidence in managing the time needed for a consultation or a feeling of fear because previous patients died of asthma despite the best treatment. This qualitative study indicated that clinical disagreement was not apparent to general practitioners because few knew of the differing opinions among their colleagues.

In a second study I explored the level of disagreement between another general practitioner and myself in the clinical act of listening to children's chests for wheezy breathing. We examined 382 seven-year-old children in the Hutt Valley where it was randomly allocated which of us would examine a child first. Furthermore, each of us was blind to the other's findings. The result was that we disagreed with each other in four per cent of cases.[10]

The final study involved examining clinical difference within myself as a general practitioner. I investigated 308 patients that presented to me in consultation with a sore throat and did two throat swabs one after another. The results for the two swabs disagreed with each other in six per cent of cases.[11]

These three studies suggest there seems to be a 'natural' level of clinical disagreement. I say 'natural' because it seems to be an aspect of being a doctor and making a medical judgement: I did not intend to disagree with myself when I did two throat swabs. My colleague and I tried

very hard to standardise our chest examinations. Many general practitioners had never appreciated how they differed from their colleagues in their management policies on asthma. None of these clinical disagreements are likely to land up in courts. However, they do need to be placed in the public arena.

Why clinical disagreement is important

Clinical disagreement ought to be in the open because it influences the behaviour of patients, doctors, and students. From a patient's perspective, an open debate on clinical disagreement will allow choice among treatment options. Keeping disagreement under wraps will only increase confusion for patients and reduce the notion that a choice is possible. From a doctor's perspective, placing clinical disagreement into a public arena will allow for self-directed learning. Doctors miss many educative pauses in the hurly-burly of every day clinical experience. Identification of clinical disagreement allows them to pause for a moment and learn. From a medical student's perspective, placing clinical disagreement into the syllabus will force them to openly debate the conflicting views on how to treat diseases and illnesses. At present the main focus is for medical students to cope with the enormous volume of clinical material needed to pass exams. These exams make them less interested in bothering with the disagreements - especially when the management of clinical disagreement is not part of what they will be examined.

It is a mistake to apportion blame too quickly when there is clinical disagreement. One general practitioner may differ from his or her colleague for any number of reasons that are not morally culpable. Physical factors can explain some of the disagreement. For example a colour-blind general practitioner will not be good at dermatological diagnoses. Technical factors explain other disagreements. For example, I have known laboratory technicians to press the wrong button when printing out a laboratory form. Finally relationship factors can create many disagreements. For example, the patient can omit to mention important facts while in consultation because of language difficulties, but not when they consult with a general practitioner who speaks their language. Many of these disagreements are due to systematic problems that are not the fault of any one individual. Quality audits of clinical work can reduce disagreement due to systematic problems.[12]

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General practitioners are entitled to reach disagreeing opinions. Sometimes one of the two opinions is likely to be mistaken (as in the case of antibiotic prescribing for acute asthma). At other times two opinions of the same facts might be right. It just needs more time, or more knowledge, for the correct interpretation to be revealed. It is not useful to study clinical disagreement only when someone makes a mistake. This will prevent the growth of knowledge that arises when both sides of an argument are made explicit. If patients and their general practitioners believe in a holistic approach to medicine (as many are openly claiming they do), then they will have to allow for clinical disagreement without the moral overtones inherent in the belief disagreement means someone has to be wrong.

Strategies need to be developed for identifying and managing clinical disagreement in general practice. General practitioners need support to allow them to obtain the educational pauses of their everyday experiences. If there are no such supports for general practitioners (and other doctors) then they will be left with crude measures imposed by the courts. We will continue to hear of the extreme cases of clinical disagreement where patients suffer, and no one is learning. If we do provide more resources for the research of everyday clinical practice this will show the world, and ourselves, that we know our clinical limits and value the freedom we have to act within those limits.

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