The Review

First do no harm:

health, rather than the outcome of medical treatment, is a process of learning

'First Do No Harm' is a series of 12 brief monthly articles with internet footnotes about harming and healing in general practice. Each instalment is based on one of the 12 RCGP competency domains, this month's being:

6. Managing medical complexity and promoting health: aspects of care beyond managing straightforward problems, including the management of co-morbidity, uncertainty, risk, and the approach to health rather than just illness.[1]

' ... risk is inherently subjective.'[2]

Risk is useful because it's expressed in numbers and therefore communicable across barriers of language — but it's provisional: it changes when the information on which it's based changes.[3] For advanced cancer, the most accurate models correctly predict only about 60% of the time whether the patient will live for days, weeks, or months.[4] Health itself can be defined in a variety of ways: psychic consonance,[5] the ability to work, love, and sleep;[6] the means and support for individuals and groups to control their lives;[7] attainment of goals;[8] an aptitude for adaptation and self-management;[9] a state of complete physical, mental, and social wellbeing; or a facility for creating meaningful stories.[10] Health, rather than being the outcome of medical treatment, is often a process of learning.[11]

HARMING

Colluding with patient passivity: prescribing long-term benzodiazepines for the anxious, protein pump inhibitors for the obese dyspeptic, and opiates for patients with chronic non-cancer pain.[11] Failing to recognise psychological problems when they're there, and supposing them to be there when they're not.[12]

HEALING

Accepting variants of normal among both symptoms and sufferers, normalising symptoms by re-attributing them to everyday processes, fostering good relationships with patients, being pastoral.[11]

Using the phenomenon of regression to the mean. Thinking flexibly, using rules not as compass but as ballast. Ensuring coordination and continuity of care.[1]

ATTITUDE

Being prepared to consider anything and everything as part of the remit of general practice, recognising that limits are based not on principle but on pragmatism.

KNOWLEDGE

There are few certainties in medicine. Patients' choices are different from, and often more conservative than, the choices that their doctors make.[14] Placebos work, doctors believe they work, and many patients are happy in certain situations to be given them.[15] Although risk and benefit may be positively correlated in the environment, they're negatively related in peoples' minds.[16] Uninformed passive patients have worse outcomes than e-patients who are equipped, enabled, empowered, and engaged in healthcare decisions.[14,17] The Quality and Outcomes Framework does not improve outcome much but makes the process less complex and more linear with apparently greater certainty and agreement.[11]

SKILLS

Obtaining information from many sources: history, examination, patient records, Patient Reported Outcome Measures,[18] guidelines, and research. Using therapeutic metaphors and healing stories.[10] Having readily accessible decision making aids.[11,14] Encouraging patients to consider: 'what are the options? What are the benefits and harms? How likely are these?[14] Using not percentages but frequency statements: 'of 10 patients prescribed this drug, three stop using it because of ankle swelling'.[19] Giving homework rather than a prescription.[20]

Wilfrid Treasure,
GP, Whalsay Health Centre, Symbister, Whalsay, Shetland.

DOI: 10.3399/bjgp12X658368

Supplementary information
The internet footnotes accompanying this article can be found at:
http://www.darmipc.net/first-do-no-harm-footnotes.html

ADDRESS FOR CORRESPONDENCE
Wilfrid Treasure
Whalsay Health Centre, Symbister, Whalsay, Shetland, ZE2 9AE, UK.
E-mail: doctorwilfridtreasure@gmail.com

REFERENCES

1. Royal College of General Practitioners. *nMRCGP 12 competency areas in detail.* http://www.rcgp.org.uk/docs/nMRCGP_12 Competency Areas in detail.doc (accessed 10 Oct 2012).
2. Slovic P, ed. *The perception of risk.* London: Earthscan Publications, 2000.
3. Douglas M. Risk and blame. In: *Risk and blame: essays in cultural theory.* Abingdon, Oxon: Routledge, 1994.
4. Glare P. Predicting and communicating prognosis in palliative care. *BMJ* 2011; **343:** d5171.
5. Festinger L. *A theory of cognitive dissonance.* London: Tavistock Publications, 1962.
6. Pledger G. A working definition of health. *BMJ* 2011; **343:** d5362.
7. Shilton T, Sparks M, McQueen D, *et al,* on behalf of the executive committee of the International Union for Health Promotion and Education — IUHPE. Proposal for new definition of health. *BMJ* 2011; **343:** d5359.
8. Tinetti M. The end of the disease era. *Am J Med* 2004; **116(3):** 179–185.
9. Huber M, Knottnerus JA, Green L, *et al.* How should we define health? *BMJ* 2011; **343:** d4163.
10. Launer J. *Narrative-based primary care: a practical guide.* Abingdon, Oxon: Radcliffe Publishing, 2002.
11. Treasure W. *Diagnosis and risk management in primary care: words that count, numbers that speak.* London: Radcliffe Publishing, 2011.
12. Rees C. Iatrogenic psychological harm. *Arch Dis Child* 2012; **97(5):** 440–446.
13. Willis J. *The paradox of progress.* London: Radcliffe Publishing, 1995.
14. Stiggelbout AM, Van der Weijden T, De Wit MP, *et al.* Shared decision making: really putting patients at the centre of healthcare. *BMJ* 2012; **344:** e256.
15. Fässler M, Gnädinger M, Rosemann T, Biller-Andorno N. Placebo interventions in practice: a questionnaire survey on the attitudes of patients and physicians. *Br J Gen Pract* 2011; **61(583):** 101–107.
16. Slovic P, Fischhoff B, Lichtenstein S. Facts and fears: understanding perceived risk. In: Slovic P, ed. *The perception of risk.* London: Earthscan Publications, 2000.
17. Parrott T, Crook G. *Effective communication skills for doctors: a practical guide to clear communication within healthcare.* London: BPP Learning Media Medical, 2011.
18. *Finalised PROMs data 2009–10.* http://www.hesonline.org.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1583 (accessed 8 Oct 2012).
19. Gigerenzer G, Galesic M. Why do single event probabilities confuse patients? *BMJ* 2012; **344:** e245.
20. Ryle JA. *The natural history of disease.* 2nd edn. Oxford: OUP, 1948.