**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:


‘... risk is inherently subjective.’

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. 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. Health itself can be defined in a variety of ways: psychic conscience, the ability to work, love, and sleep; the means and support for individuals and groups to control their lives; attainment of goals; an aptitude for adaptation and self-management; a state of complete physical, mental, and social wellbeing; or a facility for creating meaningful stories. Health, rather than being the outcome of medical treatment, is often a process of learning.

HEALING

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

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.

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

**ATTITUDE**

Being everything as part of consideration 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. Placebos work, doctors believe they work, and many patients are happy in certain situations to be given them. Although risk and benefit may be positively correlated in the environment, they’re negatively related in peoples’ minds. Uninformed passive patients have worse outcomes than e-patients who are equipped, enabled, empowered, and engaged in healthcare decisions. 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.

**SKILLS**

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

**REFERENCES**

5. Shetland.

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**Supplementary information**

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

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