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Case conference

When doctors disagree

During a discussion of problem cases a disagreement over treatment turns out to have deeper and more diverse ethical problems which threaten a partnership and reveal unresolved tensions in a family. The case was presented by a young general practitioner to a group at a postgraduate meeting.

Jason

Jason Hill, who was aged seven, was frequently brought to the surgery with colds and coughs. On the evening in question I had known him for two years. I am in a partnership with four other older doctors, and Jason's family was well-known to us all, although they usually saw the senior partner. On this occasion, Jason's mother, Mrs Hill, seemed more than usually agitated, and told me that Jason had been up all night with earache, had kept the whole family awake, and 'something must be done'.

I gathered from my enquiries and looking through the notes that Jason had had a number of middle ear infections. He seemed to be attending surgery on average once every fortnight: on each occasion he was given antibiotics, although in some cases to judge by the clinical details the justification for such a prescription seemed doubtful. I knew the family had recently been disturbed by the arrival of Mrs Hill's mother, who was now well on into her eighties and very demanding of attention, and that the main burden of her care inevitably fell on Mrs Hill, as Mr Hill was a nightworker on a production line and did not help much in the house. Jason was the youngest of four children and was always presented as having a 'weak chest'. This assessment by Mrs Hill seemed to derive from an episode of bronchiolitis when Jason was a toddler. It had obviously been a frightening episode—Jason had had severe respiratory distress and had been admitted to hospital for two weeks. As far as the rest of the family's health was concerned, Mrs Hill's father had died of pulmonary tuberculosis, and one of her brothers had been deaf since childhood, and had had bilateral mastoidectomy.

That particular evening I examined Jason carefully, and found that he had a bad cold, with a red pharynx and an enlarged tonsillar gland under his painful ear, but that the drum itself, although a little pink, was not badly inflamed, and did not represent a middle ear infection. His chest was clear, and I explained to Mrs Hill that he had a bad cold which had caused a throat infection, and that the pain was coming from the defence glands by the ear, but not from the ear itself. I accordingly recommended regular treatment with aspirin, offered suggestions about the need for a cough mixture, but stated firmly that he did not need antibiotic treatment at present, but if she was unhappy with his progress she should bring him back in a few day's time.

I had anticipated some opposition to this approach, but not the interview that followed. Mrs Hill was unable to accept my assessment, went over and over Jason's previous medical history and how he always needed antibiotics, and came near to questioning my clinical competence. As she became more agitated, I became more firm and unyielding, while Jason looked on with, it seemed to me, some satisfaction. Any chance that I thought I had of getting to the root of Mrs Hill's agitation on that evening rapidly disappeared. Finally the storm was over, and Mrs Hill rose with the comment, 'well, if that's your attitude, we must see what happens', and walked out while I made another appointment for them both.

At one o'clock that night Mrs Hill called out the doctor on duty who was the senior partner. On examining Jason he confirmed my findings but prescribed an antibiotic. He came in the following morning very angry with me, and appeared to have accepted all Mrs Hill's criticisms of my approach the previous evening. I found it difficult to contain my feelings, and our relationship has been tense ever since. Somehow this case crystallised my concern over a number of similar problems, and yet I am no further than ever before in being able to see what I should do about it.

CHAIRMAN

Can I take it that we all accept, or must accept for the purposes of this discussion, that the prescription of antibiotics for this illness was not a clinical necessity? I think we should concentrate on the other issues. Who would like to define them?

DR GEORGE: GENERAL PRACTITIONER

I think this is a very difficult, but unfortunately, very common dilemma that we face in general or

hospital practice when a patient has come to expect a certain type of treatment and we feel that this is not necessary or is no longer necessary. I can entirely see the patient's problem. Over night, medicines which were presented as important, and involved effort in taking, are no longer necessary: someone must have made a mistake, and it usually seems as if the doctor with the 'new broom' does not understand the case, and by extension doesn't care either. This may be an overstatement but it does seem to represent the difficulties of abandoning a favourite remedy. There is a sense in which Mrs Hill, perhaps a person prone to depend on drugs, has become dependent on antibiotics for Jason, and is exhibiting here all the misplaced fervour of an addict.

MRS HUNTLEY: HEALTH VISITOR

But seen from her angle the situation also has frightening aspects. We are not allowed any insight at this stage, by the very nature of the fraught interview, into her deep anxieties. Since she had often brought Jason up to the surgery with similar problems, it seems strange that she was so agitated on this occasion. Either she was disturbed by other events outside the surgery – and we can guess that the demanding grandmother may have been part of it – or she had some deep concern about Jason's earache which explains her otherwise extreme behaviour. She may have felt that this infection had a deeper significance than is apparent to us, and a probable explanation is the deafness of her brother. Anyone who has lived with a deaf relative or suffered from deafness will bear witness to the extraordinary way in which this changes the atmosphere of a home. Those with normal hearing can become uncharacteristically annoyed, and the deaf person can become abnormally suspicious and cantankerous, in a way which other disabilities do not share. Mrs Hill has vivid memories of a childhood with a deaf brother, and on top of the handicap of a 'weak chest', which itself would be a fascinating mystery to untangle, she now sees Jason as possibly developing recurrent ear infections and deafness. Perhaps Mrs Hill's mother has been consciously or unwittingly stirring up memories of her deaf son and could even be accusing Mrs Hill, by implication, of neglecting her own son. It is surprising how a mother's confidence can be undermined by the arrival of her own mother, still seen as powerful in spite of incipient senility.

MR SCOTT: HOSPITAL CHAPLAIN

I cannot understand why the senior partner, armed both with all the knowledge of this family's circumstances and with the wisdom of experience, has to become angry rather than simply to teach his junior colleague about these anxieties and how they affect the dynamics of family life. Is he simply threatened by a young keen brain dismissing his own normal therapy, or has he become too involved with the family to be able to see the wood for the trees?

DR JOHNSON: GENERAL PRACTITIONER

He may have become bound up with Mrs Hill's anxieties about the possibility of chronic ear infection and deafness for Jason and thus sees his continual prescribing of antibiotics as entirely rational and inevitable. He was born too in an age where chronic ear sepsis was common, and it may be, if the Chairman will excuse me, that he was right! There seems to be very much a problem of philosophy here.

CHAIRMAN

What do you mean by that?

DR JOHNSON

Many younger doctors are now following the public mood and questioning the effectiveness of powerful medicines in a total sense – that is, they are saying that there are short term gains by modern therapy but medium or long term losses. An example in this case would be the 'curing' of a condition that has a considerable likelihood of healing by itself anyway set against the theoretical but definite risks of drug allergy and developing antibiotic resistance of bacteria in the community. The older generation, who have seen the disastrous effects on life and faculties of unrestrained sepsis, welcome powerful remedies with open arms, and use them with a frequency that provides to them enduring proof of their effectiveness and necessity! This is an experience which the senior partner and Mrs Hill share, and has led them to develop a system where the power to cure is vested solidly in the doctor – that is, provided he continues to claim his power and uses it correctly. The younger doctor, however, with eyes towards economy, self-help and the rationalisation (or even rationing?) of therapy appears to them to be voluntarily and negligently abandoning his power and putting a child at risk in the process! Demystification has completely mystified Mrs Hill.

DR JACKSON: GENERAL PRACTITIONER

Her reaction has a great deal to do with her need for satisfaction. She has expectations of a certain type of treatment; she has been 'trained' to expect it, and she will not leave without this satisfaction. The young doctor perceived this at the very beginning, but he needed to gain job satisfaction by applying his principles of therapy, and so there was a clash. I feel by the way he describes the consultation that he had almost decided at the very outset, before the examination, that Jason was not to receive an antibiotic. He somehow wanted either to break the pattern or settle a score with his partner which was outside this consultation – an

unfinished debate about management plans. Had he prescribed, he might then have got to the bottom of what is really much more important, the reason for Mrs Hill's agitation and suppressed anger.

MR LEONARD: SURGEON
What about a placebo prescription? Surely that would leave honour satisfied on all sides?

DR MCINTYRE: GENERAL PRACTITIONER
I cannot agree: it would be the worst of both worlds. Mrs Hill would either learn nothing, or if she were perceptive or the dispensing chemist were indiscreet she would become even more angry when she discovered the deception. The doctors are landed in the practical and ethical problem that if a serious ear condition were to develop, would they continue to prescribe a placebo? If deafness resulted, would Mrs Hill have a case in law, as an effective remedy had not been applied?

DR JACKSON
In many ways his alternative is ethically worse – the prescription not of an inactive 'pure' placebo with no pharmacological action but that of an active 'impure' placebo that probably would have no useful action but might do harm. I feel we must aim to tell the truth on every possible occasion, and to use the placebo only where other methods must fail or be less useful.

DR GEORGE
In doing so you may throw away an agent which has vast curing potential, available very cheaply and with no side effects! Our task is to cure the conditions presented to us. Patients come to us for relief, not re-education.

MR SCOTT
I cannot agree. There are many cases where there is no cure, and we must offer care and compassion. A placebo is no substitute in those situations for a good relationship, and a good relationship implies speaking the truth. Already the medical profession has, rightly or wrongly, a reputation for hiding the truth either in a mountain of jargon or behind a wall of silence. Incalculable harm is done to future doctor-patient relationships if one such is exposed as a sham, however well meaning.

DR MCINTYRE
The young doctor has a very laudable mission, but he must realise that there is an element of fashion in therapy which may upset an apparently ethical argument. We have still not helped the partners to come together, except by outlining their possible attitudes. Somehow they have to be helped, perhaps by their colleagues, to reach a decision about rational therapy which will not confuse the patient with double messages, as happened here. Once decided upon, everyone must stick to it and reinforce with education wherever possible. Then Mrs Hill can be really satisfied and have her deeper problems explored in a calm context.

DR JACKSON
What appeared to be a problem of clinical judgement turns out to be a problem of relationships. Neither Mrs Hill's nor the junior partner's problems will be solved unless they are approached at this level. This is going to need a lot of hard work, but may well save both this practice and this family from further more disastrous problems in the future.