of ignorance and indeterminacy. This requires more knowledge about the patient, some of it quite reliable, some perhaps quite speculative. Will she continue to walk her dog if she is on medication? Will she begin to identify herself as ill, and will this have a health effect? How do we know that she only wanted a check-up, and did not have something else in mind? (Incontinence? A small lump in her groin?) Why is she overweight? Is this a problem? What is important for this 68-year old woman to be able to do in her remaining healthy years, and how can the GP help her accomplish her objectives? Depending upon the answers to these questions, we may find (a) other sources of uncertainty and ignorance with respect to the decision to medicate or not; (b) other options for action; (c) that the decision on whether or not to medicate loses importance. Perhaps the GP should just give it to her without further ado and then concentrate her effort on a quite different health aspect of Jane.

Conclusion: Creative Efforts May Be Rational

Sometimes one may hear the distinction *science versus art* when tensions of GP work are being discussed. We emphasize that our argument is not meant to downplay the importance of knowledge, or encourage unaccountable forms of judgment. On the contrary, we have argued that there are ways to strengthen the knowledge base and the rationality of clinical decisions in the prevailing presence of scientific uncertainty. We have outlined an approach where doctor and patient co-produce relevant knowledge about the patient. In some cases, this might lead to a re-framing of the clinical problem in which uncertainties are less critical. In other cases, uncertainties remain unresolved, actually giving the GP and patient more autonomy to develop their own path ahead.

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Marie-Anne Puel

Uncertainty, Balint and EBM

ELPS Workshop at the Wonca Europe conference 2009 in Basel – Meeting with the patient: Between fascination and routine, certainty and doubt – how do doctors cope and develop emotionally and cognitively?

Our primary motivations for practising medicine for satisfaction are: firstly, to solve medical problems, secondly, to satisfy the sense of closure, and thirdly, the desire to help people [1]. However, as Michael Balint said, medicine must compromise with: "The doctor, the illness and the patient" [2]. We (the doctors) have always and everywhere got criticism at all levels throughout all the ages. as if a "malaise" has always been set [3] (in France: Molière, Flaubert, Proust, Reverdy, Céline …).

"Difficult patients"

Nowadays, some patients are especially prone to remind us of our "malaise". We call them the "difficult patients". They are those who lead us to our status as difficult doctors; for example the "MUS" patients (with Medically Unexplained Symptoms) and especially the "Heart sink" patients, who can lead us to burn-out syndrome [4]. Why is this? Four examples may illustrate these kinds of situations.

The dependent clinger

She is about sixty five years old. He is about eighty. They live in the building where my office is located. I meet them almost every day in the corridors or in the street. When they see me, they kiss me and tell me how their last visit with the specialist was, which I never ask them to go to: all is right thanks to me! "We have a good doctor" and they leave me, happy, smiling until the next demand for the next specialist!

The entitled demander

She is a young, unemployed woman. She doesn't pay me which is not the rule in France. She usually arrives with her three children as she cannot afford a baby-sitter. Today, she consults for a sore throat.

In my opinion, she does not need AB and I try to explain why, but she wants AB and explains to me why. She also wants to know her blood-pressure and her weight. "By the way can you examine the youngest … in case of contagiousness ... Oh, I almost forgot ... I have a spot here, on my face ... since several months and I wonder." etc, etc.

The manipulative help-rejector
"Doctor, I know you can do nothing for me but I'm really feeling bad. You gave me something for my headache, not only it is worthless but it also had side effects and now, I am suffering with my stomach. My knees are worse since I have been manipulated by YOUR physiotherapist. Doctor: can't you think about a new drug or anything that really works".

The self destructive denier
She is a care-taker, fifty five years old, addicted to alcohol, tobacco and work. She lives in a "difficult" area. She has been involved in a story with hard drugs, delinquents and police that led her to the psychiatric hospital with a paranoid break-down. She lives alone with her "video" films. She calls herself Mac Gyver: she knows how to do everything in the field of "do it yourself" (electricity, painting, plumbing...). For me, there's no way to say anything about her health, or lack of health. When I tell her I'm very concerned about her, she reassures me, offers me flowers and adds before leaving ... "As my doctor doesn't want to give me a cuddle, I'm going home" and doesn't takes the change I put for her on the desk.

The rational and the irrational

Uncertainty remains a constitutional data of clinical reasoning. There are two kinds of problems to be solved: the well structured problems and the ill-structured problems, which are the huge majority of cases in medicine.
In that clinical reasoning, the acceptance that we all must age and die is intellectual (rational). However, sometimes we don't believe it at an instinctive or emotional level.
This combination of the rational and the irrational in our perception is responsible for the way we act in matters of health and for both rational and irrational anxiety [5].
The appreciation of irrational elements is essential in the relationship. Balint underlines the importance of the patients' beliefs, especially in family medicine/general practice. GPs are experts in coping with uncertainty.

Complex situations and uncertainty

We (the GPs) are well placed to adapt and respond to most (complex) situations and particularly to an evolving public health emergency (for instance: the current pandemic influenza) [5].
Uncertainty is likely to be maximal in general practice.
Primary care means: primary place to express spontaneous complaints [5]. The GP receives the first and "primary complaint". Balint called it "the inorganised stage of the disease" if there is one (disease) [2].
Coping with such complexity needs a special skill, as if the tacking of decision [6] must be thickened. Michael Balint [2] called it precisely the "deeper diagnosis".
We can never be certain and yet we still must act (even if only to give advice or for the wait and see approach).
We must act before certainty can be established (if it ever can be).
It makes clinical medicine not a science, nor an art but a PRACTICE.

Links between primary care, EBM and Balint

Now, let us think about the links between primary care, EBM and Balint.
We couldn't think of applying "Evidence" (whatever the level is) without balancing them:
– with the doctor's experience
– with the patient's preference [6]
What has Michael Balint written about the doctor's and the patient's personality? [2].
To adopt EBM is to adopt uncertainty. To adopt EBM is to adhere to experimental uncertainty and to renounce to the "almost mystic principle" of certainty [6].
To involve the patient in the medical decisions is ineluctable, not only because of ethics or juridical reasons but for MEDICAL ones; we have to adjust the (best) treatment in the best way for that patient [7].
Instead of evacuating uncertainty, EBM allows it's assessment.
Michael Balint also taught us that *medical* reasons are to fit with "deeper diagnosis" not only psychological, *ethical* or *juridical* one but *medical* one. He prevented us from making "blind diagnosis".

To share uncertainty

We can't let the patient himself decide alone what to do [7]. The authority has been relinquished by the medical profession but has it been relinquished at the same extent to the public? [6].
Today, doctors are encouraged to share their uncertainty with patients [8] (and with colleagues in Balint groups for instance!)
The Patient's empowerment: is it a myth, a threat or a utopia? The right to know and the right to choose can only increase their anxiety and aggravate their pathology.
The "AID's patients" certainly did deeply change the usual relationship: they invented the "negotiated decision"… just after Balint, who first invented the new concept about the "mutual investment company". That leads to a shared decision in a reliable contract frame. However, [9] does knowledge of uncertainty really set patients free?
Perhaps the disclosure of uncertainty does interfere with our effectiveness as healers. In a way, Balint was the first EBM' "*visionnaire*", wasn't he?

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