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The art of practicing scientific medicine

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THE ART OF PRACTICING SCIENTIFIC MEDICINE

Dear Sir,

Today, the practice of medicine has undergone tremendous change due to the unprecedented developments in medicine in the last four decades. It is no longer considered adequate to treat a patient purely on clinical experience alone, without a clear demonstration of evidence based on research.[1]

Despite the overwhelming popularity for the "Evidence-Based Medical Practice", some physicians perceive it as a devaluation of the 'art of medicine' and a threat to their professional autonomy. As a result there are calls to revise the "Evidence-Based Medical practice model", wherein greater emphasis is placed on clinical expertise and patients' preferences, both of which remain powerful influences on physicians' behaviour.[2]

It has been argued that the freedom of a doctor to treat an individual patient in the way he believes best has been markedly limited by the concept of "Evidence-Based Medicine". This becomes more relevant, when we consider that evidence for the best medical practice is often not available, limiting the practice of those who support it.[3] Moreover, the so-called "evidence-based practice", filters through the opinions of experts and journal editors, and "Opinion-Based Medicine" would be a more appropriate term.[3]

In the real world of individual patients with multiple diseases, who are receiving a number of different drugs, the practice of evidence-based medicine is extremely difficult. For each patient a judgment has to be made by the clinician and, therefore, guod medical practice still requires clinical freedom for doctors.[3]

It is the duty of all health care providers to remember that the practice of medicine is not purely a science. In its mission is the art of encouraging the individuality of each provider of medical care to interact with the individuality of his/her patients.[4]

Despite the continuing debate whether the practice of medicine is an art or a science or both, one must remember that both "science" and "art" are essential elements of "evidence-based care", which strives to integrate the best external evidence with all-round clinical expertise.

"Evidence-based medicine" is now frequently used to develop clinical practice guidelines, but clinical medicine is complex, and "Evidence-based medicine" will never provide easy answers to difficult problems, which means that there will always be an art to the practice of medicine.

As modern day practitioners, we must ensure that our medical practice is not only evidence-based but that it also incorporates patients' preferences and our own experiences. Due to the tremendous scientific progress made in health care in the previous decades, the art of practice of medicine has assumed more importance today than ever before.

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PAIN SERVICES IN HOSPITALS

Dear Sir,

Acute Pain Services (APS) are now a common feature of department of anaesthesia all over the world. New tecniques, such as PCA and continous epidural, analgesia, which were experimental then, are now well established routine measures in many hospitals.

Acute pain was known as specialty in 1998 in Seattle (USA) when Brian Ready published his concept of Acute Pain Service (APS).[1] This was followed in 990 with joint Royal Colleges report[2] that recommended the setting up of acute pain services at all hospitals. Acute pain teams are now widespread in North America, Australia and increasing in Europe; there is now even a journal dedicated soloely to the sub-specialty (International Journal of Acute Pain Management, Saldatore Ltd, Bishop's Stortford, UK).

Now it is time we, the anaesthetists, should start pain services in our hospitals. Recently, we have taken this step in out hospital. It is well documented that nurses and doctors regularly underestimate patients' pain.[3] There are several reasons for this. The most common being that patients are not asked directly about their pain. Any outside assessment will then only reflect the patient's level of distress they exhibit for a given amount of pain. Most patients have a wide variability in their perception and expectation of analgesia and pain. It is, therefore, essential that pain assessment begins before surgery. Pre-operative assessment by anaesthetist is a time to allay fear, anxiety and to explain andprovide information about proposed analgesic regimen.[3]

The role of nurses and anaesthetists is to ensure that ward staff make regular assessment of patient's pain score, as well as nausea and sedation level. It should be recorded with routine observation, which can be made using simple (four point assessment) Pakistan Coin Score. This is simple but it has been shown to be one of the fundamentals to improving pain management.[4] So I would suggest my colleague anaesthetists to introduce APS in their respective hospitals and clinics.

Many methods and techniques can be used to alleviate acute pain: A combination of local anaesthetics and opioids provides the best compromise between high efficiency and low side effects profile for epidural analgesia.

Paracetamol is curently the non-opioid of first choice for acute pain management in view of its efficacy and minimal adverse effects. Tramadol offers a useful altemative to conventional opioids.

Anaesthesiologists can use analgesic of their choice in epidural space. It is suggested that provision of standardized guidelines by an APS will increase safety and efficacy of pain management in the postoperative period. The multimodal and multidisciplinary approach is essential for postoperative pain. Close co-operation and others integration of effective analgesia in postoperative period will lead to rediced hospital stay, improved outcome and reduced complications.[5]

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