

Uncertainty Is Hard for Doctors

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My patient came to me for advice. His cardiologist was recommending that he get an I.C.D., a type of defibrillator, implanted in his heart. My patient hadn't suffered any abnormal heart rhythms, but his heart was enlarged and he was at risk. If malignant heart rhythms arose, he could die if there wasn't immediate defibrillation available. An I.C.D. could shock his heart back into a normal rhythm. However, putting in an I.C.D. is an invasive procedure with definite risks.

My patient wanted me, his internist, to tell him whether getting an I.C.D. was worthwhile. I remember the feeling distinctly: a dense cloud of agita settling over me, a needling sensation of entering a gray zone of medical decision-making. This was not a straightforward situation — we'd have to weigh the risks and benefits, and we'd have to probe carefully into what he valued in life. Was he a risk taker, who would gamely try any medical intervention that might offer benefit? Or was he risk-averse, believing it better not to fix what ain't broke?

As a group, doctors dislike ambiguity. We pride ourselves in the scientific girders of modern medicine. We are most comfortable when we are dispensing medical care to our patients that comes from a double-blind clinical trial, that fits into a validated clinical-prediction rule, that derives from an accepted algorithm and has “Level 1” evidence behind it. But very little of medicine falls into that absolute category. Many of our treatments haven't been rigorously studied, and even if they have, large swaths of the population are woefully underrepresented in clinical trials — the very old, the very sick, women, members of racial and ethnic minorities, children, pregnant women and those low on the socioeconomic scale.

Much of the time, therefore, we function in an ambiguous zone, without clear-cut answers. My patient didn't fit perfectly into the “high-risk” category, and he was from an ethnic minority that wasn't well represented in the I.C.D. trials. Tolerating ambiguity and uncertainty is a profoundly frustrating experience for most people, but especially for doctors. Living with uncertainty is like being on a slow-moving carousel, with that vague unsettling sensation permeating your body. And then, in that state, doctors are asked to make serious and profound decisions, ones that may gravely affect the life of a human being. Some doctors try to fight off that horrid feeling of unknowing with solid verdicts of certainty. From experience, I've learned to be wary of answers that sound too good to be true. The cardiologist told my patient in no uncertain terms that he needed the I.C.D., ASAP. The certainty of that recommendation unsettled me. I knew the cardiologist was recommending what he thought was best for the patient's heart, but I wasn't sure he was considering the rest of the patient.

The patient and I discussed the risks and benefits, which was in itself a complicated discussion since the risks of the procedure would be more immediate while the benefits might not be felt for some time. In fact, if he were destined never to have a life-threatening rhythm disturbance, then he would never experience the benefits at all. In the end, we decided to go forward with the I.C.D. If there was a chance to prevent sudden death, we decided it was

worth it, since he still had many good years ahead of him. The procedure, though invasive, was relatively simple and low-risk.

Low-risk, however, isn't the same as no-risk, and my patient had the bad luck to fall into that small group with bad outcomes. Right away, the I.C.D. didn't function well, shocking his heart at all the wrong times and making my patient feel as if he were being struck by lightning, over and over. His heart rate skyrocketed, and the cardiologist had to pile on medication after medication to slow it down. One medication caused constipation; another caused swollen legs; another caused fatigue, depression and impotence. The low-risk overnight elective procedure turned into a week of misery that aged my patient by a decade. Finally, he insisted the cardiologist turn off the I.C.D. So in the end, he received none of the benefit and all of the risk. It was a horrible experience for everyone involved. It took my patient almost a year to recover. For me, it took even longer. Besides the human tragedy, it was an object lesson that every decision has risks and consequences, and that nothing can be taken for granted, even "low-risk" procedures. It also gave me enhanced respect for ambiguous situations, and increased wariness of simple answers.

When faced with ambiguous situations, most of us — quite humanly — want to run for the tantalizing veneer of the certain. No doctor wants to give a murky answer and sound stupid. We want to give the sure and absolute pronouncement about what is the right thing to do. Medicine strives to be a rigorous science. But it is more often, as Dr. Sherwin Nuland called it, "an uncertain art." We have piles of data at our disposal, but how to use this information is not always clear-cut. Owning up to this uncertainty — to ourselves and to our patients — is not easy, but it is the more honest approach. The only thing certain about ambiguity is that it is a fixed part of medicine.