



When only a doctor will do

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EDITORIAL

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Medical practitioners are highly trained and possess specialist skills. However to manage many people with symptoms, not all those skills are required. It also seems that there are people who are prepared to prey on the vulnerable and deceitfully present themselves as doctors for personal gain. Sadly people across the world have been duped into believing that they were consulting a doctor by those with no qualifications. Given a choice, however, people are selective in choosing when to consult a doctor, often a practitioner in some other discipline is chosen to address problems. In this context there is a need for innovations to redirect people who have chosen to seek advice about symptoms that should be dealt with by a qualified medical practitioner.

If you were planning to colonise a newly discovered wilderness would you insist on a doctor as a core member of the team? What would that doctor offer? In what circumstances will only a 'doctor' suffice? In the 21st century many other professionals possess the skills

and knowledge that were once the preserve of the medical profession. There are few occasions when the diseased human body, unlike a malfunctioning aircraft at thirty thousand feet, will require a fully qualified expert to set it back on course. Is there a doctor on board? Does the doctor step up or do they advise that the crew

would be far better calling for a paramedic or a nurse depending on whether the unfortunate passenger needed full blown resuscitation or to be made more comfortable or stabilised before being moved to an appropriate place and to the care of a team adequately skilled to do the needful?

The greatest emergency is the occasion when the heart, the organ whose normal functioning sustains life, has stopped. There is limited evidence that a doctor is the best professional to resuscitate someone in so-called 'cardiac arrest'. Research published in 1999 concludes that only one in seven people who experience an out-of-hospital cardiac arrest survive to reach hospital alive.¹ Those with the best chances of survival are attended by a paramedic; with or without the assistance of a medical practitioner.¹ A more recent systematic review of the literature remains equivocal.² Increased survival was reported with physician treatment in trauma and, based on more limited evidence, cardiac arrest. Indications of increased survival were found in respiratory diseases and acute myocardial infarction. The role of doctors in many conditions seen in the pre-hospital setting remain unexamined.²

If doctors have skills that are not easily faked, then it is remarkable that so many doctor impersonators have duped the public over the years. Men like Dave Chatterjee who worked as a doctor at the Veterans Affairs Medical Center in the United States of America for nearly two years and was arrested as a fake in 1993.³ He treated more than 100 patients and routinely prescribed potent medication before suspicions were raised. Similarly an Australian medical student successfully impersonated a doctor for four nights between November and December 2005. Police said he administered injections and



tested equipment.⁴ In the same year the UK Times reported that a thousand successful asylum applicants faced a review of their cases after the doctor who gave expert evidence at their hearings admitted that he was really a former taxi driver with no medical qualifications.⁵ Barian Baluchi, used a string of fake qualifications to set himself up as a leading clinician, was jailed after claiming more than £1.5 million for medical services.⁵ More recently Russell Oakes, 43, tricked dozens of people into believing he was a trained GP and carried out unnecessary tests.⁶ In February 2010 Australian police arrested a man who had been working as a doctor for half a year without holding the appropriate qualifications. He was believed to be a graduate of the University of Adelaide but the University confirmed his qualification papers were fake.⁷ Matthew Brafman was jailed in 1994 for lying his way into a job as a hospital doctor. The General Medical Council failed to spot that the medical college in Alabama where Brafman claimed to have trained did not exist.⁸ Another man built up a large practice and worked as a GP for 30 years, despite having no qualifications. His prescriptions included shampoo and suppositories to be taken orally.⁹ Godwin Onubogu was jailed in 1998 after subjecting women to unnecessary tests for sexually transmitted diseases from his "clinical laboratory" in London.¹⁰ With a very limited education he had also made an income by posing as an expert witness for motorists in drink-drive cases. This year a bogus GP was apprehended in the UK after he was found guilty of sexually assaulting four women.¹¹ These and hundreds of other cases beg one question, why are so many people duped by fake doctors, sometimes for lengthy periods of time? What behaviours were these rogues displaying that made them so compelling to at least some people? They clearly had a remarkable ability to forge a trusting relationship. Such skills, in the wrong hands can, and do, mislead the vulnerable.¹²

One might also ask in what circumstance could you not fake it? There is some evidence that those with less than full medical training may function reasonably in many circumstances in which we still rely wholly on trained medical practitioners. One would certainly call for a doctor, or rather a team led by a doctor, if the occasion required the surgical removal of a diseased organ or reconstruction of traumatised tissues. One might also require such a team if a loved one was suffering from

the effects of pathology with an imminent risk of organ failure. On almost all these occasions the patient will display the signs of physiological or psychological decompensation, in other words it will be evident that he or she is close to or at risk of death. There will be no doubt in the minds of those who will have to make a decision that the patient will only survive under the urgent services of an experienced and skilled clinician with the necessary understanding of anatomy, physiology, pathology and therapeutics to administer the necessary treatment. There are of course many infections and other maladies that mandate the administration of something that could in any other circumstances be classified as a poison. However one could argue that there are many health professionals who could recognise the indications and administer the appropriate remedy. In the majority of cases people with symptoms can, and do, benefit from much less drama and fuss than we are used to witnessing on television.¹³ They receive effective and timely interventions for what are either benign, self-limiting or early symptoms of an illness that can be nipped in the bud or displays of psychological distress that have their origins in the patient's perspective on their life situation. Unfortunately there is some evidence that people are not always appropriately advised. For example a recent paper reported that a significant proportion of people who present with respiratory conditions to their local pharmacy are not referred to a doctor when indicated.¹⁴ Therefore what is warranted are innovations to identify when that people require the attention of a medical practitioner to rule out a more sinister cause for the complaint.¹⁵

If we are to believe every report in the press then there are queues of people around every corner in urgent and dire need of medical attention.¹⁶ While there may be some truth in this suggestion there is also evidence that the public knows the limitations of what medicine has to offer and that it behaves much more rationally. Over a number of years a team of researchers in the United States has demonstrated that people seldom visit a medical practitioner in the course of a normal month. In their seminal paper Green and colleagues tracked the help seeking behaviours of a thousand 'average'



Americans. Four hundred had symptoms of one sort or another, a further 200 had thought about consulting a doctor, one hundred had consulted a doctor, eight has been referred to a hospital specialist and one person was admitted to an intensive care unit.¹⁷ Most people usually consult a primary health professional. For those in search of a pill or potion to alleviate symptoms the journey begins and ends there. There is also some evidence now that the public are also willing to consult other than a medical practitioner in circumstances in which they previously would only have considered seeing a doctor.¹⁸ In the developing world with a shortage of doctors there may be no choice.¹⁹

Conclusion

Symptoms are common. However in the developed world life-limiting pathology is rare. Even in some emergencies it is likely that an individual trained to deal with that specific emergency can be as helpful, perhaps even more helpful, than the average physician. There are certainly occasions when only a doctor will do. However life-limiting illness is uncommon most people come to no harm from consulting someone who hasn't been trained as a doctor. However people do come to grief from consulting charlatans or professionals who have not set in place safeguards to protect against their limitations. The skills required to manage specific symptoms or conditions may be taught in many disciplines. However that is not to say that these skills do not require formal and regulated training. This must include clear guidance on when the patient's condition warrants the attention of an appropriately qualified medical practitioner. There is no room for deceit or complacency in the care of human being in distress.

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CONFLICT OF INTEREST

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