

# Doubt is the doctor's pillow

## *A dúvida é o travesseiro do médico*

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### ABSTRACT

Based on a quote attributed to Professor John Galizzi, we attempted to discuss the role of doubt in medical activity. We start by addressing the semantic aspects of the words “doubt” and “uncertainty” and difficulties arising from the subject-object relationship in medicine. Hippocratic indications were revisited, as well as the philosophy of Descartes and the aphorisms of William Osler, to present-day evidence-based medicine. By indicating the existence of the otherness that is the patient as a source of doubt within the medical activity, we argue that a project of eliminating doubt is neither possible nor desirable because it would imply the elimination of this otherness. We suggest doubt as an element intrinsic to clinical reasoning that puts the patient in the center of things, allowing physicians who uses doubt to cultivate the clinical method. We sought therefore to call attention to and discuss the importance of sentence attributed to the eminent professor: “doubt is the doctor's pillow.”

**Key words:** Uncertainty; Physician-Patient Relations; Clinical Diagnosis.

### RESUMO

*Com base em uma frase atribuída ao Professor João Galizzi, buscou-se discutir o papel da dúvida na atividade do médico. Iniciou-se por abordar aspectos semânticos das palavras dúvida e incerteza e a partir das dificuldades advindas da relação sujeito-objeto na Medicina. Foram recuperadas indicações hipocráticas, passando pela filosofia de Descartes e aforismos de William Osler, chegando à medicina baseada em evidências. Ao se indicar a existência de alteridade do paciente como uma das fontes da dúvida que surge no seio da atividade médica, discute-se que um projeto de eliminação da dúvida não é possível nem desejável, pois implicaria a eliminação dessa alteridade. Sugere-se a dúvida como elemento intrínseco ao raciocínio clínico e que coloca o paciente no centro do mesmo, permitindo ao médico que se utiliza dela o cultivo do método clínico. Buscou-se, assim, colocar em evidência e discutir a importância da frase atribuída ao eminente professor: “a dúvida é o travesseiro do médico”.*

*Palavras-chave:* Incerteza; Relações Médico-Paciente; Diagnóstico Clínico; História da Medicina.

### INTRODUCTION

Upon receiving the task of discussing the topic of “doubt” in a round table about clinical reasoning during the ABEM Conference in Belo Horizonte (2011), I was reminded of the phrase often delivered by Prof. Luiz Otávio Savassi Rocha, who was an internal medicine reference in our College: “doubt is the clinician's pillow”.

The invitation also reminded me of the strangeness - perhaps certain unease - that the phrase used to cause in me. I believed then that it was an opportunity to try-

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ing to better understand this strangeness, while trying to develop something on the subject of “doubt”, and, at the same time, bring the contribution of the tradition of our College, in the year of its centennial, to the discussion of this important topic.

In an email to Prof. Savassi, I asked him to give me some indication of the origin of that phrase and clarification to my strangeness, asking him the following question: does doubt haunts the clinician, always doomed to wonder “what if?” in their sleepless nights or is it a more benign companion, more beneficial, compatible with a good night of sleep, and is there to remind us that we are not all and neither can do all? What bothered me in that sentence, I believe, was a certain condemnation of the doubt that it contained in itself.

In his reply, Prof. Savassi corrected me, expanding the scope of the phrase that in actuality said, “doubt is the pillow of the doctor,” rather than the clinician’s. In addition, he revealed that he heard the phrase repeatedly during the lessons of the late Prof. João Galizzi, and could not say whether it was of his authorship. He suggested that I should seek further clarifications, which I did without success. Gently, he was still able to offer some insight to the issues set forth in the electronic correspondence, which helped me advance in my reflections about doubt in Medicine, which I reproduce here:

*The interpretation of the phrase to which I refer would require a long digression. In summary, I would say, ‘mineiramente’ regarding the “doubt”, that it is not mere “haunting”, nor a “more benign companion, more beneficial”, but a “beneficial haunting”, as long as it is seen as an essential instrument in the obstinate, painful, and often, frustrating search for the Truth.*

Continuing in the started search to discuss the proposed topic, I found some aphorisms of the great clinician William Osler in which the themes of uncertainty, variability, and ignorance are present to indicate possible proximity between the phrase of Prof. Galizzi and ideas of the illustrious physician who can also help to discuss the subject “doubt”:

*Medicine is the science of uncertainty and the art of probability.<sup>1</sup>*

*Variability is the law of life, and as no two faces are the same, so no two bodies are alike, and no two individuals react alike and behave*

*alike under the abnormal conditions which we know as disease.<sup>1</sup>*

*The greater the ignorance the greater the dogmatism.<sup>1</sup>*

We will try to deepen a little more on the theme to try to understand the role of doubt in the doctor’s work, trying to retrieve something from the clinical reasoning and activity, from the phrase by Prof. Galizzi and the oslerian statements.

The uncertainty (uncertainty) is the most found word in the Anglo-Saxon literature to define the hesitation before a medical decision. We practically do not find “doubt” (doubt) as a keyword for the search on the topic.

In the English language, it is possible to still say “I m uncertain.” In Portuguese, we, usually, do not say “I’m uncertain.” You could say “I have doubts” or “I am not sure”, but it is not common in the Portuguese language to say “I have uncertainty.” Houaiss defines uncertainty as “state or character of which is uncertain”.<sup>2</sup> Heisenberg used the expression “the uncertainty principle” (or indeterminacy) and not “principle of doubt” to name the impossibility to define, at the same time, the speed and position of a particle, object of physical observation. In fact, the same Heisenberg discussed the role of the observer as capable of affecting the result of the observation, questioning the subject-object relationship in Physics.<sup>3</sup>

If we tried to graphically represent the point in a line drawn between subject and object of observation, these linguistic and semantic issues seem to indicate that, between the subject who observes (and who decides about the truth or the certainty of his observation) and the observed object, the impossibility of decision may depend on factors that are sometimes closer to the subject, sometimes closer to the object.

Without wishing to conclude, one can speculate that “doubt” would be linked to the condition of the subject of observation or of the decision while uncertainty was related to the object. Doubt, an abstract noun in its own right, while uncertainty, although also an abstract noun, is the negative of certainty, lack of certainty.

Although it is not for us here to get to a final decision on the true meaning of the words doubt and uncertainty, the discussion serves to highlight an important question. Doubts or uncertainties that come into play in the exercise of the medical activity prob-

ably did not arise only from a current impossibility of knowing the object because of momentary failure of our knowledge or our means of observation, i.e. something to be remedied with the development of science and technology. It is possible that it comes not only from the complexity of the human object, but also from the complex relationship between the observer and the observed, doctor and patient.

Descartes, the creator of the methodical doubt as a means of achieving certainty, created a separation between the *res extensiva*, the extensive thing, the corporeal world, and the *res cogitans*, thinking. The body object, part of this bodily world, was compared to a machine by Descartes.<sup>4</sup>The project of the philosopher had also, as an aspect of his method, the act of intelligence that, decomposing and recomposing a machine, understands the composition of an object. Currently, fruits of the scientific thought inaugurated by Descartes, after splitting the body in organs, systems, and various compartments, we mapped it with a variety of exams, know about its DNA, its fluids, and various tissues, and thus, explain the phenomena that present themselves to the Medicine to be deciphered and treated. The separation operation between the *res cogitans* and *res extensiva* has created the conditions for the scientific knowledge of objects in that same world at the same time that it put in doubt the existence of the sensible world through systematic doubt, paradoxically. The body-machine, divided to be known and transformed into a knowable object will have its bowels and enlightenments, and the uncertainties about its operation by the progress of science progressively eliminated.

The scientific advancement, from the cartesian procedure, brings us to the point where we ask: why then doubt or uncertainty, if we are immersed in a scientific and technological evolution of proportion never before observed? However, several authors highlight uncertainty and ambiguity as intrinsic aspects of contemporary Medicine. They note, however, that the culture of Medicine has little tolerance for uncertainty and ambiguity and that patients and their doctors are equally intolerant.<sup>5,6</sup> Thus, they update hippocratic issues, which are still present in the midst of all this evolution. The free translation of English from Lloyd<sup>7</sup> and the Wikipedia site <[http://en.wikipedia.org/wiki/Ars\\_longa,\\_vita\\_brevis](http://en.wikipedia.org/wiki/Ars_longa,_vita_brevis)>, accessed on 11/7/2011, where the aphorism appears in Greek, Latin, and English, with comments on its translation and interpretation:

- life is short
- the art (techne) long (the task is big)
- the opportunity fleeting,
- the experiment (the experience) fallible
- the trial (distinguishing between similar things) difficult.<sup>7</sup>

We highlight that this expression of hippocratic doubt about the experience does not seem to represent a rejection of experience, but the realization of its fallibility, a warning not to rely too much on it. The phrase maintains its actuality in regards to relations between the medical activity and doubt or uncertainty, applying also to the understanding and discussion of one of the contemporary products to solve it – the evidence-based medicine (EBM).

Therefore, it is worth noting that the emergence of EBM identified, among other things, the need to review the role of “non-systematic” clinical experience as a valid instrument to build and maintain the knowledge regarding prognosis, the value of diagnostic tests, and therapeutic effectiveness.<sup>8</sup> Young doctors were urged to question the value of authority and pursue skills that allow independent assessment of the credibility of the opinion of experts. In an article about principles, Gwyatt et al. observed that “clinicians must be ready to accept and live with uncertainty and recognize that decisions about the clinical management are often taken in ignorance of their true impact”.<sup>8</sup>

Although one criticism of EBM is beyond the purpose of this communication and the ability of the author, unlike the initial profession of faith, we cannot affirm that EBM contributed to the conviviality with uncertainty. Apparently, the proliferation of guidelines and statistically well-founded decision processes may be contributing to the outsourcing of medical decision, with the intent for the doctor to not incur in doubt and anguish that this necessarily entails, serving to placate the intolerance to uncertainty mentioned earlier. In some ways, the criticism that EBM express over the non-systematic experience and its emphasis on evidence takes it closer to renovated Cartesianism, in which evidence, that is left in the cartesian operation harassment of the object of knowledge through systematic doubt, corresponds to the clear and distinct truth, the true cartesian procedure object.

The medical decision-making process is organized from three separated moments: first, the data collection – clinical history, physical examination, and ancillary tests; after the analysis of the obtained data

and its integration with the experience and knowledge of the doctor (the so-called clinical reasoning, which is already in action when the patient enters the room and when the doctor collects his history); and, finally, the taking of a conduct – one communication, one therapy, one recommendation. The evidence of EBM is likely to serve as a set knowledge that leads to devaluation or even an elimination of the time of reasoning. What does not serve as evidence becomes a second-class knowledge, useless for the purpose of medical decision, and the reasoning runs the risk of turning into categorizing and filling algorithms.

Resuming the axis that motivates this text, when underlining the importance of the moment of clinical reasoning and the risk of its depletion, we assume that this is the moment when the doctor may become the subject of doubt and not necessarily, the victim of uncertainty.

The question, based on the reasons listed below, does not seem to be able to be treated only by procedures aimed at the production of evidence, clear and distinct version of the truth in the cartesian thought.

Starting from a more obvious reason – that of, to be rigorously scientific, we have to recognize that, regardless of the advances in the direction of knowledge of the body organism, the task of knowing it and the physical universe is immeasurable -, problems in this field are diverse, including the attempt to reduce the biological object to any object in the physical world. Influential thinkers emphasize the distinction of the characteristics of the Physical Sciences from those in Biological Sciences.<sup>9,10</sup> Following this line of reasoning, there is, a specificity in life sciences based exactly on the idea of life, in which living organisms have features that are not applicable to common physical objects, such as self-regulation, reproduction, and selection. This biological specificity must be highlighted as it defines an impossibility that a mathematical certainty applied to Physical Sciences is automatically applicable, in the same way, to Life Sciences, even if we consider that quantification and measurement are fundamental aspects of modern Biological Science and the application of Physical Sciences in the diagnostic field has been responsible for major breakthroughs. Mathematics in Biology serves mainly as a measure of variability and not necessarily as an index for certainty. Remembering Osler<sup>1</sup> again: “[...] *no two faces are the same, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease*”.

Another reason: does everything that we know about the body organism apply to the sufferings that the patient presents us with? Would all suffering that is expressed as a symptom and presented to the doctor has its site in the *res extensiva* or even having their site there, wouldn't it have its origin in its well-being in the world, its ways of living life, and how to relate to others?

The clinic and epidemiology provide some thought-provoking indications. If we observe the listing of complaints and diagnoses that are common in primary care, we will find various conditions that, although they constitute symptoms of organic diseases, they can also present etiology, clinical course, and undefined therapeutic: fatigue, dizziness, dyspepsia, abdominal pain, non-anginal chest pain, constipation, headache, backache, insomnia, impotence, various mental sufferings, and several others lashing out precise pathophysiological explanations that unequivocally find lesions in organs or systems. In addition, the extensive list of diseases of modernity, some with epidemic characteristics such as obesity, diabetes, cardiovascular diseases, AIDS, and eating disorders are clearly related to modern ways of living.

Finally, the reason, which concerns the issue of doubt as a condition of the doctor, as opposed to a state of the object patient (or of an organ or system) and, thus, insoluble from the knowledge of the object. That is, we would doubt not necessarily for not sufficiently knowing our object, but because our judgment hesitates before what our patient presents as a complaint, his interpretation of suffering, and given what he asks from us. Is that possible that for all the complaints we are able to diagnose the cause or provide the object what restores its well-being - a medicine, a prosthesis? Or, is that what we have enough to fit what is good for our patient? Or more, will that be that science knows what is good or what is the good in our patients? By the way of a provisional conclusion, one can say that the doctor hesitates (or doubts) when there is an otherness involved, because the other's complaints, the patient, when conceived as what is good for him, or what is right for him, cannot be answered only from the point of view of the knowledge of the corporeal world, *res extensiva*, but must take into account a subjectivity that belongs to that patient. It is evident that, in certain situations, this otherness is enclosed in parentheses, such as during surgery or during an emergency response, for example, when the physician should focus as much as possible on the technical act. Conversely, the indication

of surgery should take more than clinical abnormalities and changes of biological variables into account. The concept of functional capacity, for example, that can take a surgeon to indicate a knee or hip prosthesis, although it may involve objective and quantifiable variables, is tinted by doubt, that asks: functional capacity of whom and for what? The concept of quality of life, so in use and as important as the outcomes in certain types of clinical trials, when applied in the care to a specific patient, the doubt adds the quest: quality of life for whom, and for what?

Thus, the elimination of doubt (or uncertainty) is not possible or desirable. It is not possible, because there is not, as mentioned, possibility of depletion of knowledge about life and about the biological body.

Is not desirable because the project of elimination of doubt has, as a fundamental methodological assumption, the elimination of otherness. The absence of doubt means that the medicine can set well-being as well as designate objects that promote or restore the good in their patients unequivocally. However, the sharp ability that we have today to diagnose and treat problems as diverse, in the context of contemporary nosology, in which large numbers of people suffer or get sick by choices, adopted life styles, the standardized or uniform answer is not possible for all cases, the application of the scientific universal ideal to the: obese, negative energy balance, even with medication and surgery; dyspeptic, endoscopy and proton pump inhibitor; depressed, serotonin reuptake inhibitors; impotent, phosphodiesterase inhibitors.

Such resources can and should be used when necessary. However, when doubt appears, perhaps, listen to her. The doubt that appears at the time of clinical reasoning makes us want to know more. The source of this knowledge is, first of all, the patient. By returning to what he has to say about his illness, we can find some answers that take into account the

specifics of his case and allow a clinical conduct that is more careful and precise. We would then cultivate the listener and clinical reasoning, basic categories of the clinical method that a project for the elimination of the doubt would also eliminate.

Let's move along with the teachers Galizzi and Savassi. Doubt is the doctor's pillow. 'Mineiramente', we think that it is not mere "haunting", nor only "a more benign companion, more beneficial", but a "beneficial haunting" as long as it is seen as an essential instrument in the obstinate, painful, and often frustrating search for the Truth".

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