

Evidence based myths of Anaesthesia

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'Many societies have two categories of traditional narrative - true stories or myths and false stories or fables.' "When a myth loses its status (often religious) it becomes folklore.' " A myth in one society may be folklore in another".

In this context a medical myth may be a fundamental belief that remains a core value for a clinician but the practical implementation of which may vary according to current opinion or fashion. This is seen in several forms one of which is the recurrent emergence of particular treatment modalities followed by their speedy repression. Steroids and frusemide spring to mind. The former the great panacea that everyone feels must do some good, and the latter heavily dependent on the natural affinity between clinicians and urine. That affinity dates back millennia even if frusemide doesn't.

Every generation of doctors from time immemorial has tried to do the best for their patients using the best practices of their day and with an evidence based approach. In that regard all that has changed is the specific mechanism by which the value of evidence is weighed. The newly established ranking of evidence initially hailed as fit for purpose and now beyond reproach, on the basis of popular opinion, may indeed be a modern myth in evolution. It is in its ascendancy and hence has strong advocates and there is enthusiastic association with the method. When belief fades then it will become folklore, dissociation will occur and it will take its place as an interesting phase in medical history. At present it is the new method and as such unassailable. In this clinical era the treatments and technologies available to physicians have proliferated and one of the more pronounced changes has been the decline in bedside clinical skills in favour of technology. This is not surprising given that clinical acumen was all important when nothing else was available. Slightly more disconcerting is the similar decline in the value of experience in favour of the all knowing database. The fundamental questions still remain as to whether what we think is right and whether what do works but now to answer these questions we apply an evidence based coda rather than judge by experience. The problem is the data base is far from all knowing but we do not seem to know that.

In similar vein, in days gone by hypothesis led to popular theory supported by opinion. Facts as are understood today were few and far between but exchange of ideas experience and opinion were the mediators of medical opinion. This resulted in the behaviour of the many following slavishly in the footsteps of the few. The strength and character of the protagonists of ideas and treatments was as important as the concepts themselves. Curiously nothing has changed here except that the message from the few is now couched in the contemporary evidence language which is a transducer for turning an opinion supported by some relatively circumstantial evidence to hard fact. The alchemists stone of modern medicine. That message is very important as even a solid gold New England paper needs the endorsement of the recognized few before many clinicians will change their practice.

It is a fact that most clinicians have a comfort zone and prefer to stick to what they know unless there is a significant persuasive force to change.. They know what they know , don't know what they don't know and are probably more comfortable that way. The term 'what we know' could be phrased belief. Belief underlies much of what we do and is key to the comfort zone.

John F Kennedy said many things but one quotation that relates closely to medical practice goes as follows;

