

## Prognostication of Critically Ill Patients – The ‘Science’, the ‘Art’ and the Creeping Commercialism

DE Aarons

Risk assessment using prognostic models to make decisions regarding the management of individual patients carries an ethical dimension to the process. The degree of accuracy of the models as well as their reliability and utility in the care of individuals are therefore important considerations. The article in this Journal comments on some of these issues, as well as the possible influence of commercialism in the development of the models, and the role of the physician in using his/her own clinical judgement when caring for the individual patient (1).

The article describes the evolution of the APACHE and other scoring systems for the severity of illness of critically ill patients, which all seek to predict an individual patient’s outcome, and which are used for intensive care unit (ICU) and surgical patients, as well as victims of trauma. It critiques the usefulness of these scoring systems in every day practice, and regards their use of the term “prognostic” as erroneous, since it opines that the systems are not helpful in predicting the prognosis of the individual patient under care. Rather, the article opines that the systems are better at statistical modelling for groups of patients having similar illnesses.

This article further opines that physicians who routinely provide care to particular groups of patients will be able to “innately predict their prognosis with a reasonable degree of accuracy”, which it regards as the “art” aspect of the particular clinical practice. However, some readers may query whether such ability is in fact “innate” to physicians because of the nature of their work. Abilities and skills in clinical practice are developed and “honed” over time; they are not “innate” to the physician. The “art” of medicine

refers to the caring, sensitive, empathetic (affective/socio-emotional), non-technical side of medicine on which historically the practice of the “science” of medicine has been built. This point notwithstanding, however, the article provides interesting examples of reports which conclude that a physician’s ability to clinically predict the outcome of ICU patients may be comparable to that predicted by the described scoring systems. It also held (more reasonably) that a physician’s ability to more accurately prognosticate improves with time and experience.

In light of the foregoing, this article infers that, since prognostic models have continued to evolve over time, several factors may be fuelling their evolution (science seeking to provide sophisticated investigations, the need for improved statistical methodologies and the significant commercial benefits that likely accrue). It also opines that the high-technology practice of medicine today is undermining the “art” aspect of clinical practice but does not provide any examples or argumentation to substantiate this opinion. It further holds that the current medical curriculum does not “foster” the art of medicine, but does not state which university’s curriculum it is commenting on. Reasonably, it concludes that, while “evidence-based practice” is important, the curriculum should seek to produce a well-rounded doctor with an emphasis on the importance of the human touch. In this analysis, machines and statistical software would only be of secondary importance in the care of patients.

### REFERENCE

1. Hariharan S. Prognostication of critically ill patients – the ‘science’, the ‘art’ and the creeping commercialism. *West Indian Med J* 2007; **56**: 474–6. .

---

From: Department of Community Health and Psychiatry, Faculty of Medical Sciences, The University of the West Indies, Kingston 7, Jamaica, West Indies.

Correspondence: Dr DE Aarons, PO Box 65, Tower Isle, St Mary, Jamaica, West Indies. Fax: (876) 975-5719, e-mail: daarons@infochan.com