



President's message. Clinical courage

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As many of you will know if you are attending this year's Rural and Remote Medicine Course, the theme of the conference is clinical courage. I don't know whether he is the author of the term, but I first heard it from my colleague and former SRPC president, Dr. Keith MacLellan. It's a difficult concept to get one's head around. Clinical courage inhabits that grey zone at the fringe of competence, where the fog gets thicker as we approach the edge of the cliff. How far is it reasonable to go? How close to the edge must we be before we put down our heavy load?

I wonder how this dilemma might sound to a patient? Many would be forgiven if they wanted no part of it. "Pass on decisions to the next (presumably more competent) level at the first sign of trouble!", might be a very reasonable reaction from a patient faced with a medical problem being handled by his or her local rural physician. We all know, however, that in the real world such options are frequently not available, and even if they are, they may not be the best choice.

Take the single mother (with 3 other young 'uns in tow) who brings her febrile 5-year-old to see you in the middle of the night. Ninety-nine times out of 100 this child has a viral illness or some other easily identified non-life threatening illness that requires little in the way of investigation or treatment. The clinical picture this time, however, suggests that a full septic workup, including lumbar puncture, is the best option. Perhaps the child is more toxic than you are comfortable with. Perhaps the neck seems a little stiff ...

The last lumbar puncture you did was 2 years ago. The closest pediatrician

is in bed 100 km away. The child is squirmy and might need sedation to get through the procedure. You weigh your options.

It is still likely that this child does not have meningitis, but nevertheless the adage, "if you think it, do it" applies. It takes clinical courage to initiate a course of action at the edge of your comfort zone. It is far easier to transfer the problem to someone else.

Doing the lumbar puncture locally will likely result in the elimination of a serious diagnosis from consideration; reassurance of a worried mother; the avoidance of a disruptive, expensive and probably unnecessary middle-of-the-night transfer; and the rather straightforward initiation of treatment for fever of unknown origin, which, even if unknown, is now known to not be in the central nervous system.

The above example can be tweaked or replaced by something else to fit individual variations in scope of practice and the parameters that define one's willingness to act. Although to some this scenario is nowhere near their "cliff edge," something else is likely to be, and rest assured, someday it will walk through that ER door to challenge you.

Clinical courage is that inner debate that we must all have with ourselves, in that space where the needs of our patients and the extent of our training and experience intersect. Sessions at the Rural and Remote Medicine Course in Collingwood, May 5-7, will hopefully fill in the gaps and solidify confidence, and make the overlap just a little bit larger than it was before you came. Have fun, and if you are reading this after the fact, I hope you enjoyed yourself and that you will come back next year.

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