Prisoners of ritual

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The indelible memories of my medical undergraduate days include one of a lecture delivered by the late Karl Stern, then professor of psychiatry at McGill. His topic was the role of ritual in preventing anxiety. He began by asking us to recall the silly games we had played as children — avoiding cracks in the sidewalk ("step on a crack, break your mother's back") or holding your breath when you passed a graveyard. We laughed with a tinge of embarrassment as we remembered our foolishness. But Stern suggested that we had never really abandoned ritualized behaviours; we had simply substituted new rituals for old. To illustrate this phenomenon, he reminded the class that most of us probably observed an unvarying sequence of activities when we got up in the morning and when we went to bed at night — for example, showering, shaving and brushing our teeth, always in the same sequence — or went through a specific sequence of positional changes just before falling asleep. He pointed out how variations in the order of these activities could induce anxiety. The truth is that all of us are, to greater or lesser degrees, prisoners of ritual. But these illogical practices, which have no known basis in science, serve an important role in our personal systems of preventive health care. Their function is to reduce our level of anxiety or, at least, to prevent it from rising. I realize now that Stern's insights may have been one of my earliest lessons in preventive health care.

This lesson is recapitulated, in a different context, in the report by Marie-Dominique Beaulieu and colleagues in this issue (page 519).[1] They have documented that physicians, like patients, are just plain folks after all, enslaved to ritual and tradition, reiterating beliefs and practices that both groups believe, logically or not, have served them well. All of us are easily seduced by the attractive notion that secondary prevention is possible provided you catch the disease at an early stage. This plausible idea is especially attractive where life-threatening diseases, such as cancer, are concerned — even though the paradigm may turn out to be less valid than we have traditionally believed.[2] Another attractive concept that has been widely promoted is the belief that if more money were spent on prevention, less would have to be spent on treatment — a concept that, with a few exceptions, does not stand up to close scrutiny.[3,4] The public is, understandably, not particularly interested in hearing from the heretics who have thrown such treasured beliefs into question.

There is ample evidence that many patients put more stock in wishful thinking than in analyses of scientific evidence. After all, if there's a chance that something might help, why not do it? Witness the explosion of interest and investment in what we euphemistically refer to as "alternative" therapies and ostensibly preventive products. Orthodox pharmaceuticals are being squeezed off the drug store shelves by a plethora of herbal and "natural" preparations, most of which have not been subjected to the sort of scrutiny required by the methodology of the Canadian Task Force on Preventive Health Care. Paradoxically, all of this is occurring in parallel with appeals from the scientific community for evidence-based prevention and clinical practice guidelines.

Meanwhile, the group headed by Beaulieu (who has a distinguished record of personal contributions to the Canadian Task Force) offers us a strong dose of tincture of reality. They remind us that there is a quantum leap from the epidemiologist's computer to your neighbourhood physician's office. The medical scientist for the most part studies disease. The clinician, by contrast, must give equal time to illness (how the patient *feels*) and must do so as effectively as he or she deals with the organic disorder. Consciously or subconsciously, most doctors understand that half the battle is helping people to feel better — relieving their anxiety, if you will. Therefore, it should come as no surprise to learn from this study that both doctors and patients are reluctant to abandon time-honoured practices that seem to comfort both groups. Professional resistance to the implementation of evidence-based clinical practice guidelines is not new. Lomas and colleagues[5] documented how Ontario obstetricians had failed to implement their own widely approved clinical practice guidelines, designed to reduce the unnecessary performance of cesarean section, despite the fact that many claimed to agree with the guidelines. Perhaps we shouldn't be too surprised or disappointed. Disease and dis-ease are 2 different forms of reality, each requiring our full attention in the course of the clinical encounter. It may be that failure to implement new strategies in preventive health care is directly related to the degree to which they defy established traditions. Bridging the gap between science and ritual remains the most significant challenge in improving preventive health care in the clinical encounter. The first step may be to sharpen our understanding of the preventive, anxiolytic functions of ritual in our daily lives.

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Competing interests: None declared.

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