

## Correspondance

## Physician, know thy limits

I enjoyed the first article by Donald Redelmeier and colleagues on problems for clinical judgement.<sup>1</sup> I was particularly interested to note that overconfidence ranks high as a source of clinical errors (3 of the 9 causes of fallibility relate to overconfidence, if one considers unquestioning self-approval and unawareness of limits of judgement as aspects of overconfidence). I suspect that a key reason for this lies not in physicians' lack of knowledge of cognitive psychology but in the fact that hubris is actively encouraged and rewarded during medical training.

As someone who went to medical school after several other careers, I was often appalled by the way arrogance and overconfidence were encouraged during medical training. Indeed, during clinical training I was frequently criticized for expressing uncertainty and humility to patients or teachers. It struck me as ironic that awareness of the limits of one's knowledge or data is encouraged in graduate school (I have a PhD in biology), where the degree of uncertainty is far less than in clinical practice. Perhaps the level of certainty in professional discourse is inversely proportional to a profession's scientific rigour?

Will Rogers is reputed to have said, "The problem is not what you don't know but what you know that ain't so." I believe that medical educators should take this to heart and reform their approach accordingly.

## Rachelle Sender

Family physician  
Hamilton, Ont.

## Reference

1. Redelmeier DA, Ferris LE, Tu JV, Hux JE, Schull MJ. Problems for clinical judgement: introducing cognitive psychology as one more basic science [commentary]. *CMAJ* 2001;164(3):358-60.

In their introductory article on problems for clinical judgement, Donald Redelmeier and colleagues stated that "examples of clinical judgement range from the monumental (such as whether to discontinue life-support for a patient

on dialysis) to the banal (such as whether to discontinue a telephone call when on hold with nephrology)."<sup>1</sup> The authors' example of a situation requiring monumental clinical judgement is unclear. If a patient is competent, he or she should make the decision to stop treatment. If the patient is not competent, then family members should decide. Physicians may, of course, need to determine if life-support is in fact only prolonging the dying process. I suspect it is this decision that the authors felt requires monumental clinical judgement.

## Stephen Workman

Assistant Professor  
Division of General Internal Medicine  
Dalhousie University  
Halifax, NS

## Reference

1. Redelmeier DA, Ferris LE, Tu JV, Hux JE, Schull MJ. Problems for clinical judgement: introducing cognitive psychology as one more basic science [commentary]. *CMAJ* 2001;164(3):358-60.

## Do women treated for breast cancer at teaching hospitals really fare better?

Breast cancer is a disease that is notoriously heterogeneous. Virtually every week a new factor is identified to help predict which patients will have a superior chance of survival. Ruhee Chaudhry and colleagues provide another: whether the surgery is performed at a teaching or nonteaching institution.<sup>1</sup> Although this is an interesting factor to consider, their study is potentially damaging to community hospitals, particularly when the majority of breast cancer surgeries in Ontario are performed in nonteaching hospitals.

Tumour grading was not done in almost half of the cases in the community hospitals, whereas estrogen receptor status was not known in 21% of the teaching hospital cases. These differences in tumour characteristics, along with differences in Her-2/*neu* oncogene status, would likely account for the differences in

survival outcomes. The factors the authors suggested to try to explain the differences, including the use of multidisciplinary teams, closer follow-up and improved supportive care, are important in management, but they have never been shown to make any difference to survival.

## Robert E. Myers

Medical oncologist  
Credit Valley Hospital  
Mississauga, Ont.

## Reference

1. Chaudhry R, Goel V, Sawka C. Breast cancer survival by teaching status of the initial treating hospital. *CMAJ* 2001;164(2):183-8.

Ruhee Chaudhry and colleagues suggest that treatment at teaching hospitals rather than community hospitals may be advantageous for women with small breast tumours.<sup>1</sup> I suggest that the reason women treated at teaching centres live longer than those treated at community hospitals has more to do with differences in the patient populations than with differences in the quality of treatment at the 2 types of hospitals.

## T.J. Muckle

General pathologist  
Vineland, Ont.

## Reference

1. Chaudhry R, Goel V, Sawka C. Breast cancer survival by teaching status of the initial treating hospital. *CMAJ* 2001;164(2):183-8.

In many jurisdictions there is increasing pressure on oncology services to specialize. Ruhee Chaudhry and colleagues provide evidence that survival following breast cancer treatments is better when care is provided at teaching hospitals rather than at community hospitals.<sup>1</sup> This is not supported by Golledge and colleagues, who found that specialization of breast cancer treatments, not the teaching status of the treating institution, affected outcomes.<sup>2</sup> From 1990 to 1992, care of breast cancer patients in a community hospital in England was managed by all 5 local surgeons. From 1993 onward, care of breast cancer patients was concentrated in the hands of 2