Epistle

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Unless the rest of you are all saints, and I'm the only sinner here, then I suspect we've all got personal diagnostic blind spots. These are clinical situations in which we're weak, and which we make repeated errors. With luck, supportive colleagues – who thankfully do not have identical weaknesses – and with a focus on spotting the shortcoming, we can turn this into a strength. The better doctors I work with transform this into a shared learning experience; a registrar I did clinics with turned his anxiety about managing headaches into a powerful and lasting teaching session. Personally, I'm very bad at diagnosing atypical appendicitis, in ways that I cannot bring myself to write here. However, I don't believe I've missed a case in some time because of this heightened awareness. (Note to clinical colleagues: This would be a bad time to come forward and tell me about a couple of dozen cases…).

The teenage girl losing weight is probably, if not a diagnostic blind spot, then an area replete with error, and in which I struggle because of my internal biases which take me to an answer – sometimes the wrong one – a bit too quickly. With this priming, I suspect that you may read this month's Problem Solving in Clinical Practice by Michal Ajzensztejn with more than usual care (***see page 67***). I find these very valuable since, at the very least, they show me that the diagnostic blind alleys I venture down aren't unique.

It makes good sense to work out what you're bad at, and try either to get better at it, or stop doing it. Now, I don't want to get political, but whatever else you might think of ex US Secretary of Defense Donald Rumsfeld, I think he was unfairly maligned over the 2002 speech where he referred to "Known knowns (.....) Known unknowns (.....) and Unknown unknowns." It's a profoundly important concept. There are points at which you can appreciate the limits of your understanding, and then there are points at which even the extent of your ignorance is not clear. The boundary between the two states is not always entirely obvious; as an early boss of mine, Peter Daish, would quote with gleeful frequency, "Experience is just making the same mistakes with more confidence". So, it's helpful in that context to be given a helping hand with a condition which I should know something about, given the frequency with which I see it in the outpatient department. Anne Garden discusses vulvovaginitis (***see page 73***) which affirms that I seem to be mostly doing the right thing in this distressing condition.

Personal resuscitation plans are something which I would imagine that few of us feel we are doing very well at. In the complex and stressful area of life care in the child with disability, I find the fact that there isn't a clear, predictable trajectory one of the most challenging aspects. By this I mean that in some conditions, there comes a point where it is clearer and clearer that a child is going to die. But I'm sure most of us have sat with a family and said something along the lines of "I'm really worried that he won't last the night" – only to find oneself seeing the same child in clinic years hence. Toni Wolfe and colleagues describe some very good practice which they've developed, and include some vignettes which most of us would recognise – and hope to achieve some of their positive outcomes (***see page 42***). They provide, online, their proforma for you to adapt for local use.

So, I've mentioned what you know, and what you know you don't know, and how we ought perhaps to worry more about what we don't know we don't know. But how do we figure out, rapidly, if something important is wrong? There are lots of methods of assessing weaknesses in very complex situations, but here's one I've been thinking about a lot recently, which I call the Brown M&Ms method after a story I read about the rock band, Van Halen. During the early nineties, Van Halen gained a reputation for elaborate riders – the list of demands for backstage perks for the band before and after their set. Urban legend had it that Van Halen demanded a bowl of M&Ms, with all the brown ones removed. When the band arrived and discovered brown M&Ms mixed in with the rest they threw a rockstar hissy fit, sometimes causing significant amounts of damage. So far, so predictable – spoilt people behaving badly. However, there is a very interesting different interpretation. Years later the lead singer was questioned about this demand, and surprisingly he confirmed the story, but highlighted the underlying intent. Van Halen's tour had three times the gear of any comparable tour, and so required significant safety adaptations to the venues. The stages had to be up to taking the additional weight; the electricity supply had to be adapted to take their enormous amplifiers, and so on. The specification describing what the venue had to provide to ensure a safe concert ran to some hundreds of pages, and was too complex for any one person on the road crew to check in the turnaround time they had between arrival, practice and performance. So, they inserted the brown M&M rider deep inside the contract. The band would arrive to play a gig, and go straight backstage to look for the M&Ms. A bowl free of brown M&Ms meant they could relax. However, the presence of the banned brown M&Ms was an instant indicator that attention had not been paid to detail, which meant that they were at risk of falling through the stage, or shorting the electrics, or any one of a number of potentially disastrous outcomes. The true genius of this is on a number of levels – not the least being that, rather than cancelling for "Health and Safety" – the true reason – they could behave true to their advertised image and kick off like rockstars. Their image is only enhanced, in the eyes of the fans.

So, I finish with two questions. Firstly, what are your brown M&Ms? And secondly, is this the first time you've seen Donald Rumsfeld and Van Halen written about in the same piece?

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