Editorial

Do not let sleeping dogmas lie!

While most of our clinical choices are largely based on sound evidence, there is always the occasional decision we take that is based on what we have assumed to be right simply because we haven't seen it being done any other way. These decisions are based purely on the dogmas in our practice: ideas or beliefs accepted as authoritative – unquestioned, undisputed, and unchallenged. These dogmas could be based on anecdotal evidence, hearsay, words handed down by seniors during training, or simply in practice just because "everybody does it this way." Can cataract surgery be performed in the presence of a chalazion, even though we know that it is not an infective focus? Is there irrefutable Class I evidence that shows the benefit of stopping anticoagulants before cataract surgery? Can implants be placed after evisceration for panophthalmitis/endophthalmitis? Why is not simultaneous bilateral cataract surgery advised routinely?

Sir William Stewart Duke-Elder was a prolific author: he single-handedly wrote 7 volumes of Textbook of Ophthalmology and 15 volumes of System of Ophthalmology – books that ophthalmologists, the world over grew up on. Moreover, it is no coincidence that his name is mentioned in an editorial about scientific dogmas. He famously said once, "It can be well argued that while the results of a cataract extraction are usually so good and the use of contact lenses so safe and easy it is perhaps unwise to gamble on further surgical procedures like intraocular lens insertion."[1] This was his reaction because someone had managed to question the dogma of routinely leaving patients aphakic. And not just question it, but propose a radical answer too. Sir Harold Ridley's solution to aphakia was unique, path breaking, and more importantly, revolutionary, not merely evolutionary.[2]

However, let this not be an invitation to throw caution to the wind and start doing something unusual – simply in an attempt to be different, just for the sake of it. Let us not forget that as doctors, our first duty is "primum non nocera" – "First, do no harm." As long as patients' interests and ethics of research are upheld, it is acceptable to think out of the box and only with sound scientific backing, put those ideas into practice. While perhaps the average practicing ophthalmologist may not be able to partake in basic science research or large-scale clinical trials; keeping an open mind, updating one's knowledge, and auditing own surgical results – looking for means to improve – are all ways to constantly evolve and stay updated. Often at times, as teachers we instruct our students, "If you encounter an 'Old-timer' as your examiner in your viva-voce, make sure you include this in your answer…." My question is why be an "Old-timer?" Why cling on to outdated practices, old knowledge, and stagnate?

As doctors, we would do well to maintain a degree of cautious skepticism for both bold new fashions and received wisdom, whether generated by the world or by the self. They would do even better to question what they do and see such questioning as an asset.[3] On one hand, while it is extremely reassuring to stay in our comfort zones and continue doing what we have been doing, doing that is not going to give newer ideas to ophthalmology, reinvent science, or change the course of medicine. Our function in as doctors in society at large is no longer restricted to the traditional role of a "healer of the sick." The times have changed: The traditional medical model has evolved from being a provider-centric model that offered disease-oriented care to a patient-centered model that focuses mainly on the outcomes of importance for patients.[4] Moreover, this patient-centered medicine not only implies a paradigm shift in the relationship between doctors and patients, but also requires the development of patient-oriented research,[4] a research that can improve outcomes and reduce morbidity for patients, much like what Harold Ridley did.

The medical fraternity must learn how to ask questions systematically, how to find the answers in literature, how to critically appraise the literature, and how to eventually apply the results to practice.[3] Only when clinicians rise above the mundane, think out of the box, and come up with new ideas, will science progress. After all, nobody gets a Nobel Prize for maintaining status quo!

Hence, do not let sleeping dogmas lie, kick them and drive them out!

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