

Experts in uncertainty: Strengthening our core skills

Justin Coleman

First, a confession. I have always been a ‘less is more’ type of general practitioner (GP). I find my people clustering at the outer edges of conference trade floors (hypocritically ordering extra coffee shots) swapping stories of how we tamed an overly enthusiastic registrar or underwhelmed our avant-garde peers on social media.

My career span has seen snowballing diagnostic capability, proliferating treatment options and instantaneous health information. Concepts such as hand-pumping a sphygmomanometer and counting someone’s chromosomes made way for wearable continuous monitoring and whole-genome sequencing with artificial intelligence (AI) suggestions.

Yet early on, I recognised that the drive to do more is not always synonymous with better care. The article by Guppy et al suggests my patients have been all the safer for my hesitancy.¹ Ordering tests that do not – or at least should not – meaningfully alter management risks inadvertently taking patients down obscure (and expensive) rabbit holes. General practice is tortuous enough already.

The implication is not to retreat from diagnostic excellence, but to recalibrate when and why we test, and carefully select which patients will benefit from additional medication. A ‘less is more’ lens helps counter the truism that we health practitioners consistently overestimate the benefits of our interventions and underestimate their harms.²

If over-treatment is the problem child of modern medicine, then its parents are overtesting and overdiagnosis – the correct identification of abnormalities that

would not cause harm if left untreated.¹

This ‘over’ family thrives on the availability of more investigations of higher sensitivity, ever-widening disease definitions and the rise of set-and-forget medication lists that pay too little heed to the perils of polypharmacy.

‘Too much medicine’ is sometimes encouraged by patients, the media, subspecialist narratives and, of course, the medication and device industries. It is by no means peculiar to primary care, but GPs are exceptionally placed to help protect the community from it.

Its harms are real – not merely academic – and include direct harm to patients from unnecessary interventions, plus the cascade effect of tests and treatments begetting more of the same. The myriad opportunity costs suffered downstream might even stretch to include a GP staying back late to battle their overflowing inbox.

Central to the practice of ‘less’ is the skilful management of uncertainty. Doust et al reminds us that we do not require certainty to deliver safe, effective care; we need a nuanced appreciation of risk, experience in contextualising findings, and confidence in our clinical judgement.³ We are not called to be nihilistic – merely prudent.

Even where a diagnosis eludes us, we can be certain instead that we have followed a robust process (history, targeted examination, selective testing) to ensure the patient can safely make headway.

Empathetic communication and shared decision making are powerful safety nets that allow us to practice restraint without alienating the recipient. The relationship gives us permission to prioritise care that matters and avoid interventions that do not.

In the hands of skilled practitioners, restraint can itself be a substantive expression of care.

Author

Justin Coleman MBBS, MPH (Hons), FRACGP, General Practitioner, Inala Indigenous Health Service, Brisbane, Qld; Senior Medical Educator, The Royal Australian College of General Practitioners, Brisbane, Qld

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correspondence ajgp@racgp.org.au

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