

# New Challenges Facing the Doctor-Patient Relationship in the Next Millennium

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## THE ROLE OF MEDICINE

*“What greater value have doctors than to serve the needs of patients under their care?”* – Arthur S M Lim (1998)

The very core of Medicine can perhaps be encapsulated in the Doctor-Patient relationship. Despite centuries of human progress and change, this sacrosanct relationship can still be described as paternalistic, top-down or summed up by the common phrase ‘Doctor knows best’. In the days when doctors had few real tools to combat the scourges of disease and injury, it was perhaps truly best that the patient be reassured at the expense of full disclosure and choice. In these days of lamb cloning and limb replacement, that may not always be the case.

It is useful to remind ourselves of the role of medicine in society, especially when we have been accustomed to an exalted and respected position in virtually every society around the world. In the words of Dr Wilmot R Rasanayagam (1996), former President of the SMA, “... *We can argue that modern medical science is an indispensable adjunct for a comfortable life on this planet, but it is also obvious that it is not essential for the survival of the human race. Therefore no matter how spectacular our medical skills a balance between pride and humility should be the philosophy of the physician of today.*” Along the same lines, it is illuminating to reflect on the words of Florence Nightingale in her *Notes on Hospitals*: “*It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.*”

It is perhaps humbling to realise that while Medicine has been responsible for saving the lives of millions of people throughout the ages, the person who developed the sewage system has been responsible for preventing illness in probably billions of people. With all this in mind, it may be easier to keep in mind the words of psychologist Dorothy Rowe (Messon, 1992), “*Power ... is the right to have your definition of reality prevail over all other people’s definition of reality.... The most dangerous people in the world are those who believe that they know what is best for others.*”

## NEW CHALLENGES IN THE DOCTOR-PATIENT RELATIONSHIP

Doctors are guided by a plethora of ethics and oaths and declarations. Besides the Hippocratic Oath, Singapore Medical Council Oath, Declaration of Helsinki and many others, each hospital in Singapore has also set up its own ethics committee to resolve ethical conundrums. It is all rather confusing. Details often distract from the bigger picture and give us a myopic view on events. What is important is not to forget the four *prima facie* maxims (beneficence and non-maleficence; respect for autonomy; justice and professional competence) that are the cornerstones of medical ethical thinking and behaviour.

Of the four, the one that will bear watching in the next millennium will be Autonomy. Bearing in mind the distinction between the ideal autonomy of the healthy person and autonomy of choice of a sick patient as well as the difference between independence and autonomy, it is still useful to define autonomy as such:

*“The freedom to make realistic choices against a background of good physical and mental health and an awareness of the well-being that accompanies good health.”*

Modern medicine descends from a shamanistic healing tradition where the shaman holds not only the keys to health and life, but very often sickness and death. We have rejected this power the healing professional possesses and adamantly hold to the idea that we are masters of our fate, captains of our destiny. This change has resulted not only from the increasing dominance of democracy and individualism in our society, but from the fact that it is increasingly difficult for the doctor to say that he truly knows best.

We have come from an age of “mono-biotics” to a time when it becomes a Sisyphean task just to know the names of all the antibiotics in the market. Similarly, there are almost always alternative treatments for just about every medical condition. Doctors do not just have to contend with the science of medicine (which measures “best” treatment in terms of mortality, survival over standard times and complication rates), but with patients’ values that may be at divergence with their

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own. Controversies over the increasing popularity of alternative or complementary medicine and issues like euthanasia make it increasingly difficult for doctors to reassure patients by saying 'Doctor knows best'.

#### **PREPARATIONS FOR A NEW MILLENNIUM**

What can be done? It is illuminating to realise that 50 years ago, patients in America registered far higher satisfaction rates with their doctors than current generations despite the doctors then having few effective treatment regimens for many diseases (Little 1996). Perhaps this was because the doctors then were forced to emphasise the biohumane over the biopositivist in lieu of the scientific discoveries that the reductionistic paradigm of medicine had yet to yield. The critical account Dr Inglefinger (1980) wrote of his experience as a patient with fatal oesophageal cancer seems to concur with this view.

Psychologists Annie Mitchell and Maggie Cormack (1998) advocate the therapeutic power inherent in the doctor-patient relationship. It might not be far fetched to say that when facing a new millennium of uncertainties, an improved doctor-patient relationship with more trust and understanding on both sides (at least at the primary care level) would be a good thing. To accomplish this, all that may be required is for doctors to remember the simple C & C: Communication and Care.

#### **Communication in the Doctor-Patient Relationship**

*It is the province of knowledge to speak and it is the privilege of wisdom to listen.* – Oliver Wendell Holmes

Good communication with patients is often emphasised, and for good reason. Professor Anne Sefton (Miles, 1996) has shown that literature and language skills predict 'success' in the medical undergraduate course at the University of Sydney far better than the mathematics and science skills which earn the students' entry to the medical faculty.

Dr Gwee Ah Leng, a former specialist physician and later medical superintendent at SGH said there are four things a patient should know after seeing a doctor, "*What is wrong with him, what expectations he can have, who is the doctor responsible for him and what he has to do when he leaves*". It is frustratingly clear that disarmingly often patients do not know the name of the disease they have, much less its basic pathology and how it affects him. Patients often leave the hospital with a variety of medications but only a vague idea of how his illness will affect his life and how he should modify his life, or not, because of his illness. Sometimes patients do not even know the name of the consultant in charge of him. Communication in the local setting has room for improvement.

Why is this so? In the local context, three main points come to light. The "Kuhnian gap" refers to the increasing difficulty in communicating the latest advances till it reaches a point where only specialists can understand each other (e.g. string theory in quantum mechanics). This is especially true in Singapore where the majority of the population has had little education in basic biology or physiology and are still firmly rooted in lay theories of health and disease.

A more unique aspect of medical communication is the stochastic nature of its data and the inherent difficulties of communicating probabilities. The heart of the problem is that physicians are using objective *frequentist probabilities* (the frequency with which an event is likely to occur in a long run of trials) to tell patients about *subjective probability* (the degree of certainty with which a person believes a hypothesis to be true). The patient wants to know what will happen to him, but the physician can only tell him what is likely to happen to him. This persistent false assumption that medicine is deterministic rather than probabilistic is difficult to explain under the best of circumstances but is continually compounded by medicine as a profession. We emphasise science more than humane understanding. The empirical, positivist element in medicine has overwhelmed the humane, devaluing discourse and rendering language less important than objective measurements and structural appearances.

The last problem is a very local phenomenon. As a result of history and design, orthodox medicine in Singapore is taught in English, while the main language in use by the populace is Chinese or one of its dialects. The problem is compounded by the fact that we have a significant Malay and Indian population who also do not speak English fluently or at all. While local practitioners and medical undergraduates have risen admirably to the challenge, learning several languages during their education, the fact remains that many doctors cannot communicate well except in English. It has always struck me as odd that the university can make a rather abstract course like Human Resource Management compulsory for the medical cohort, yet have no formally structured medical language courses available even as elective modules!

What can be done about these challenges? It would be prudent to consider that together with the second and most important C: Care.

#### **Care in the Doctor-Patient Relationship**

*To cure sometimes, to relieve often, to comfort always.*

At my last visit to Borders, the bookshelves in the medical section were chock-full of volumes on herbal medicine, holistic medicine, massage medicine, aroma

medicine, traditional medicines etc. The only orthodox layperson medical book I could find was the Merck Manual for the Family. Perhaps it is time to take a step back from what doctors want for patients, and ask what patients want for themselves.

McIver (1993) summarised the core themes which seem to be of concern to patients whichever service they were using.

1. Effective treatment and care
2. Relationships with health care professionals based on good communication and being treated as a person
3. Good information to help allay anxiety
4. A feeling of control

Orthodox medicine excels in point 1, which is probably a reason for its dominance, but it does not perform so well with diseases that require what Needleman (1985) describes as patient "psychic power", where psychic power is the individual's personal ability to heal, based on his sense of meaning in life, motivation, determination and will-power. Such diseases are not exclusive to psychiatry. Chronic, incurable conditions like diabetes, asthma, rheumatoid arthritis and gout all require a great deal of compliance (and thus motivation) for control of complications. Although the patient has a disease (organic), in the initial phases he will not have an illness (a personal experience). However the treatment, from drugs to lifestyle modification, gives him a sickness (the social aspect of disease) which he will have to bear with for the rest of his life. Dealing with this requires reverent power (Strong and Claiborn, 1982), which is based on the relationship between the practitioner's personal resources and the patient's need to have someone with whom he can realistically compare himself and whose positive qualities he can aspire to and which to integrate into his own sense of self. It is easy to see that unless the doctor-patient relationship is good enough to offset giving the diseased patient a sickness, effective treatment will be difficult.

*"In the West there is loneliness, which I call the leprosy of the West. In many ways it is worse than our poor in Calcutta". - Mother Teresa*

It is apparent to most that almost nothing means anything if you don't have someone to share it with. Dr Patch Adams (1998) advocates that medicine should be a community effort but health is ultimately the individual's responsibility. What medicine can and should do is provide the therapeutic relationship that can aid healing and sustain health. To this end health practitioners need to treat the patient with truth and honesty and be real; patients need to feel

that the doctor is a real person with whom they can engage, someone who is at ease with his own personality but who does not impose or invade the patient with his own views or self-revelations.

Points 3 and 4 are closely linked with the autonomy maxim. It is in this respect that local practitioners have the most work to do. We are used to and expect to play a paternalistic role in the consultation. Many patients often expect the same and will usually be highly suspect of the doctor's abilities if he keeps asking what the patient thinks is wrong and what should be done. However, the future patient will be more educated, more affluent and far less willing to follow vague guidelines issued by his doctor. Instead the patient will want to know why he has the disease, why now and what he can do about it. Answering these questions will require not only the patient to understand what the doctor is telling him, but for the doctor to appreciate what the patient is saying about his ideas, concerns and expectations through his questions. It will not be easy.

## CONCLUSIONS

What can be done to tackle these challenges? The specific solutions are complex and beyond the scope of this discussion. But it would be fairly safe to say that the very first step would be for us as medical practitioners to acknowledge and understand the challenges facing us. To do this we must know our ethics. We must also know that every bioethical issue needs the individual doctor or the profession as a whole to make critical choices or recommendations. As Adam Smith (1930) believed, the make of the man is vital for his performance as a professional (doctor).

Some would advocate a greater emphasis on medical ethics in school. But just as a stream can never reach above its source, a person cannot be taught to be better than his nature allows him to be. Just as we acknowledge the importance of communication and its relation to an interest in literature, writing, reading and creativity, we must acknowledge that there will be people who will have no such aesthetic inclinations and yet be competent doctors. The most effective change might be to look at the type of doctors we are training for the new millennium. It may come to a time when a proven interest in the arts and literature will be just as important as scientific acumen in the selection of a doctor.

As Sir William Osler says in his essay *Books and Men*, "This high education so much needed today is not given in the school, is not to be bought in the market place, but is to be wrought out in each of us for himself; it is the silent influence of character on character".

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