The Doctor-Patient Relations & Art of Practice of Medicine

C. M. K. Reddy

Published online: 11 October 2011
© Association of Surgeons of India 2011

It is said that Medicine is a science of probabilities whereas the practice of medicine is more an art than science. It is certainly an art to tailor the therapy to suit a particular individual, to explain the therapeutic options, to guide them in choosing the best possible one, to make the treatment cost-effective, to communicate with an unsatisfied patient with empathy, to disclose the news of an incurable disease, to face the bereaved family with compassion, to filter the relevant information from the plethora of medical literature and above all, to make your actions objective, noncommercial and ethical.

Notwithstanding the rapid advances in medicine, patient dissatisfaction is also on the rise. Apart from genuine reasons, there is an opportunistic group that aims at reaping a fast buck by threatening the doctor. Yet another group tends to encash on the emotions of the bereaved, to extract

money from the hapless doctor, not to speak of legally ignorant doctors, getting into quicksand by doing unlawful things, as we see happening from time to time.

Insignificant incidents such as death of a critically ill or high risk patient following surgery or death of a severely dehydrated or septicemic patients, brought late to the hospital, despite adequate emergency treatment instituted without success, are blown out of proportion, politicized, the doctor threatened/manhandled/demoralized and the hospital ransacked.

Some of the pressure tactics adopted are to take the matter to streets, send frivolous notices and playing on the public sympathy. We heard about the doctor, who did laparoscopic appendectomy, was blamed for 'kidney theft' since subsequent USG revealed one kidney being absent. Fortunately, though late, the matter was settled when a CT scan identified a contracted kidney on the 'missing' side, but what about the reputation of the doctor, which was tarnished by then? Erroneous interpretation of the scans may be disastrous.

All of have the ironical experience in our practice, that even on occasions of death of a patient, the relatives leave the hospital grateful and satisfied, whereas on the other hand, sometimes patients who apparently got discharged 'improved', want to seek legal remedy, because they felt there was some deficiency of service, leading to suboptimal outcome. Obviously the key word is 'trust and satisfaction' rather than 'success' of therapy.

Wherever the doctor maintained 'transparency' in what was going on, kept the party constantly informed of the progress and plans, discussed the pros and cons of the therapeutic options, with their outcome probabilities, cost considerations, anticipated risks and involve them in 'decision making' to the extent practical, there was little scope for litigation. The medical team should constantly

C. M. K. Reddy (✉)
Apollo Hospitals & Halsted Surgical Clinic,
306, Poonamallee High Road,
Chennai 600 010, India
e-mail: profcmkr@yahoo.co.in

C. M. K. Reddy
Tamil Nadu Medical Practitioners' Association (TAMPA)
& Indian Chapter, Royal College of Surgeons,
Dublin, Ireland

C. M. K. Reddy
Stanley Medical College & Hospital Medical Director,
Sri Jayendra Saraswathi Institute of Medical Sciences,
Chennai, India

C. M. K. Reddy
Tamil Nadu Medical Council,
Chennai, India

C. M. K. Reddy
Legal Cell Association of Surgeons of India,
Bangalore, India

strive to eliminate gaps in communication, particularly in intensive care set up for the critically ill. The sensitive issues are preferably touched upon by the senior consultant, in whom the patient and the attendants would have maximum faith. The days are gone, when the doctor could ask the patient, in aggressive voice : “who is the doctor ? I know what I am doing”. Now you could expect a prompt reaction: “of course, I know you are the doctor, but you are operating on me and I need to know more about the options and your plans”.

Unfortunately the medical curriculum doesn't give due importance to this highly sensitive subject, though most of the heartburn and litigations stem from these areas and not so much for want of academic expertise or high-tech knowledge and skills. A study done by an American Psychologist, to identify the causes of litigations against medical profession, concluded that the main culprit was inadequate or inappropriate communication. In the Indian scenario, another factor may be added: a loose uncharitable remark made by a physician about the treatment given to the patient by another physician, the so-called, “one-up-manship”. This sets the chain reaction in motion and forms the starting point for mistrust and strained “doctor-patient relationship”. What was not realized by the second doctor at that point of time, he might be at the receiving end in an another case, in this free-for-all situation. Even if the patient was asking accusing questions about the previous physician, it's prudent to brush them aside by saying “he must have acted in the best judgment under the circumstances, let's not worry about it and concentrate of what had to be done now”.

However it requires profound commitment to ethics and etiquette, to restrain us from blaming others (To err is human and pass on the blame to others is more human). I remember a refreshing incident happened about 35 years ago, when I was a junior surgeon: I called a senior surgeon for a second opinion in a case of advanced carcinoma esophagus. The patient had symptoms for over 3 months and his physician was treating him as “acid-peptic disease”, till an endoscopy disclosed the diagnosis on the previous week. After he examined the patient, we both were discussing about the management in my chamber, when I made a remark: “it's a pity that his doctor didn't properly investigate him for several months”, indirectly casting aspersion on the previous physician. But my senior colleague took a different view and said: “in a case of esophageal carcinoma, it probably wouldn't have mattered anyway in terms of ultimate outlook”. His attitude of protecting the co-practitioner was an eye-opener to me, on that day.

Though all of us read the same books and pass the same examinations, why then one doctor becomes very popular and much sought-after, whereas most others remain average “run-of-the-mill” type of practitioners? Because, he had mastered the ART and developed astute communicative

skills to capture the minds of his clients. Often patients put some inconvenient questions such as, will I be alright after surgery? The question can be easily dispensed by saying nothing in the world is 100% safe, much less one could guarantee about a major operation, however we have to do it because the benefit of surgery is far greater than the anticipated risk (favorable risk/benefit ratio) if we don't do it.

Another question by an elderly patient before undergoing a major operation, “should I write a WILL on my properties before coming for surgery?” is rather tricky, because if you say “yes, it is a good idea”, in all probability he may not come for surgery and if you say “no - not necessary”, we are probably doing disservice to him, since no one could predict the ultimate outcome of any major operative procedure. We figured out an appropriate answer for it: “look, your operation is scheduled for next week, but where is the guarantee that you would be alive till then or I will be alive till then. Any day anything could happen, crossing the road, riding a car, train or a flight and many more and after all, surgery is only one event in life. So if there is a need for you to execute a WILL, please do it immediately, but not necessarily for the sake of the operation”. Ultimately you make him write a “will” but not frighten him more than warranted, about surgery.

One Forensic Professor always advised his students to be careful while issuing certificates but once committed, not to change the opinion and he recalled an anecdote: he was giving evidence in a case, where his opinion was different from that expressed in the Modi's Text book of Medical Jurisprudence. When the opposite lawyer pointed it out to him, implying the opinion given him was incorrect, the Professor said “what I said was my opinion and what was in the book was his opinion, the only difference between us was that that guy had time to write a book. You take whichever you want”.

If a patient has advanced (non-resectable) malignancy that couldn't be operated upon, a news which is likely to demoralize them, it is better to tell them that the disease didn't require surgery, rather than to say that the disease was too far advanced that surgery could not be done. During my training period in USA, I was assisting my Chief for a mastectomy for suspected malignancy. He first excised the mass, cut the specimen, got convinced that it was malignant and proceeded with mastectomy, but requested that the mass be sent for a frozen section examination. After 15 min, the pathology department called to confirm that it was a carcinoma, by which time, the removal of the breast was almost over. Then I asked my Chief “you had decided to proceed with mastectomy, then how the frozen section report after the operation was useful?” He said, “you know, when we go out and talk to her relatives, it's much better to say that I removed the breast because it was cancerous, rather than to say I removed the breast because I thought it was cancerous”.

Now the public has ready access to various media and the net, by which they are becoming increasingly aware of latest medical facts and developments and are in a position to put insinuating questions embarrassing a not-too-well informed physician. It is a pity that many of the doctors don't read medical journals, don't attend continuing medical education (CME) programs nor scientific meetings and only depend on lay press or medical representatives to update themselves. It is disheartening to know that despite the escalating number of legal proceedings against doctors, they don't want to take a cue from it and try to improve their efficiency by keeping abreast of medical developments or statutory implications.

Advertizing in any manner is clearly unethical and has been shown to have some short-lived commercial advantages, but more logistic and legal drawbacks in the long run. When the patients come to us with high expectations and if we don't exhibit those standards of care, they get quickly disappointed and disheartened. Promising guarantee of cure by any form of therapy (medical or surgical) is neither wise, realistic nor desirable. If any procedure has to be performed on a critically ill patient or if the outcome of the procedure is unpredictable, it is advisable to obtain a "high risk" consent drafted in the language, which the patient or attendant understands. Besides providing additional legal protection, this step also prepares their mind for an adverse outcome.

Extreme caution has to be exercised while obtaining an "informed consent". To decide how much information to be disclosed in a given circumstance requires shrewd judgment and recording "informed refusal" of an investigation or treatment is as important as the consent, in a legal context. However, neither of these confer immunity against suits of alleged professional negligence or incompetence, but administration of any treatment without them could be considered a criminal offence.

We should realize in this context that the medical science is developing faster than our laws can cope up, posing new

challenges. The problem in Developing Countries is going to be still worse and unless the state and the medical councils seriously apply their minds on issues such as regulating quality of medical education, minimum standards in hospitals, mushroom growth of pharma industry, unethical advertisements, dichotomy etc., the future of our 'noble' profession in this country is going to be at stake.

There can be several instances in our practice, where highly diplomatic communicative skills are called for but the most important ART we should possess is to preserve the nobility and maintain the dignity of our profession, so as to pass on a conducive, healthy environment of medical practice to our next generation, realizing the dreams of Hippocrates. To sensitize the young doctors towards trouble-free professional life, we have compiled "12 commandments" for healthy medical practice:

- 1) TIDY APPEARANCE & WARM RECEPTION
- 2) ENCOURAGE FREE COMMUNICATION & CLEAR ALL THEIR DOUBTS
- 3) EXPLAIN THERAPEUTIC OPTIONS & INVOLVE THEM IN DECISION-MAKING
- 4) OUTLINE THE RISKS INVOLVED, OBTAIN INFORMED CONSENT & NEVER GUARANTEE CURE
- 5) BE PUNCTUAL & AVAILABLE FOR EMERGENCIES
- 6) MAINTAIN PROPER RECORDS & PROMPT CORRESPONDENCE
- 7) BE CONSIDERATE, NON-COMMERCIAL & AVOID ADVERTIZING
- 8) READ LITERATURE, ATTEND CMEs & UPDATE YOURSELF
- 9) RESPECT CO-PRACTITIONERS & BE WILLING TO GET A SECOND OPINION
- 10) OBSERVE ETHICS, KNOW THE STATUTES WELL & ACT JUDICIOUSLY
- 11) INVOLVE IN COMMUNITY SERVICE ACTIVITIES
- 12) DON'T FORGET YOUR FAMILY & CHILDREN