Editorial

Credat Emptor – The Sacrosanct Doctor-Patient Relationship

C Rajasoorya, [1,2,3] *FAMS, FRCP(Edin), FRCP(Lond)*

Of late, holistic patient care and rising healthcare costs have entered the public discourse, leading to a call for judiciousness in healthcare utility and for more generalist doctors. An optimal doctor-patient relationship allows patients to believe that the doctors caring for them will work for their betterment with prudent utilisation of resources. Doctors are also held in high esteem and trust because of the public's perception that there is an intricate process of professional training, certification and on their need to abide by a strong regulatory and ethical framework. When this trust is eroded, a cascading detrimental effect occurs in both the doctors' practice and patients' care. This editorial is a personal viewpoint on the problems influencing the doctor-patient relationship, and explores ways of circumventing these.

Doctors—by nature of their profession—are influential in deciding what, when and how healthcare services are delivered. It is estimated that they influence or determine at least 60% of healthcare costs,[1] with wastage in the United States accounting 20% of healthcare costs.[2] The doctor's dictum—to "do no harm"—is perhaps a timely reminder on the need to avoid causing financial harm inadvertently to patients. There have even been calls to teach doctors healthcare economics.[3] Yet, doctors may not be fully cognisant of this responsibility and power within them, preferring instead to delegate the responsibility and culpability to politicians, legal professionals, administrators, insurance companies, drug and device manufacturers, hospitals and even patients.

Doctors embark on a career that begins on a broad-based footing with the patient (rather than the disease) as the centre of focus. The lack of sufficient time spent on talking to and clinically examining patients remains a concern in current day practice, despite this playing a key role in the cost-effective care of patients. The underappreciation of bedside clinical skills and the over-reliance on costly tests that are prevalent across the spectrum of the medical profession have been highlighted.[4] We need no reminding that a clinical evaluation is not just an exercise in diagnostic data gathering but remains the bedrock of a physician's art. The clinical encounter establishes a professional doctor-patient relationship that enhances trust and confidence. Inadequate communication and a hurried assessment due to insufficient time spent during the clinical consult can further erode the trust of the patient who may feel that assessment was cursory.

Subspecialisation—with its reductionist thinking of patients as a set of multiple organs—has contributed to the deterioration of the broad-based footing acquired during the formative years. Patients can be perceived as a constellation of diseased organs that transit an "assembly line" where duplications, omissions and wastages propagate inefficiency and result in fragmented care. Institutions and hospitals have attempted to circumvent this issue by borrowing and implementing concepts from the automotive, entertainment, hospitality, mega-stores and other industries of "lean thinking" to improve efficiency and accessibility. Others have suggested a more generalist care model that thwarts this fragmentation. Changing disease patterns, population demographics, medical knowledge democratisation, technological advances, and increased complexity of health problems have heightened the need for specialist care and need not create an antipathy towards specialist practice that has its proven medical benefits.[5] Optimal healthcare is not only facilitated by a balance between specialists and generalists but by the ability of both groups to interact well in patients' best interest.

Evidence-based medicine (EBM) enhances confidence in decision-making using a heirarchy of reseach evidence. Strangely, the premise that clinical research alone is insufficient to make a clinical decision has often been glossed over; ignoring the primary tenet of EBM where the personal and clinical context of the patient as well as the values and preferences of the informed patient must contribute to a decision. Concerns have also been raised on EBM when questionable practices like relying on corrupt

[1]Department of General Medicine, Sengkang General Hospital, Singapore
[2]Yong Loo Lin School of Medicine, National University of Singapore, Singapore
[3]Duke-NUS Medical School, Singapore
Address for Correspondence: Prof C Rajasoorya, Department of General Medicine, Sengkang General Hospital, 110 Sengkang East Way, Singapore 544866.
Email: c.rajasoorya@singhealth.com.sg

research evidence or falsified publication of data arise.[6] Individual patients differ, and to incorporate a patient into a specific protocol or pathway without due thought on his individuality or wishes is not only an aberration of good clinical practice but contributes to doctor-patient mistrust. End-of-life issues can be highly emotive and yielding to pressures of doing everything possible to increase quantitative life may occur at the expense of the wishes, quality of life and dignity of individual patients.

Doctors face a dilemma when they prescribe an intervention—even if they know it is ineffective—in order to appease the patient, to safeguard themselves from accusations of malpractice, or in the true belief that denying the patient such an option would be inappropriate.[7] The World Health Organization[8] has recommended good prescribing guidelines that include evaluation of the patient's problems, specification of the therapeutic objective, appropriate drug initiation, patient education and regular evaluation of therapy. Therapeutics is an important contributor to iatrogenic disease and the practice of deprescribing has been encouraged with mounting evidence on its efficacy.[9]

Patient care is often equated with "customer satisfaction" as an indicator of quality, with its roots in consumer marketing; hence the plethora of patient satisfaction surveys in institutions. Every patient is pleased with a doctor who understands his needs, and every doctor feels accomplished when his patient is satisfied with his care. This "satisfaction-quality" relationship, however, remains complex and has been debunked by 2 recent studies.[10,11] In part, the surprise findings has been explained by doctors' desire to satisfy patients by ordering more tests and inappropriately prescribing, yielding to patient demands (with the most demanding patients getting disproportionate care that works to their detriment). Therefore, we cannot be distracted by "customer satisfaction" as an indicator of the care we provide.

Patients benefit when inappropriate diagnostic procedures or treatments are avoided. Yielding to pressures to overtest, overdiagnose and overtreat puts doctors in a vulnerable position where they can be said to be prioritising their interests rather than the patient's. We have gradually descended into an era of intolerance for uncertainty and risk averseness (in part due to increased patient expectations and the fear of medico-legal consequences) thus enabling the practice of "defensive medicine". This has allowed our practice to over-react and for us to forget our responsibilities in protecting the safety of patients and our moral responsibility to prevent wastage of finite resources. Patients cannot in the medical professional eyes be treated like "customers" who pay, demand and get what they want. This, however, in no way, negates the doctor's need to listen to the patient's perspective. As doctors, it is good to remind ourselves that patients and their relatives are often in an extremely vulnerable position during illness and rely heavily on the managing physician, likened to entrapment in a hostage bargaining syndrome.[12] The key lies in being open minded, listening to their concerns, avoiding judgement based on our biases, educating the patient and not succumbing to threats. The Choosing Wisely campaign[13] has reinforced in us the need to stimulate conversations between doctors and patients about unnecessary tests, treatment and procedures.

A substantial proportion of lawsuits regarding malpractice arise due to poor communication and poor doctor-patient relationships[14-16] adding credence to the perception that the medical professional's best defence against being brought to court is probably not to lose the trust of his or her patient or relatives. Trust is established with good two-way communication.

An authentic and ethical doctor-patient relationship is indeed very sacrosanct allowing for a privileged licence given to the medical profession where the patient reposes trust and confidence in a practitioner to cure, protect against or palliate illness. In no other profession, can one be so advantaged to get an individual's consent to expose, look, feel, touch, move, listen and sometimes even invade their privacy. A collection of organs or systems do not entirely make a patient. The patient has feelings, wishes, desires, hope and sometimes, ambivalence or defiance. Yet evidence[17,18] suggests that doctors today often remain distant, technical, organ-focused and technology-oriented in their encounters. Healthcare organisations increasingly refer to patients as "customers", thus eroding the primary tenet of medicine that wrongfully prioritises the doctors' interest to monetary considerations and commercial interests, while dehumanising a medical issue and taking advantage of patients' vulnerabilities.

Medicine should remain a profession and not a business. As endorsed by American sociologist Everett Hughes,[19] professions should go by the motto of *credat emptor* (let the buyer believe or have trust) instead of *caveat emptor* (let the buyer beware). This has also recently been echoed by our Chief Justice who aptly highlighted that the medical profession should strive "to be worthy of the trust reposed in it by the members of the public, which have entrusted to the profession some of the most important aspects of their lives".[20] We do have a responsibility to prevent the perpetuation of mistrust, that drives our patients not to listen to us (and vice versa). In the quest for quality care and to help the healthcare conundrum, it is prudent that we, as guardians of our resources, make a concerted effort to preserve the sacrosanct doctor-patient relationship and neither abuse our patients' trust nor the public's trust in our profession.

Incorporating clinical reasoning that includes critical thinking (metacognition), clinical and communication skills,

shared decision-making, appropriate use and interpretation of diagnostic tests and understanding cognitive biases, human factors and cultural sensitivities can only enhance the trust factor in a doctor-patient relationship—a very sacrosanct relationship that cannot be allowed to be eroded.

REFERENCES

1. Agrawal S, Taitsman J, Cassel C. Educating physicians about responsible management of finite resources. JAMA 2013;309;1115-6.
2. Berwick DM, Hackbarth AD. Eliminating waste in US health care. JAMA 2012;307:1513-6.
3. Donaldson C, Bates A. Teach doctors economics, not management fads. BMJ 2010;340:657.
4. Elder A, Chi J, Ozdalga E, Kugler J, Verghese A. The road back to the bedside. JAMA 2013;310:799-800.
5. Britnell M. The role of the 'specialist' in healthcare. Clin Med 2011;11:329-31.
6. Montori V, Guyatt GH. Corruption of the evidence as threat and opportunity for evidence-based medicine. Harvard Health Policy Rev 8;2007:145-55.
7. Fuchs VR. The doctor's dilemma – what is "appropriate" care? N Engl J Med 2011;365:585-7.
8. de Vries TP, Henning RH, Hogerzeil HV, Fresle DA. Guide to good prescribing. A practical manual. World Health Organization Action Programme on Essential Drugs. Available at: http://apps.who.int/medicinedocs/pdf/whozip23e/whozip23e.pdf. Accessed on 15 May 2018.
9. Scott IA, Hilmer SN, Reeve E, Potter K, Le Couteur D, Rigby D, et al. Reducing inappropriate polypharmacy. The process of deprescribing. JAMA Intern Med 2015;175:827-34.
10. Chang JT, Hays RD, Shekelle PG, MacLean CH, Solomon DH, Reuben DB, et al. Patients' global ratings of their health care are not associated with the technical quality of their care. Ann Intern Med 2006;144:665-72.
11. Coulter A. Patient engagement – what works? J Ambul Care Manage 2012;35:80-9.
12. Berry LL, Danaher TS, Beckham D, Awdish R, Mate K. When patients and their families feel like hostages to health care. Mayo Clin Proc 2017;92:1373-81.
13. Levinson W, Born K, Wolfson D. Choosing Wisely campaigns. A work in progress. JAMA 2018;319:1975-6.
14. Hickson GB, Clayton EW, Githens PB, Sloan FA. Factors that prompted families to file medical malpractice claims following perinatal injuries. JAMA 1992;267:1359-63.
15. Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. Lancet 1994;343:1609-13.
16. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor patient relationship and malpractice. Lessons from plaintiff depositions. Arch Intern Med 1994;154:1365-70.
17. Weiner SJ, Schwartz A, Weaver F, Goldberg J, Yudkowsky R, Sharma G, et al. Contextual errors in individualizing patient care: a multicenter study. Ann Intern Med 2010;153:69-75.
18. Levinson W, Gorawara-Bhat R, Lamb J. A study of patient clues and physician responses in primary care and surgical settings. JAMA 2000;284:1021-7.
19. Hughes EC. Professions. Daedalus (Fall) 1963;92:655-68.
20. Menon S. Medicine and law: comparative perspectives on professional conduct and discipline. Available at: http://www.annals.edu.sg/PDF/SundareshMenon/LectureCJMarch2018_2.pdf. Accessed on 15 May 2018.